Imperial College Healthcare NHS
NHS Trust

TRUST BOARD AGENDA – PUBLIC

Oak Suite, W12 Conference Centre, Hammersmith Hospital
23 May 2018
11:00-13:00

		Presenter	Timing	
1	**Administrative Matters**			
1.1	Chairman's opening remarks and apologies	Chairman	11.00	Oral
1.2	Board member's declarations of interests	Chairman		Oral
1.3	Minutes of the meeting held on 28 March 2018	Chairman		1
1.4	Record of items discussed at Part II of board meeting held on 28 March 2018	Chairman		2
1.5	Action log and matters arising	Chairman		3
2	**Operational items**			
2.1	Patient story	Director of nursing	11:05	4
2.2	Chief Executive Officer's report	Chief executive officer		5
2.3	Integrated performance report	Safe/effective: Medical director Caring: Director of nursing Well-led: Director of P&OD Responsive: DD Medicine & Int care DD surgery, cancer & CV DD Women's, chil'n & CS		6
2.4	Finance report	Chief finance officer		7
3	**Items for decision or approval**			
3.1	Final quality account	Medical director	12:00	8
3.2	NHSI self-certification declarations	Trust company secretary		9
4	**Items for discussion**			
4.1	Infection prevention and control quarterly report	Director of infection prevention and control	12:15	10
4.2	CQC update	Director of nursing		11
5	**Items for information**			
5.1	Board assurance framework	Trust company secretary	12:30	12
5.2	Trust seal annual report	Trust company secretary		13
5.3	Board self-assessment of effectiveness	Trust company secretary		14
6	**Board committee reports**			
6.1	Quality Committee	Committee chair		15
6.2	Finance & Investment Committee	Committee chair		16
6.3	Redevelopment Committee	Committee chair		17
6.4	Audit, Risk & Governance Committee	Committee chair		18
6.5	Remuneration Committee	Committee chair		19
7	**Any other business**			
8	**Questions from the Public relating to agenda items**			
9	**Date of next meeting**			
	Trust board: Wednesday 25 July 2018 10:00-14:30, New Boardroom, Charing Cross Hospital			

Imperial College Healthcare NHS Trust

MINUTES OF THE TRUST BOARD MEETING IN PUBLIC

Wednesday 28 March 2018
11.00 – 13.00
Clarence Wing Boardroom, St Mary's Hospital

Present:	
Sir Richard Sykes	Chairman
Sir Gerry Acher	Deputy chairman
Sarika Patel	Non-executive director
Prof Andy Bush	Non-executive director
Victoria Russell	Non-executive director
Prof Julian Redhead	Interim chief executive
Prof Janice Sigsworth	Director of nursing
Richard Alexander	Chief financial officer
Dr Bill Oldfield	Medical director
Prof Tim Orchard	Medical director & divisional director, medicine & IC
In attendance:	
Michelle Dixon	Director of communications
Kevin Jarrold	Chief information officer
David Wells	Director of people and organisational development
Dr Katie Urch	Divisional director, surgery, cancer & CV
Prof TG Teoh	Divisional director, women's, children's and clinical support
Prof Jonathan Weber	Dean Imperial College Medical School
Dr Eimear Brannigan	Infection control consultant
Jan Aps	Trust company secretary (minutes)

1	**Administrative Matters**	**Action**
1.1	**Chairman's opening remarks and apologies** Sir Richard Sykes welcomed all members and attendees to the meeting. Apologies had been received from Dr Andreas Raffel, Peter Goldsbrough, and Nick Ross.	
1.2	**Board member's declarations of interests** There were no additional declarations of interest made at the meeting.	
1.3	**Minutes of the meeting held on 31 January 2018** The minutes of the previous meeting were accepted as an accurate record.	
1.4	**Record of items discussed at Part II of board meeting held on 31 January and 28 February 2018** The Trust board noted the report.	
1.5	**Action Log and matters arising** The Trust board noted the updates provided.	
2	**Operational items**	
2.1	**Patient story** Prof Janice Sigsworth introduced Mrs ID, who outlined her experiences of admission for an elective procedure at Charing Cross Hospital. Travelling on a very snowy day, she had left early, and becoming anxious and concerned about being late, rang in a couple of times to confirm arrival time. Each time she was put through to a different ward /department and had not been reassured by the calls. Shortly after arrival at	

	08.30, Mrs ID was informed by a consultant there was severe pressure on beds, and her procedure may have to be delayed, creating further concern as to how she would be able to return home. After three hours on a hard chair, pre-operative tests were undertaken, and she continued to wait. At approximately 14.30 she was taken to theatre, her personal effects were to be taken to the ward to which she had been informed she would return. Further delays occurred following the procedure, with poor arrangements in place to ensure the patient's comfort, including, on being taken to the ward at 17.30, no food or drink being provided, although promised. Mrs ID eventually made her own tea having found the ward kitchen, and found a couple of biscuits. Her personal effects were nowhere to be found, even after a thorough search and Mrs ID eventually left the hospital at 21.30, exhausted, to be driven home still in a hospital gown and blankets; parting advice was to return the next day by which time her bag would have been found. Mrs ID was at pains to mention that throughout, staff were lovely and caring, but the processes surrounding her care would benefit from significant improvement. On contacting the Trust, Steph Harrison-White had responded to her concerns. Dr Katie Urch thanked Mrs ID for having made contact; it had given real impetus to plans awaiting implementation to address a poor situation, whereby patients went to theatre from one location but returned to another, neither of which were appropriate accommodation. Having been able to describe Mrs ID's experiences had personalised the situation, and meant staff focused on implementing a much improved situation; patients now left and returned to the same environment, designed specifically for their needs. Dr Urch also apologised that she had been asked to return to the hospital to collect her belongings, this should have been couriered directly to her at home. Prof Sigsworth also commented that 'nil by mouth' timings, especially for the day case pathway. Michelle Dixon also noted that the Lay Forum were reviewing pathways from the patient's viewpoint to identify further opportunities for improvement. Sir Richard Sykes extended the Trust board's apologies to Mrs ID for her experience, and thanks for being willing to share this. The Trust board noted the patient story.	
2.2	**Chief Executive's report** Prof Julian Redhead particularly: • Reflected on the financial position as year-end approached, and reported that Month 11 had seen a deficit of £1.7m (before sustainability and transformation funding, and winter funding), and the year to date position was also £1.7m adverse to plan; focus remained on achieving the control total set at the beginning of the year. • Reported that financial planning for 2018/19 was well-advanced; it would be another very challenging year. • Extended thanks to all staff that had worked endlessly over the winter to keep patients safe under very difficult circumstances, although noting that it had not been possible to achieve the A&E four-hour and elective procedures targets. • Welcomed the planning approval and completion of the outline business case for St Mary's Phase I (Triangle building), which would see the consolidation of many outpatient services into a purpose-built environment and enable the move of services from the Western Eye Hospital. • Reported the change of responsible officer (required under the Medical Profession Regulations 2010) from himself to Prof Tim Orchard and Dr Bill Oldfield who had completed the required training. The Trust board noted the report; and supported the appointment of Prof Orchard as Responsible Officer, and Dr Oldfield as the deputy responsible officer.	
2.3	**Integrated performance report** SAFE and EFFECTIVE: Dr Bill Oldfield reported a total of 9 serious incidents in	

	February (against 19 in January), with one extreme harm incident and no severe or major harm, and no never events since July 2017; the Trust remained a high incident reporter with low harm (in the top 25 per cent nationally). He also highlighted that: more than 95 per cent of inpatients had received a VTE risk assessment within 24 hours of admission; the Trust had engaged in 43 of the 44 available national audits; and that mortality rates remained very good. Responding to a query from Sarika Patel, Dr Oldfield acknowledged that recognising what the Trust 'norm' for serious incident (SI) reporting would be difficult. This was an areas where benchmarking was complicated by different approaches; the Trust chose to report a number of issues as SIs (including mental health delays in A&E) which other trusts may not, but the focus tended to support improvement. CARING: Prof Sigsworth reported that pressure ulcers (bed sores) had seen a 60 per cent reduction over the previous couple of years, and now mainly only occurred in intensive care, where patients may have severely reduced circulation or it may be dangerous to move them – even here, focus would continue to ensure further reduction. She also highlighted that nurse staffing levels were being maintained effectively, noting that further indicators for daily review at the site meeting had been introduced, and confirmed that patient bed numbers were closed if necessary to ensure safety and quality of care. Turning to the friends and family recommendations, Prof Sigsworth noted that most patients continued to demonstrate a willingness to recommend, with the outpatient department achieving its highest score to date, reflecting the impact of the improvement programme, and an improvement in the number of patients providing feedback for the A&E departments. A slight increase in the number of complaints received reflected a higher level of cancellation of patients with elective procedures as a result of the extreme winter pressure, but responses continued to be timely and well-received. WELL-LED: David Wells reported an increasingly positive picture. He highlighted that: overall headcount had grown by 6 per cent in a year, nursing and midwifery shifts continued to have a good fill-rate; turnover was at a good level; and sickness rates remained low. While he noted that compliance with core skills training was improving, he recognised that there was lots of work underway to review and improve how this was addressed. RESPONSIVE: Prof Tim Orchard commented that the A&E's success in ensuring patients did not wait in ambulances, at times, meant the departments attracted even more ambulances. He noted that there had been a significant increase in elderly trauma patients, and, once stabilised, it was sometimes difficult to move these patients to more local hospitals. Patients with a length of stay in excess of six days met a national definition as 'stranded patients'; nationally this figure was approximately 45 per cent, while at the Trust this was 33 per cent of patients, although he noted that patient length of stay in acute medicine had slightly increased during the previous year. Prof Orchard also reported on a recent visit from the National director for emergency care, where a number of helpful observations had been provided. He extended thanks to the team for having continued to provide safe care in constrained and difficult environment over a very busy winter period. Responding to a query from Sir Richard Sykes, Prof Orchard reported that the ambulance service had an intelligent conveyancing system, but that this is being reviewed at a London level, as the thresholds did not appear appropriate; he also noted that staffing was flexed across the week to increase resource at the times which normally experienced the greatest pressure. Dr Katie Urch reported that the Trust was currently treating approximately 82% of elective patients within the target of 18 weeks; she extended thanks to patients who had shown support during a period when an increase in undertaking day-case procedures had seen some patients called in at short notice. Noting that March had been more operationally challenged than expected, Dr Urch confirmed that this had reduced the number of patients with particularly long waits that it had been possible to treat, but that the target was still to have no patients waiting in excess of 52 weeks	

	by the end of July. All cancer targets had been achieved, and Dr Urch was pleased to note that even with the recent pressures only two cancer patients had their procedure cancelled and both had been treated within a week of their original date. Turning to theatre efficiency, Dr Urch reported theatre efficiency at 73 per cent, the reduction in efficiency over the winter period reflecting a lack of beds for elective procedures; working with external support from Foureyes, the Trust was focused on scheduling and turn around in theatres, and expected to see good improvement over the coming months. Prof TG Teoh reported that the Trust had achieved its target of having less than 1 per cent of patients waiting over six weeks for a diagnostic procedure, reflecting a good improvement in waits for an endoscopy. For the second month, less than 11 per cent of patients had not attended outpatient appointments, and this was expected to continue; while hospital cancellations looked high, this was partially as a result of bringing patient appointments forward. The Trust board noted the integrated performance report.	
2.4	**Month 11 Finance report** Noting that Prof Redhead had covered the headlines in his briefing, Richard Alexander commented that the Trust remained focused on achieving its year-end planned position; further information was available in the report. The Trust board noted the report.	
3	**Items for decision or approval**	
3.1	**Quality account indicators** Dr Bill Oldfield introduced the paper which updated the Trust board as to progress made in the development of a new quality strategy, provided information on the quality account due to be published at the end of June 2018, and outlined the proposed quality indicators for 2018/19. The new strategy is taking into account the findings of the recent CQC inspections reports and be brought in line with the CQC domain descriptions, and will not be ready to include in the 2017/18 quality account. The Trust board supported the approach being taken, and the proposed indicators as outlined.	
3.2	**Gender pay gap report 2017/18** David Wells reported that, as of 31 March 2018, all organisations employing a minimum of 250 staff were required to publish a series of indicators which provided a broad measure of the difference in the average earnings of men and women, regardless of the nature of their work. On any measure of the average, overall there were a higher proportion of male employees in the upper pay quartiles, and there was a significant difference in clinical excellence awards awarded to male consultants rather than female consultants. David Wells noted that this was a sensitive issue, but the Trust would seek to understand and address the drivers behind the differentials. Prof Andy Bush commented that this was of concern, and the Trust would need to be sure that local awards were being appropriately awarded. The Trust board approved the publication of the report on the Trust website, supported the data being incorporated into the annual quality and diversity report, and sought assurance that any issues identified were addressed robustly.	**DW**
3.3	**Corporate risk register and risk appetite framework and statements** Prof Janice Sigsworth highlighted key changes since the previous Trust board review (November 2017). Overall, the themes in the register included workforce, operational performance, financial sustainability, clinical site strategy, regulation and compliance, estates critical equipment and facilities, delivery of care, cyber security, data quality, data quality, medicines management and statutory and mandatory training. Recent additions focused on issues identified in the CQC inspections, improvement in these areas would be given focus at the executive and quality committees. The target date for the risk relating to cleaning standards had been extended as improvement had not progressed as hoped, particularly in public areas	

	including toilet facilities; additional measures were being implemented to add this. Introducing the proposed risk appetite framework and statements, Prof Sigsworth noted that an early version had been discussed at the Board seminar in December, and also with the leadership team; where possible feedback had been incorporated, and, once approved by the Trust board, the aim would be to share with staff at all levels, and for the document to help staff when balancing competing priorities in decision–making. Sir Gerry Acher, noting that the paper had been discussed at the audit, risk and governance committee, reported that the external auditors felt that the work reflected a mature attitude to risk, and was among the best they had seen in NHS. Welcoming this, Prof Sigsworth recognised there was further work to do on the controls and assurances ascribed to a number of the corporate risks, and confirmed that responsible executive would ensure this was completed. The Trust board noted the corporate risk register and approved the proposed risk appetite framework and statements.	
4	**Items for discussion**	
4.1	**Learning from deaths: update on the implementation and reporting of data** Dr Bill Oldfield introduced the paper which provided an update on the Trust's implementation of recommendations of the CQC *learning, candour and accountability review.* Each patient death in the Trust now potentially underwent a review to understand if there were any lessons to learn; and all patient deaths were reported including any identified as having been deemed to be avoidable. Whilst still a new process, good progress was being made, with 27 investigators now trained, and further numbers being sought, to enable a fully multi-disciplinary team approach. Although national guidance was still awaited on how most appropriately to engage patients and relatives in this, the Trust was developing its own approach into the bereavement information provided. Responding to a query from Sarika Patel about the use of reflective practice, Dr Oldfield confirmed that all junior doctors had been contacted with guidance as to how to record their reflections following the recent media interest in this; he also commented that the learning from death system provided a clear, standardised approach which would be helpful to both individual practice and learning. The Trust board noted the paper, and welcomed the progress made towards full implementation of the *learning from deaths* framework.	
4.2	**Infection prevention and control – quarterly report** Dr Eimear Brannigan introduced the quarterly report, particularly highlighting: that there had been no cases of Trust-attributed MRSA during October to December 2017, and only one Trust-attributed case of C difficile (the Trust remained below its threshold); an 8.4 per cent reduction in antibiotic usage between 2016/17 and 2017/18; and proposed changes to the way that hand hygiene compliance was monitored to ensure a more robust approach. She also reported some concern resulting from the *Get it right first time (*GIRFT) audit which had identified higher than expected vascular surgical site infection rates; this was being investigated and actions would be implemented to improve. Dr Brannigan reported that the Trust was preparing to report Gram-negative bloodstream infection (BSI) from April 2018 (the government's target was to halve incidence by 2021). She also noted that the Trust was taking a keen interest in Carbapenemase-producing Enterobacteriaceae (CPE) and ensuring appropriate admission screening; only one or two patients, those exhibiting clinical symptoms were being treated. Public Health England had been engaging with the Trust in this work. Dr Brannigan also noted that international antibiotic shortages had, on two occasions, required changes to treatment protocols. The Trust board noted the report and extended thanks to the IPC and operational teams for the successes in preventing and controlling infection across the Trust.	

4.3	**Staff survey results** David Wells introduced the paper, and was pleased to report that the Trust had seen its overall score in the National Staff Survey rise for a second year from 3.80 (average) to 3.84 in 2016 (above average) in 2017. He noted that this was against a national overall decline in engagement scores for acute trusts (average of 3.79). The staff friends and family test scores had also improved, and Trust's scores were again above average for acute trusts. David Wells acknowledged that the survey was only sent to 10 per cent of the staff population; the more focused local survey, conducted twice a year, covered a higher percentage. There were results which demonstrated a clear need for focus - discrimination and bullying; the Trust was concerned about this and was trying hard to address. Sarika Patel expressed concern that bullying had regularly been reported as an issue, and asked that a detailed action plan be presented to the Trust board at a future meeting. The Trust board welcomed the improvements reported and sought further detail as to how the Trust would tackle discrimination and bullying.	**DW**
4.4	**Healthwatch central west London report on Charing Cross Hospital** Michelle Dixon introduced Olivia Clymer, CEO of Healthwatch central west London, who presented the report, which had been published in February 2018, noting Healthwatch's statutory role. Key positive feedback had been that patients had expressed themselves to be extremely satisfied overall with their experience, especially in terms of satisfaction of treatment and staff communication; also patients valued the hospital for its role in the community. Olivia Clymer reported that patients wanted more opportunities to be involved in shaping the future of the hospital, and were confused as to the definition of a 'local hospital' and sought more information. She recognised that the issue of the services that would be part of the hospital was also the responsibility of the CCGs and this was also being discussed with them. Responding to a query from Sir Gerry Acher, Olivia Clymer confirmed that, as an independent organisation, Healthwatch provided an objective view, and would seek to provide the Trust with any intelligence it received. Michelle Dixon reflected that the Strategic Lay Forum was keen to ensure that more patients and public were involved in shaping the Trust's services, and this was an area of focus for the future. The Trust board welcomed the helpful report from Healthwatch.	
4.5	**CQC update** Prof Sigsworth reported on the overall changes to the Trust's rating following a number of cores services and a 'well-led' inspection in the previous 12 months. With an overall 'requires improvement' rating for the Trust and each of the three main hospital sites, a total of 20 'tiles' demonstrated improvement, 9 'tiles' had worsened, and 38 remained the same. The Trust is clear where further improvement is needed, particularly in the 'safe' and 'responsive' domains; it was disappointing to have been rated 'requires improvement' for the well-led review. Much of the Trust's activity will focus on working across the Trust with new learning and vigour to deliver improvement for patients which will be reflected in future inspections. Responding to a query from Sarika Patel, Prof confirmed that a future seminar would be focused on further discussion on this subject; she also confirmed that the Trust had a self-assessment framework which was reported to the executive and quality committee. Trust board noted the report and welcomed the focus on further improvement.	**JS/JA**
4.6	**Cost improvement plans; quality impact assessment** Prof Sigsworth reported on the quality impacts assessments undertaken since the previous report in November 2017; all QIAs had been approved. Alongside the reviewing new plans, post implementation evaluations were undertaken on 17 previous plans; all were found to have improved quality and that the original QIA risk had reduced. In one case, that of a pharmacy post held vacant, the decision had been taken to fill the post to support addressing concerns identified by CQC during	

	their inspection. Moving to email and text communication had progressed well, as had tendering for an ophthalmology service which delivered an improved service delivered closer to home. The Trust board welcomed the assurance provided in relation to the cost improvement plans.	
5	**For information**	
5.1	There were no items for information.	
6	**Committee reports**	
6.1-6.5	The Trust board noted the reports from the following committees: • Finance & investment committee • Quality committee: Prof Bush welcomed the rapid response to fire safety concerns at Western Eye Hospital. • Redevelopment committee • Audit, risk and governance committee: Sir Gerry Acher noted that PwC had made a good early contribution, that NWL Pathology governance and a deep dive into cleaning standards would be presented in July • Hammersmith & Fulham integrated care board: Prof Orchard noted the first meeting of the board held as a formal committee of the Trust board.	
7	**Any other business**	
	Sir Richard Sykes noted that the meeting would be Jan Aps's last as Trust Company Secretary. He extended the Trust board's thanks and appreciation for her contribution over the previous three years.	
8	**Questions from the public relating to agenda items**	
	The following responses were given in response to questions: • The Trust continued to work closely with the CCG contractor, Vocare, in the delivery of effective services; it was hoped that new ownership may help improve services. • The Trust would seek to improve the diversity position vis a vis the consultant body. • The financial deficits reported in the Health Service Journal were stated without the impact of sustainability and transformation funding (STF). HSJ say that Imperial saying will be in deficit - how are we getting away with it. • Any move of services from the Western Eye Hospital was dependant on funding becoming available; the Trust sought such funding and would need to start building within three years to comply with the planning permission. • The redevelopment of the emergency department at Charing Cross Hospital had commenced, and fracture clinic, urgent care centre and major were expected to be completed by November 2018; there would then be a pause over the winter, and the resuscitation department would be completed by the following autumn. • Prof Sigsworth would take the details of the patient who had offered to share her story with the Trust board. • CQC had been provided with a list of all public Trust board dates, and had an open invitation to attend • The Trust, as an NHS trust would not invest its funds elsewhere. The Imperial Health Charity was an independent body, and any questions as to their investment portfolio would need to be directed to them; Michelle Dixon would provide contact details, and further information as to the role of trustees on their board.	
	Date of next meeting	
	Public Trust board: 28 March 2018, Clarence Wing Boardroom, St Mary's Hospital	

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	23 May 2018

Record of items discussed at the confidential Trust board meetings on 28 March 2018 and 26 April

Executive summary:

Decisions taken, and key briefings, during the confidential sessions of a Trust board are reported (where appropriate) at the next Trust board held in public.

March 2018

At the meeting held on 28 March 2018, the Trust Board considered:

Business planning 2018/19 – the Trust Board considered the draft business plan for 2018/19, and agreed that it would be presented to the next Board meeting for approval.

Charing Cross Hospital emergency department business case – The Trust board approved the business case to redevelop the Charing Cross Hospital emergency department, to accommodate the increase in attendances being experienced and further growth expected in future years.

St Mary's Hospital strategic vision planning document – The Trust Board considered an options appraisal for addressing the particularly poor state of repair and significant backlog maintenance liability at the St Mary's site, and approved the submission of the St Mary's strategic vision document to NHS Improvement for consideration as part of the broader redevelopment priorities of the NHS.

Updates on the Charing Cross Hospital emergency department development is included in the Chief Executive's report being presented at this meeting.

April 2018

At the meeting held on 26 April 2018, the Trust Board considered and approved the business plan for 2018/19.

Recommendation to the Trust board:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

To realise the organisation's potential through excellence leadership, efficient use of resources, and effective governance.

Author	Responsible executive director
Jan Aps, Trust company secretary	Prof Julian Redhead, Interim chief executive officer

Imperial College Healthcare NHS Trust

TRUST BOARD MEETING IN PUBLIC

ACTION LOG

Action	Meeting date & minute number	Responsible	Status update
The Trust board approved the publication of the gender pay gap report on the Trust website, supported the data being incorporated into the annual quality and diversity report, and sought assurance that any issues identified were addressed robustly.	March 2018, 3.2	Director of P&OD	In progress
Staff survey results The Trust board welcomed the improvements reported in the staff survey results and sought further detail as to how the Trust would tackle discrimination and bullying.	March 2018, 4.3	Director of P&OD	In progress

MATTERS ARISING

Minute Number	Action /issue	Responsible	Update

FORWARD PLAN AGENDA ITEMS FROM BOARD DISCUSSIONS

Report due	Report subject	Meeting at which item requested	Responsible

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	23 May 2018

Patient Story

Executive summary:

Patient stories are seen as a powerful method of bringing the experience of patients to the Board. Their purpose is to support the framing of patient experience as an integral component of quality alongside clinical effectiveness and safety. This month's patient story focuses on the glaucoma outpatient's clinic at Western Eye Hospital. This clinic has been one of 9 clinics that took part in the Experience Lab outpatient improvement programme over the past year. The patient (D.A Hannigan) has been using these services during this time.

Ms Hannigan has a history of glaucoma and will describe her overall experience of the clinic, highlighting the most important aspect of her care and those areas where we need to continue to improve. For example whilst the environment could be improved upon, Ms Hannigan stresses that what matters the most to her is the expert care and kindness shown to her by her consultant.

Quality impact:

The board will hear kind and expert staff can positively impact on patient experience.
This activity is relevant to the safe and caring CQC domains.

Financial impact:

The financial impact of this proposal as presented in the paper enclosed:
1) Has no financial impact.

Risk impact:

None

Recommendation(s) to the Committee:

The Committee is asked to note this paper and the patient story

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.

Author	Responsible executive director	Date submitted
Stephanie Harrison-White Guy Young	Janice Sigsworth	11 May 2018

Patient Story

1. Background

The use of patient stories at board and committee level is increasingly seen as positive way of reducing the "ward to board" gap, by regularly connecting the organisation's core business with its most senior leaders.

The perceived benefits of patient stories are:

- To raise awareness of the patient experience to support Board decision making
- To triangulate patient experience with other forms of reported data
- To support safety improvements
- To provide assurance in relation to the quality of care being provided (most stories will feature positive as well as negative experiences) and that the organisation is capable of learning from poor experiences
- To illustrate the personal and emotional sequelae of a failure to deliver quality services, for example following a serious incident

The Board has previously approved the patient and public involvement strategy, a key part of which is engagement with users of our services and increasing the number of patients who are actively involved.

2. D.A Hannigan's story

In April 2017, the Trust embarked on a year-long outpatient improvement programme referred to as Experience Lab. The purpose of this programme was to build upon existing improvement work by using structured and tested improvement methodologies and tools, supported by an external consultant.

Nine outpatient departments were selected through a rigorous application process and the glaucoma outpatient clinic at Western Eye Hospital was one of these.

In March 2017, a new patient survey was developed that included additional questions relevant to the outpatient services. These included questions about waiting times; the environment; how welcoming and kind our staff were; the overall service and patient experience.

Through listening to patients and reviewing the feedback they received, the team identified a number of priorities for the year, including improving the waiting room environment and communication re: waiting times. Hospital initiated cancellations were also a concern for this clinic.

The initial phase of the project involved establishing weekly staff huddles and integrating the information they already held to help inform relevant changes. Ms Hannigan has been using these services during this time. She will describe her experiences of the clinic.

These include the waiting area that feels 'drab' and unwelcoming from a patient perspective. The toilet facilities on the ground floor (near the clinic) that are somewhat limited and access can be difficult. Ms Hannigan reflects that there are other toilets on the site that could be signposted to help patients.

Waiting for an appointment can be stressful and as Ms Hannigan will describe, this is made worse when staff speak too quickly and too softly meaning that patients can miss their name being called.

With regards to her overall treatment, Ms Hannigan highlights the expert skills and the kindness of her consultant as being the most important aspect of her care. She describes how her consultant treats her as an individual, 'you don't feel like a number'.

3. Lessons learnt

Berwick (2013) describes the importance of really understanding the patient's perspective by moving from asking 'what's the matter?' to 'what matters to you'? This principle has formed the basis of this improvement programme and has enabled our teams to understand and then focus on those aspects of the service that were important to patients.

What mattered most to Ms Hannigan was how her consultant treated her. She felt valued as an individual and cared for by a kind person with expert knowledge and skills. She did highlight some additional areas for improvement that have mirrored other patient's feedback.

By utilising the quality improvement methodology, the team has been able to test a number of changes through the 'PDSA model (PLAN Do Study Act), refining these changes to maximise the impact.

For example, a new role has been developed called the 'failsafe officer'. The 'failsafe officers' primary function is to oversee the patient pathway from overseeing daily operational issues related to clinic bookings and cancellations to being accessible to patients for additional support or advice.

The clinic environment has recently been decorated to brighten the area. Patient information has been reviewed and improved and is readily available in the waiting areas alongside other reading materials such as a daily newspaper.

New signage has been put in place on the ground floor toilets to identify alternative facilities for patients. The matron is continuing to work with the department staff to encourage and support them in how they 'call' for patients.

During the past year the clinic has seen an almost 10% increase in the patient experience feedback with positive comments being received about the improved facilities (tea and coffee now available in the clinic and music being played in the waiting area) and improving efficiencies with less waiting times and cancellations.

.Patient experience huddles are now embedded in the clinic with staff working *collaboratively* to continue to build upon these positive changes and *aspire* to continue improving patient experience. We hope that these changes will continue to improve overall patient experience in this clinic.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust Board - public	**23 May 2018**

Chief Executive Officer's Report

Executive summary:

This report outlines the key strategic priorities and issues for Imperial College Healthcare NHS Trust. It will cover:

1) Financial performance
2) Financial improvement programme
3) Operational performance
4) Stakeholder engagement
5) Update on major building improvements
6) Charing Cross Hospital A&E expansion update
7) Improving intensive and high dependency care
8) Cerner electronic patient record system at West Middlesex Hospital

Quality impact:

N/A

Financial impact:

N/A

Risk impact:

N/A

Recommendation(s) to the Trust board:

The Trust board is asked to note this report.

Trust strategic objectives supported by this paper:

To achieve excellent patients experience and outcomes, delivered with care and compassion.
To educate and engage skilled and diverse people committed to continual learning and improvements.
As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care.
To pioneer integrated models of care with our partners to improve the health of the communities we serve.
To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Author	Responsible executive director	Date submitted
Julian Redhead, Chief Executive Officer	Julian Redhead, Chief Executive Officer	15 May 2018

Chief Executive Officer's report

1. Financial performance

For the financial year of 2017/18 (i.e. the 12 months to March 2018) the Trust reported a favourable variance of £2.6m against the £25.2m control total before Sustainability and Transformation Funding (STF). This was mainly due to winter pressures funding of £2.5m received by the trust from NHS improvement. The operational variance was £0.14m favourable to the control total, a significant achievement given the pressures in year.

Core STF achievement is based 70 per cent on meeting financial targets and 30 per cent on meeting our A&E four hour trajectory (to see and admit or treat and discharge patients within a four hour time scale). The Trust did not achieve the four hour A&E target, core STF was therefore £6.2m adverse to plan for the full year. The Trust received additional STF for achieving the financial control total of £11.0m.

The final Trust position after STF was therefore a £3.0m surplus against a £4.5m deficit plan, a £7.5m favourable variance.

The Trust achieved the Capital Resource Limit for the year, the net Trust funded capital plan was £47.5m with Trust outturn spend of £46.7m.

The Trust has set a financial plan for 2018/19 of a £20.6m deficit before STF; this meets the control total set by NHS Improvement. To meet this plan the Trust will need to deliver a £48m cost improvement programme. Agreement to the control total gives the Trust access to £34.2m STF, this will be monitored based on meeting financial targets and the A&E four hour trajectory as in 2017/18.

2. Financial improvement programme

The Trust set a £54.4m cost improvement programme (CIP) in 2017/18 as part of its overall financial plan; this was in line with the value achieved in 2016/17 of £53.8m.

Against this target the trust has delivered £43.1m in year against identified programs, resulting in a (£11.3m) adverse variance to plan.

A major factor in the under delivery this year has been an extended period of significant winter pressures and challenges with meeting the referral to treatment waiting time standard work, alongside capacity constraints and an ailing estate. The undelivered target has been carried over in to 2018/19 and there are some programmes that we expect to deliver in 2018/19 following work carried out in 2017/18.

The £43.1m of savings were delivered in the following areas:

- Income – net improvement of £21.5m of clinical income, from delivering contracted demand growth more productively.
- Other Income – net improvement of £5.7m of other operating income benefits, mostly private patients and other commercial based income.
- Non-Pay - savings of £11m of which £4.2m was through procurement and drugs as well as a further £1m through contracts, £2.6m was across Estates and Facilities, £2.3m was delivered by improvements in ways of working, and drug savings we made delivered £0.9m of benefits to the trust (though more was saved by us for benefit of the wider health economy).
- Pay – savings of £4.9m across all staffing groups but predominantly through reduction in bank, agency and overtime, as well as vacant posts.

3. Operational Performance

Cancer 62 day waits: In May 2018, performance was reported for the Cancer waiting times for March 2018. The Trust delivered treated 85 per cent of patients within the 62-day standard which met the national standard.

Accident and Emergency: Performance against the four-hour access standard for patients attending Accident and Emergency improved and was 84.6 per cent in April 2018. The Trust continues to experience significant pressures and the key issues remain as follows:

- Increased demand and acuity within type 1 departments;
- An increase in arrivals via ambulance and daily trauma presentations at St Mary's Hospital;
- Difficulties with late transfer of patients from the Vocare Urgent Care Centre to the Emergency Department at St Mary's Hospital;
- High levels of bed occupancy; &
- A drop in WEH performance due to changes in attendance patterns

The Trust continues the programme of patient flow improvements which are overseen by the four-hour Performance Steering Group. As a result of supporting wards to improve patient flow and prevent unnecessary waiting for patients, we have seen more patients being discharged before noon (a key marker of good patient flow) and a reduction in the overall average time of discharge.

Referral to treatment (RTT): At end of March 2018 (the latest submitted performance), 83.3 per cent of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the standard of 92 per cent (February performance was 82.8 per cent). There were 267 patients who had waited over 52 weeks for their treatment since referral from their GP.

The temporary postponement of non-urgent elective activity in January 2018 (to support the emergency pathways as part of the national response), and continued bed pressures in February led to significant numbers of cancellations. This is now feeding through to more long-waiting patients on the waiting list. RTT action plans and recovery trajectories for the most challenged specialties are now in place, and the Trust-level RTT recovery trajectory for 2018/19 is being finalised in line with the updated 2018/19 NHS planning guidance.

Diagnostic waiting times: The Trust has returned its previous good delivery of the national standard of 1 per cent or less patients waiting. At end March 2018 (the latest submitted performance), 0.9 per cent of patients waited over six weeks.

4. Stakeholder engagement

The Trust's strategic lay forum met on 18 April 2018 for the latest of its bi-monthly meetings.

The usual level of activity in our external stakeholder contact programme has been reduced over recent weeks to take into account the requirements of the pre-election period in the run-up to the Local Government Elections which were held on 3 May.

In late March we were pleased to welcome to St Mary's Hospital Rt Hon Nick Hurd MP, Minister of State for Policing and the Fire Service, and Victoria Atkins MP, Parliamentary Under Secretary of State for Crime, Safeguarding and Vulnerability and Minister for Women. The Home Office ministers were interested in learning more about the Youth Violence Intervention Programme run in partnership with Redthread and Imperial Health Charity.

In addition, we published the Trust's three, bi-monthly electronic newsletters for stakeholders, GPs and Trust members.

5. Update on major building improvements

Refurbishment of Main Outpatients Departments – All Sites:

Building works to the main outpatients and renal outpatient departments at Hammersmith Hospital has been completed. Works at Charing Cross Hospital outpatients department continues, with phase 1 and phase 2 now complete; works for Phase 3 have now commenced. The overall planned project completion date is end of June 2018. The whole refurbishment program for outpatients has been funded by Imperial Health Charity.

Paediatrics intensive care unit (PICU) at St Mary's Hospital:

Phase 1 – New Paediatrics Research Unit (PRU) on the second floor of Cambridge Wing is complete and the new unit is in use.
Phase 2 – Works to form the first half of PICU commenced in January 2018; demolitions have been completed, and 1st fix mechanical & electrical is underway, new partitions, doors and frames installed with floor finishes to commence mid May 2018. Phase 2 handover scheduled for mid-August 2018
Phase 3 – Due to commence late August 2018 with final completion date scheduled for late February 2019.
The PICU project is funded through both Trust capital and Imperial Health Charity funding.

7 North Ward at Charing Cross Hospital:
This is a four phase refurbishment project within an occupied ward.
Phases 1 and 2 and 3 have been completed and have been re-occupied. Phase 4 will complete on May 23rd.

Imaging replacement programme:

A programme of works to upgrade and replace five of the existing imaging x-ray suites is underway on all three sites. At St Mary's Hospital, the upgrade to the existing software system and minor refurbishment of both of the angio suites is complete with a new storage system also being installed in the store room.

At Hammersmith Hospital, the interventional radiology machine replacement works are complete with the new changing room, equipment room and nurse store now all in use.

The world's first Philips Bi-Plane scanner has been installed at Charing Cross Hospital imaging suite, with significant services upgrades, bringing the room up to current standards. The staff are currently undergoing intensive training, in order to maximize the clinical benefits from this equipment. The second room at Charing Cross is due to be upgraded during the summer, and this room will also then be compliant with current guidance and standards.

LINAC Replacement Programme at Charing Cross Hospital:

Trust plans to replace two LINAC (linear accelerator radiotherapy treatment) machines at Charing Cross Hospital have commenced, with the first LINAC room refurbishment completed with the LINAC machine delivered and installed last financial year. The second LINAC machine refurbishment will commence in September 2018 with completion and commissioning due for February 2019.

Charing Cross A&E expansion – see below

Full refurbishment of Multi-disciplinary team (MDT) Rooms:
The purpose of this project is to refurbish existing MDT spaces with the provision of adding a further space to increase capacity. As part of the refurbishment it includes the upgrading of the AV equipment, plus the introduction of conference calling to share images/data with other NHS Trusts and other external specialist advisors. The project works are over the

three main Trust sites.

The AV equipment supplier procurement is currently progressing with enabling works planned to commence in Autumn 2018

New Parent Accommodation:
Creation of a 12 bedded parent accommodation unit in Crusaid ward, St Mary's Hospital. Strip out works to Crusaid Ward were ongoing. The project is funded through Imperial Health Charity.

Works to support bringing together level 2 and level 3 care at St Mary's – see below

Some other capital projects currently in the feasibility include:
- New sixth Catheter Lab at Hammersmith Hospital.
- Hybrid Theatre at St Mary's Hospital
- Imaging Recovery refurbishment at St Mary's Hospital
- New MRI in Acute Imaging Centre at St Mary's Hospital

6. Charing Cross Hospital A&E expansion

In April 2018, the Trust board approved a business case for the expansion of the Charing Cross A&E department.

This business case sought approval for the expansion of A&E to accommodate the increase in attendances seen over the last few years as well as future predicted growth. The redevelopment will:

- Increase the number of rooms in the urgent care centre (UCC) from seven to nine
- Increase the number of cubicles in A&E 'majors' from 12 to 15
- Create two dedicated mental health rooms
- Increase the number of resuscitation bays from five to eight
- Expand the capacity of ambulatory emergency care (same-day consultant review for patients with urgent or emergency health problems without the need for hospital admission).

Benefits

The redevelopment will bring benefits to patient safety and experience, reduce risk and support compliance with the national target to admit or discharge 95 per cent of patients who present to A&E within four hours. Despite significant improvements in our urgent and emergency pathways last year, we could only achieve an average performance of 87 per cent across 2017/18.

A key improvement will be the expansion of the resuscitation area from five to eight bays as in periods of high demand the number of patients in this area can exceed planned capacity.

The redevelopment will reduce waiting times in A&E by ensuring that the department has sufficient physical capacity. Currently, performance deteriorates significantly when the department becomes overcrowded as patients cannot be assessed and treated as there is no physical space in which to do this.

The redevelopment will create a shared entrance and waiting area for all patients who walk-in rather than arrive by ambulance. These patients may be best treated in the urgent care

centre, ambulatory emergency care unit or the emergency department – creating a shared arrival and waiting space will help improve collaboration and joint working across the three services, and allow for a more seamless experience for patients. Expanding the ambulatory emergency care space will allow us to continue to increase the proportion of patients who can be assessed and treated without needing to be seen in the emergency department or to be admitted.

It is also anticipated that the expanded department will improve patient and staff satisfaction by reducing waiting times and crowding. These improvements will have a positive impact on staff morale, sickness absence and retention of staff.

Programme plan

The additional capacity will be created by repurposing space on the ground floor of the pilot wing to allow the UCC and reception areas of A&E to be decanted into the space currently occupied by the fracture clinic, which will move into space already vacated by the Hammersmith and Fulham Centre for Health.

The project is split into seven stages and will be fully completed by June 2019. The first four stages (fracture clinic, ambulatory emergency care, UCC and A&E 'majors') will be completed by November 2018 meaning that additional capacity will be available for winter 2018/19. The A&E will remain fully operational throughout the period of the redevelopment. works will pause during the winter period before the final phases are completed in 2019.

Capital costs

The total cost of the redevelopment will be £7.2m. This is an increase of £3.2m from the estimated cost at the outline business case stage and the initial allocation in the Trust's capital plan. This is largely due to essential mechanical and electrical works, and is another example of the financial and operational impact of our ageing estate. With the largest backlog maintenance liability in the NHS, we have to spend a significant proportion of our annual capital budget on essential repairs and refurbishment.

The Trust has a capital resource limit of £37m for 2018/19. As the 'priority' level of demand for capital in 2018/19 is currently in excess of £75m, capital planning meetings were held between December 2017 and February 2018 to prioritise 2018/19 plans. The Board's decision that we should proceed with the Charing Cross A&E expansion despite the additional cost has required some reprioritisation of the initial capital plan.

Wider urgent and emergency pathway improvements

The expansion of A&E at Charing Cross forms part of a wider programme to improve our urgent and emergency care pathways. The programme was launched in early 2017 and improvements have been realised in a number of key areas.

Key achievements through the improvement programme last year include:

- *expanding ambulatory emergency care*: by moving to longer hours and seven-day working and encouraging direct GP referral, our two ambulatory emergency care units saw a 37 per cent increase in attendances, up to just over 17,500 patients in 2017/18. We believe this has helped to reduce the rate of increase in A&E attendances and enabled many patients to get faster diagnosis and treatment.
- *expanding and refurbishing St Mary's A&E*: supported by funding of £3.2m from Imperial Health Charity, the development increased the number of resuscitation bays from two to four and added a new, four-bed paediatric assessment unit within the children's A&E department. Work continues on further improvements to the department including a sensory room and mental health support area.
- *Rolling out best practice*: as part of a national focus on improving urgent and

emergency care pathways, NHS Improvement issued guidance to all acute trusts on best practice that helps reduce delays for patients in adult inpatient wards, which it calls the 'SAFER' patient flow bundle'. 'SAFER' was piloted on two wards at St Mary's Hospital and one ward at Charing Cross Hospital. By April 2018, the average time of discharge was an hour earlier than the previous year and the proportion of patients discharged before noon had nearly doubled. The best practice is now being rolled out across all of our wards.

Improving our urgent and emergency pathways therefore remains a key focus for 2018/19 and, in addition to the expansion of A&E at Charing Cross, we are:

- improving processes within our A&E departments, such as through the introduction of point of care testing
- streamlining our specialist pathways, particularly for acute medicine and major trauma
- introducing an electronic system to enable 'real-time' bed management
- continuing roll out of the 'SAFER patient flow bundle'.
- working with our external partners to minimise delays for patients who no longer require care in an acute hospital setting.

7. Improving intensive and high dependency care

On Wednesday 6 June, high dependency (level 2) care beds from four different locations in the Queen Elizabeth the Queen Mother building at St Mary's will be brought together with adult intensive (level 3) care beds on the ninth floor. We are also expanding the critical care team with over 50 additional staff –doctors, nurses, health care assistants, pharmacist and therapist – and investing £800,000 in additional equipment and ward refurbishments.
This allows us to concentrate specialist skills for patients with the highest needs on one whole floor and to flex staffing quickly to change the balance of level 2 and level 3 care in response to need. The changes bring us in line with all national standards and best practice. The total number of level 2 and level 3 beds will remain the same at 32.
The St Mary's changes follow a similar initiative at Charing Cross last year and we will be exploring similar plans for Hammersmith. Responding to patient feedback, the whole ninth floor will be called intensive care (adults) and we will work to make this approach consistent across our sites. The service will be managed by the critical care directorate with support from the relevant specialties.
The changes also enable:

- five additional major trauma beds to be created, bringing the new total to 19
- in patients who need specialist care for complications of diabetes affecting their feet to be cared for together
- eight beds allocated within Manvers ward to focus on acute respiratory care.

8. Cerner electronic patient record system at West Middlesex Hospital

We have now successfully completed the migration of the West Middlesex Hospital on to the Imperial Cerner electronic patient record system. The emergency department, theatres and wards went live on Sunday 6 May and outpatient use started in volume on Tuesday 8 May. The Cerner system at Imperial has continued to run throughout this period as normal. However, there has been a delay to the production of reports that has impacted upon our ability to report our RTT position. The issue has now been resolved and reports are being produced and we are working to evaluate the impact on the month end deadline. On the positive side we are already seeing clinical benefit – an example was that

clinicians at St Mary's were able to see the clinical record for an emergency patient transferred from the West Middlesex.

Imperial College Healthcare NHS Trust

Report to:	Date
Trust board - public	**23 May 2018**

Integrated Performance Report

Executive summary:

This is a regular report which outlines the key headlines relating to the reporting month of March 2018 (month 12).

In line with the new process for performance and quality reporting, this report and subsequent reports will refer to figures for two months previous. This change is intended to allow each of the sections to be appropriately discussed at the executive and quality committees before the meeting of the Trust Board.

The July 2018 meeting of the Trust Board will also receive the report in a revised format, with more detail against relevant improvement plans and actions for the 2018/19 indicators.

Recommendation to the Trust board:

The Board is asked to note this report.

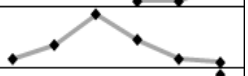
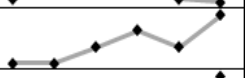
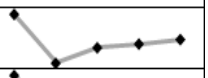
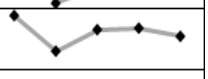
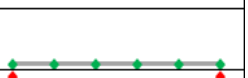
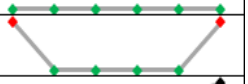
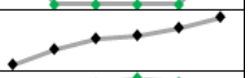
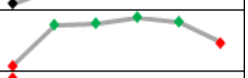
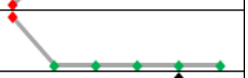
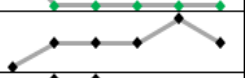
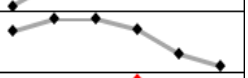
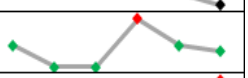
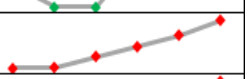
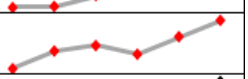
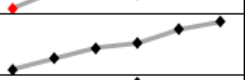
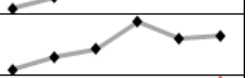
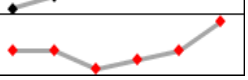
Trust strategic objectives supported by this paper:

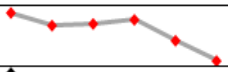
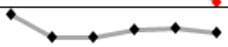
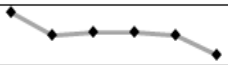
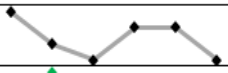
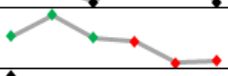
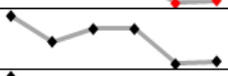
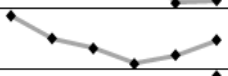
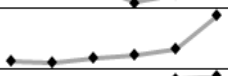
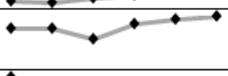
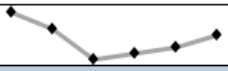
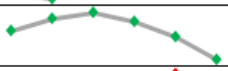
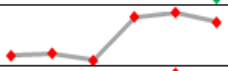
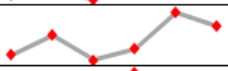
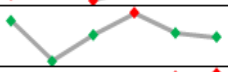
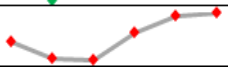
To achieve excellent patients experience and outcomes, delivered efficiently and with compassion.

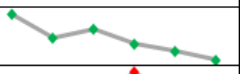
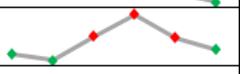
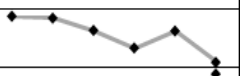
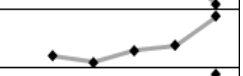
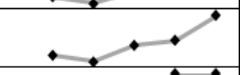
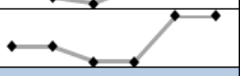
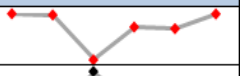
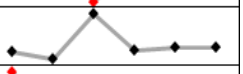
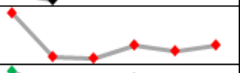
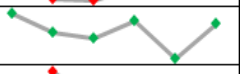
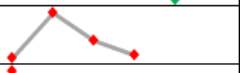
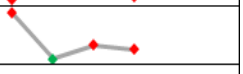
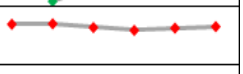
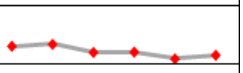
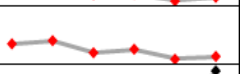
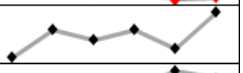
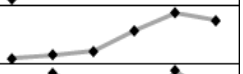
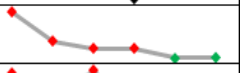
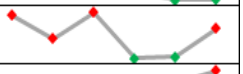
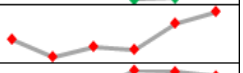
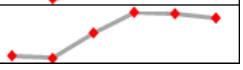
Author	Responsible executive director
Performance Support Team	William Oldfield (Acting Medical Director for Quality, Safety and Strategy) Janice Sigsworth (Director of Nursing) David Wells (Director of People and Organisational Development) Catherine Urch (Divisional Director) Tim Orchard (Divisional Director and acting Medical Director for Development, Education and Research) Tg Teoh (Divisional Director)

Contents

1. Scorecard

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Safe					
Serious incidents (number)	William Oldfield	Mar-18	-	**7**	
Incidents causing severe harm (number)	William Oldfield	Mar-18	-	**1**	
Incidents causing severe harm (% of all incidents YTD)	William Oldfield	Mar-18	-	**0.08%**	
Incidents causing extreme harm (number)	William Oldfield	Mar-18	-	**3**	
Incidents causing extreme harm (% of all incidents YTD)	William Oldfield	Mar-18	-	**0.08%**	
Patient safety incident reporting rate per 1,000 bed days	William Oldfield	Mar-18	44.0	**51.64**	
Duty of candour compliance at 09/04/2018:					
Compliance with duty of candour (SIs)	William Oldfield	Mar-18	100%	**98.0%**	
Compliance with duty of candour (Level 1 - internal investigations)	William Oldfield	Mar-18	-	**89.0%**	
Compliance with duty of candour (Moderate and above incidents)	William Oldfield	Mar-18	-	**79.0%**	
Never events (number)	William Oldfield	Mar-18	0	**0**	
MRSA (number)	William Oldfield	Mar-18	0	**1**	
Clostridium difficile (cumulative YTD) (number)	William Oldfield	Mar-18	62	**59**	
VTE risk assessment: inpatients assessed within 24 hours of admission (%)	William Oldfield	Mar-18	95.0%	**94.6%**	
CAS alerts outstanding (number)	William Oldfield	Mar-18	0	**0**	
Avoidable Pressure Ulcers	Janice Sigsworth	Mar-18	-	**1**	
Staffing fill rates (%)	Janice Sigsworth	Mar-18	tbc	**95.7%**	
Post Partum Haemorrhage 1.5L (PPH) (%)	Tg Teoh	Mar-18	2.8%	**2.7%**	
Core Skills (excluding Doctors in Training) (%)	David Wells	Mar-18	90.0%	**87.4%**	
Core Skills (Doctors in Training) (%)	David Wells	Mar-18	90.0%	**74.8%**	
Core Clinical Skills (excluding Doctors in Training) (%)	David Wells	Mar-18	tbc	**85.9%**	
Core Clinical Skills (Doctors in Training) (%)	David Wells	Mar-18	tbc	**66.5%**	
Staff accidents and incidents in the workplace (RIDDOR-reportable) (number)	David Wells	Mar-18	0	**6**	

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Effective					
Hospital standardised mortality ratio (HSMR)	William Oldfield	Nov-17	100	**69.0**	
Mortality reviews at 12/04/2018:					
Total number of deaths	William Oldfield	Mar-18	-	**178**	
Number of local reviews completed	William Oldfield	Mar-18	-	**107**	
% of local reviews completed	William Oldfield	Mar-18	100%	**60.1%**	
Number of SJR reviews requested	William Oldfield	Mar-18	-	**23**	
Number of SJR reviews completed	William Oldfield	Mar-18	-	**3**	
Number of avoidable deaths (Score 1-3)	William Oldfield	Mar-18	-	**0**	
Clinical trials - recruitment of 1st patient within 70 days (%)	William Oldfield	Sep-17	90.0%	**53.3%**	
Unplanned readmission rates (28 days) over 15s (%)	Tim Orchard	Sep-17	-	**6.6%**	
Unplanned readmission rates (28 days) under 15s (%)	Tg Teoh	Sep-17	-	**4.9%**	
Outpatient appointments not checked-in or DNAd (app within last 90 days)	Tg Teoh	Mar-18	-	**2553**	
Outpatient appointments checked-in AND not checked-out	Tg Teoh	Mar-18	-	**3089**	
Diagnostic and surgical orders waiting to be processed (Add/Set Encounter)	Catherine Urch	Mar-18	0	**1763**	
Caring					
Friends and Family Test: **Inpatient** service - % patients recommended	Janice Sigsworth	Mar-18	95.0%	**97.5%**	
Friends and Family Test: **A&E** service - % recommended	Janice Sigsworth	Mar-18	85.0%	**90.9%**	
Friends and Family Test: **Maternity** service - % recommended	Janice Sigsworth	Mar-18	95.0%	**94.1%**	
Friends and Family Test: **Outpatient** service - % recommended	Janice Sigsworth	Mar-18	94.0%	**92.3%**	
Complaints: Total number received from our patients	Janice Sigsworth	Mar-18	100	**88**	
Mixed-Sex Accommodation (EMSA) breaches	Catherine Urch	Mar-18	0	**44**	

Core KPI	Executive Lead	Period	Standard	Latest performance (Trust)	Direction of travel (Trust)
Well Led					
Vacancy rate (%)	David Wells	Mar-18	10.0%	**12.7%**	
Voluntary turnover rate (%) 12-month rolling	David Wells	Mar-18	10.0%	**9.1%**	
Sickness absence (%)	David Wells	Mar-18	3.1%	**3.1%**	
Personal development reviews (%)	David Wells	Jul-17	95.0%	**-**	
Doctor Appraisal Rate (%)	Tim Orchard	Mar-18	95.0%	**84.5%**	
Staff FFT (% recommended as a place to work)	David Wells	17/18 Q1	-	**70.6%**	
Staff FFT (% recommended as a place for treatment)	David Wells	17/18 Q1	-	**85.1%**	
Education open actions (number)	Tim Orchard	Mar-18	-	**3**	
Responsive					
RTT: 18 Weeks Incomplete (%)	Catherine Urch	Mar-18	92.0%	**83.3%**	
RTT: Patients waiting over 18 weeks for treatment (number)	Catherine Urch	Mar-18	-	**10776**	
RTT: Patients waiting 52 weeks or more for treatment (number)	Catherine Urch	Mar-18	0	**267**	
Cancer: 62 day urgent GP referral to treatment for all cancers (%)	Catherine Urch	Feb-18	85.0%	**88.5%**	
Cancelled operations (as % of total elective activity)	Catherine Urch	Jan-18	0.8%	**0.9%**	
28 day rebooking breaches (% of cancellations)	Catherine Urch	Jan-18	8.0%	**8.2%**	
Theatre utilisation (elective) (%)	Catherine Urch	Mar-18	85.0%	**74.5%**	
A&E patients seen within 4 hours (type 1) (%)	Tim Orchard	Mar-18	95.0%	**61.9%**	
A&E patients seen within 4 hours (all types) (%)	Tim Orchard	Mar-18	95.0%	**83.2%**	
A&E patients spending >12 hours from decision to admit to admission	Tim Orchard	Mar-18	0	**8**	
Discharges before noon	Tim Orchard	Mar-18	35.0%	**13.3%**	
Waiting times for first outpatient appointment (routine) (average weeks waited for attended appointments)	Tg Teoh	Mar-18	-	**7.9**	
Patients waiting longer than 6 weeks for diagnostic tests (%)	Tg Teoh	Feb-18	1.0%	**0.9%**	
Outpatient Did Not Attend rate: (First & Follow-Up) (%)	Tg Teoh	Mar-18	11.0%	**11.8%**	
Hospital initiated outpatient cancellation rate with less than 6 weeks notice (%)	Tg Teoh	Mar-18	7.5%	**9.0%**	
Outpatient appointments made within 5 working days of receipt (%)	Tg Teoh	Mar-18	95.0%	**87.3%**	

2. Key indicator overviews

2.1 Safe

2.1.1 Safe: Serious Incidents

Seven serious incidents (SIs) were reported during March 2018, compared to nine last month. All of them are undergoing root cause analysis.

The categories of SIs reported in March are comparable to previous trends. This month the highest numbers related to maternity/obstetric (baby only) and treatment delay (availability of mental health beds), with two SIs reported for each. The availability of mental health beds category is an internally amended version of the StEIS category; 'Treatment Delay' which was introduced to enable the capture of any patient safety risks that are being experienced in the emergency departments due to a lack of downstream mental health beds. An action plan is in place, led by the MIC division to address the root cause of these incidents. The Trust has also agreed that this work will be scoped as a safety improvement stream for 2018/19.

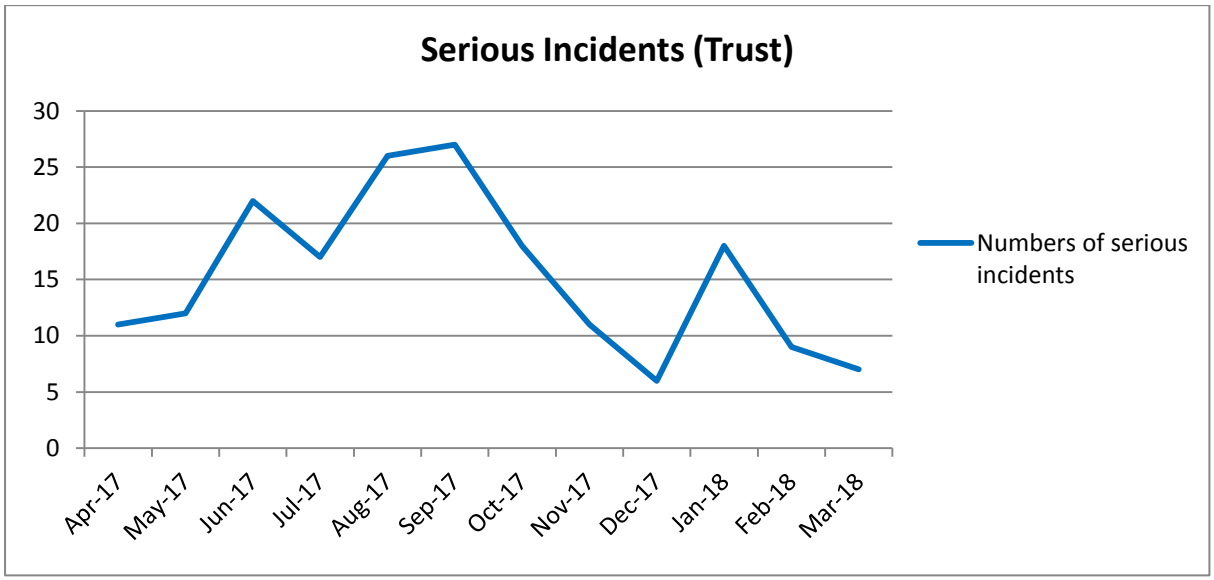


Chart 1 - Number of Serious Incidents (SIs) (Trust level) by month for the period April 2017 – March 2018

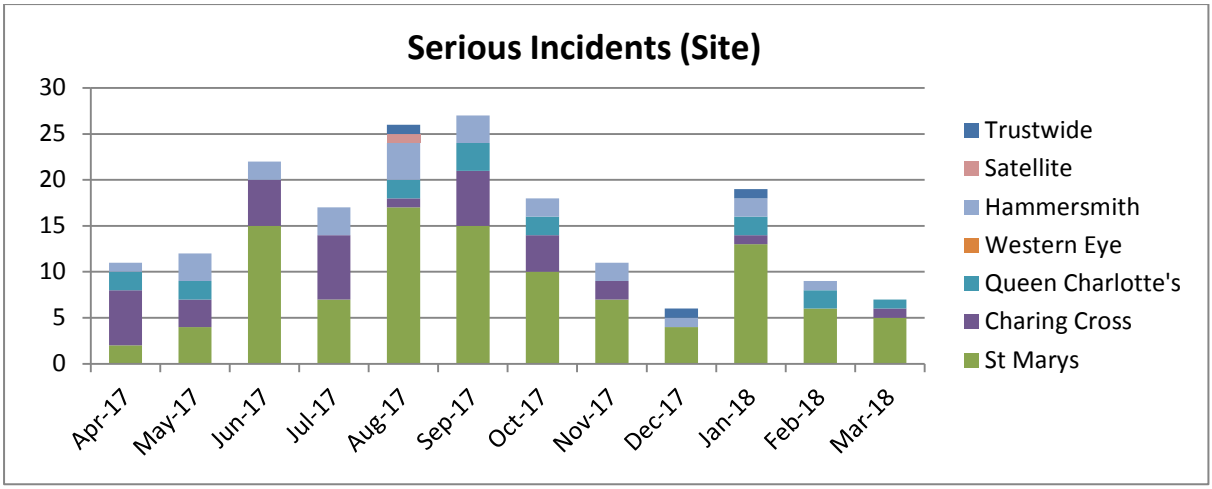


Chart 2 - Number of Serious Incidents (SIs) (Site level) by month for the period April 2017 – March 2018

For the first time we have not seen an overall increase in the number of SIs reported cumulatively over the preceding twelve month period, reporting 190 compared to 185. Our overall incident reporting rate continues to rise, and the decreases in a number of SI categories are due to focused improvement work. Those showing the largest decrease are aligned with the safety improvement programmes (safety streams), with the three largest decreases in pressure ulcers, falls and the deteriorating patient categories. We have also reviewed and implemented a more detailed 72 hour report for all moderate incidents which may be contributing to this plateauing of our reporting.

2.1.2 Safe: Incident reporting and degree of harm

Incidents causing severe and extreme harm

The Trust reported one severe/major harm and three extreme harm/death incidents in March 2018. These incidents are being investigated.

There were fourteen severe and thirteen extreme harm incidents reported during 2017/2018. This is below average when compared to data published by the National Reporting and Learning System (NRLS) in March 2018 for the March 2017 – September 2017 period.

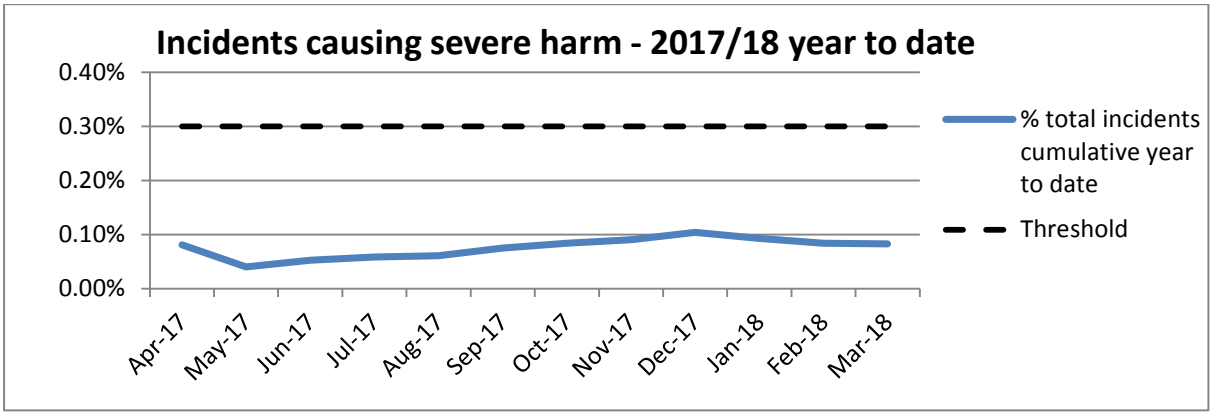


Chart 3 – Incidents causing severe harm by month from the period April 2017 – March 2018 (% of total patient safety incidents YTD). Threshold Source: National Reporting and Learning System (NRLS)

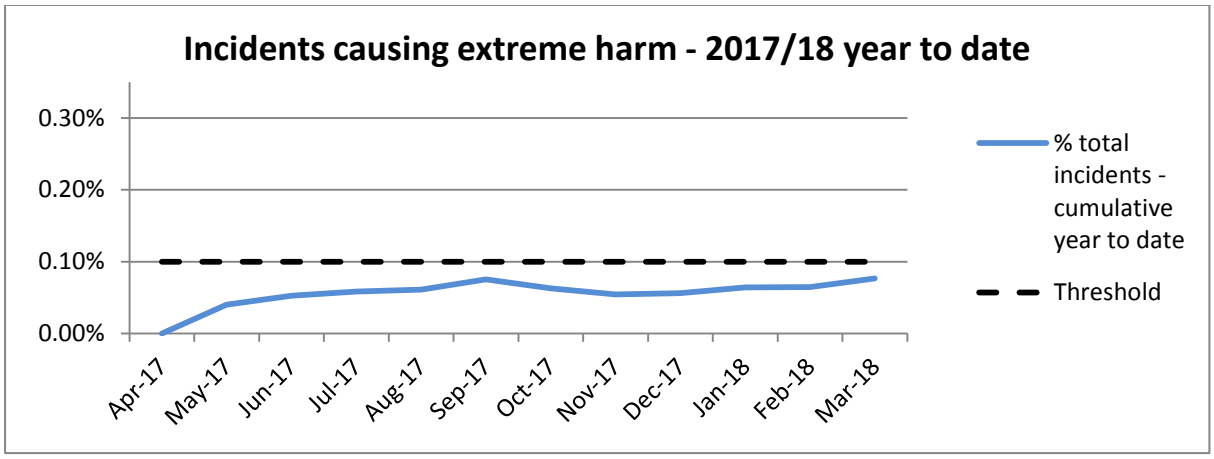


Chart 4 – Incidents causing extreme harm by month from the period April 2017 – March 2018 (% of total patient safety incidents YTD). Threshold Source: National Reporting and Learning System (NRLS)

Patient safety incident reporting rate

The Trust's incident reporting rate for March 2018 is 51.64 which places us within the highest 25% of reporters nationally. A high reporting rate with low levels of harm is one indicator of a positive safety culture and is one of the key focus areas for the safety culture improvement programme launched in July 2016. We consistently report 1% of incidents as moderate or above and this has not changed.

Over the last 6 months there has been a steady increase in patient safety incident reporting in a number of directorates as a result of focussed local improvement work.

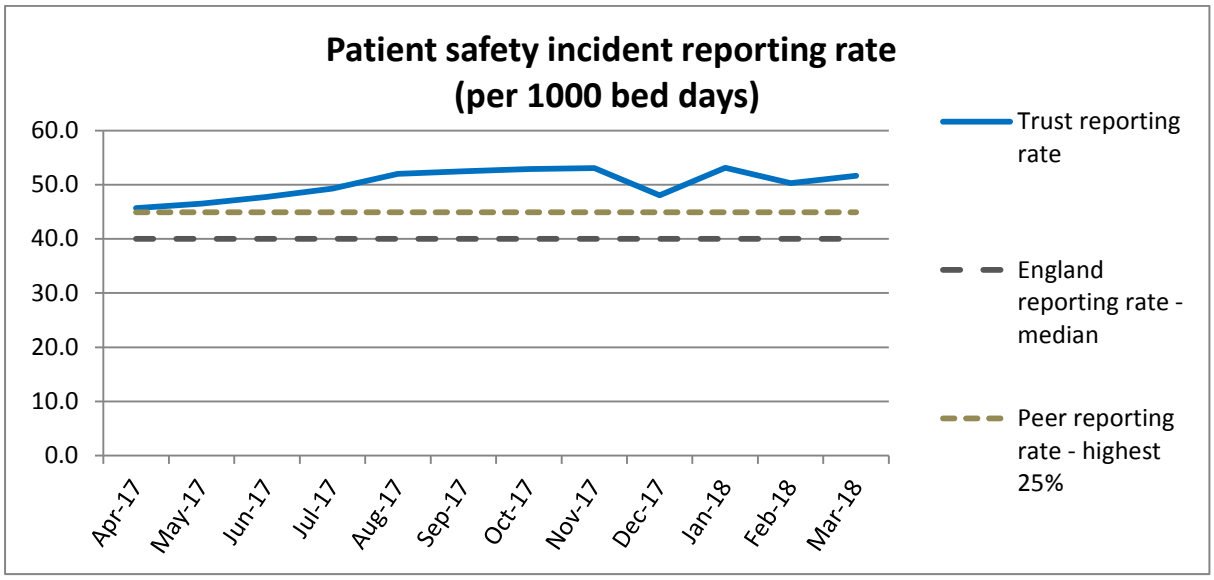


Chart 5 – Trust incident reporting rate by month for the period April 2017 – March 2018

1. Median reporting rate for Acute non specialist organisations
2. Highest 25% of incident reporters among all Acute non specialist organisations

2.1.3 Safe: Duty of candour

A full review of duty of candour processes across the Trust was commissioned by the Medical Director in 2017 following limited assurance audit outcomes and specific examples where candour was not found to be adequate. Compliance is now monitored through the medical director's incident review panel. As reported last month focussed work is underway with the divisional teams to ensure that the evidence of the duty of candour conversation and copies of the letter sent are uploaded on to Datix as the single repository for compliance data.

The table below shows the number of SIs, internal investigations and cases of moderate harm reported between April 2017 and February 2018, and the percentage of these which have had stage 1 and stage 2 of the duty of candour process completed which are all improving.

The compliance for March 2018 is not yet available as data is reported one month in arrears.

	SIs	Level 1 (internal investigations)	Moderate and above incidents
Number of incidents (Apr 2017 – February 2018)	162	70	62
Total with stage 1 complete	160	62	50
Total with stage 2 complete	159	63	50
Total with both stages complete	159	62	49
Percentage fully compliant with duty of candour requirements	98%	89%	79%

Percentage of incidents fully compliant with duty of candour requirements at 9 April 2018.

2.1.4 Safe: Never events

There have been no further never events declared since the case in July 2017. The surgery, cancer and cardiovascular (SCCS) division have implemented immediate action to minimise recurrence of the July case by using an alert on epidural lines in the form of a printed sticker. This is a short term measure until new products which do not allow connection of epidural lines to inappropriate devices become available.

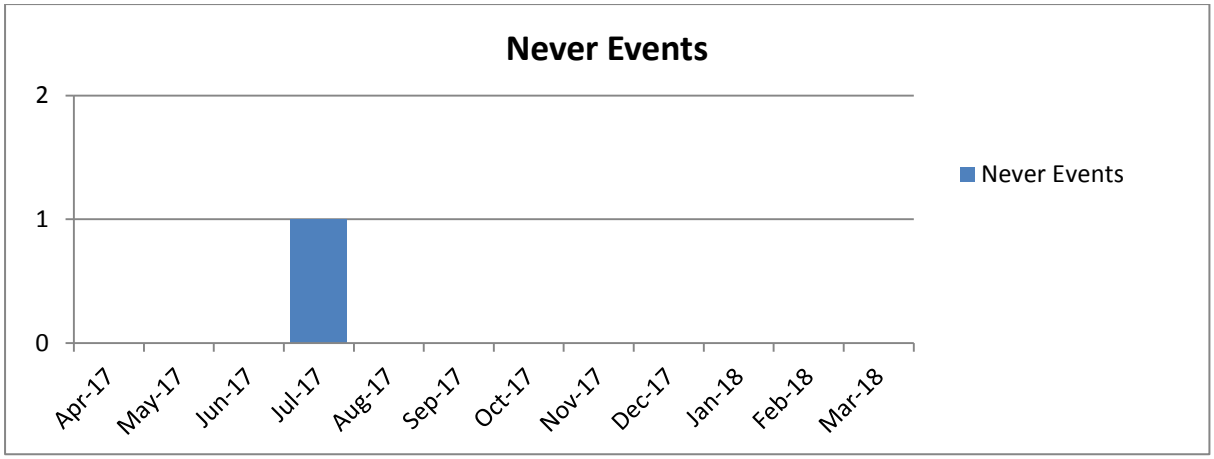


Chart 6 – Trust Never Events by month for the period April 2017 – March 2018

2.1.5 Safe: Meticillin - resistant *Staphylococcus aureus* bloodstream infections (MRSA BSI)

One case of MRSA BSI was assigned to the Trust in March 2018. This was a surgical patient known to be MRSA colonised, who subsequently had a positive blood culture. The source of infection was considered to be either the skin or a surgical site infection. We have reported a total of three Trust MRSA BSI cases this year, which is the same number we reported in 2016/2017. The sources for the three Trust-attributed BSIs were an infected vascular graft, a central veneous access device, and the skin or a surgical site infection. Actions arising from the multidisciplinary post-infection review of these cases include improving documentation and management of vascular access devices, improving the flagging of infection status/MRSA status on Cerner, and improving the administration of suppression therapy. These actions are being implemented by the relevant groups, reporting through TIPCC.

2.1.6 Safe: *Clostridium difficile*

Sixty three cases of Clostridium difficile have been allocated to the Trust in 2017/18, which is below trajectory. During Q4, there were sixteen cases of Trust-attributable C. difficile, three of which had lapses or potential lapses in care identified. All three of these lapses in care in Q4 were in the month of March 2018 (there were no lapses in care in January or February 2018). One of the cases related to potential transmission and has undergone local investigation. The other two cases were related to antibiotic non-compliance; these cases have been discussed with the prescribers and clinical teams involved.

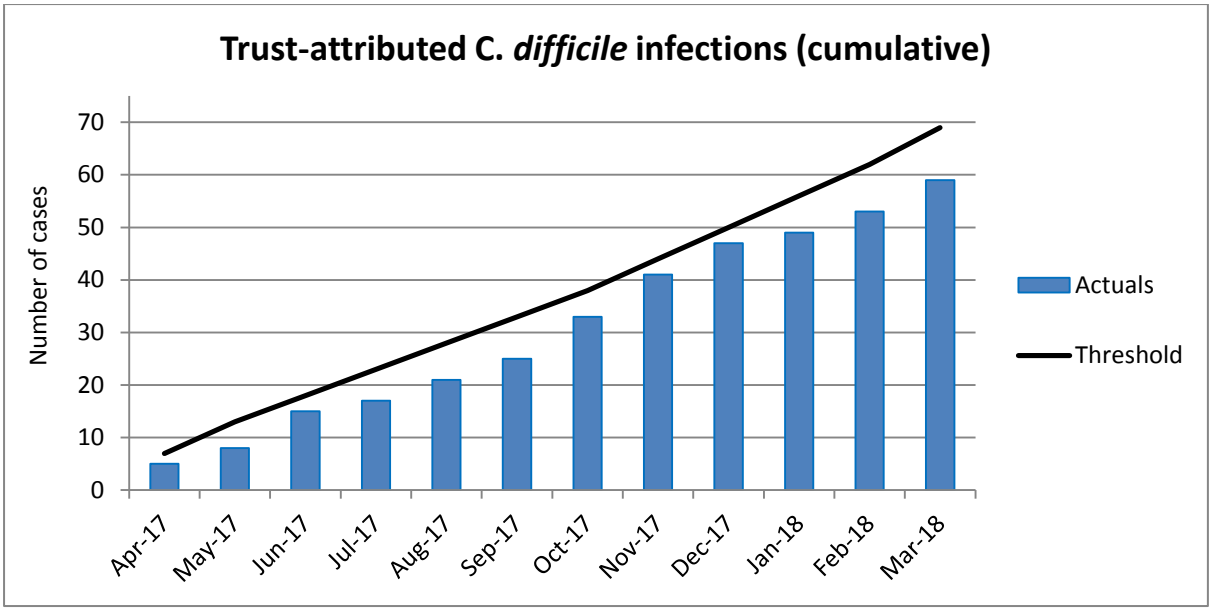


Chart 7 - Number of Trust-attributed *Clostridium difficile* infections against cumulative plan by month for the period April 2017 – March 2018

2.1.7 Safe: Venous thromboembolism (VTE) risk assessment

The Trust performance is just below target at 94.56 per cent for the month of March. This reduction has been driven by a reduction in compliance in the divisions of MIC and WCCS during one week in March with specific issues in Maternity and CDU. Sustained improvements had previously been reported across all divisions as a result of local action plans and monitoring arrangements. Divisions are reviewing the cause of this dip in compliance however we have returned to 95% for all weeks since 19th March 2018.

TIAA have now completed their 'Assurance Review of the VTE Risk Assessment' to evaluate the accuracy, completeness and timeliness of VTE data reported both internally and externally. The review concluded that there was substantial assurance in comparison to the limited assurance given in December 2015.

VTE data quality will also undergo an external audit as part of the indicator testing for the Trust's 2017/18 Quality Account.

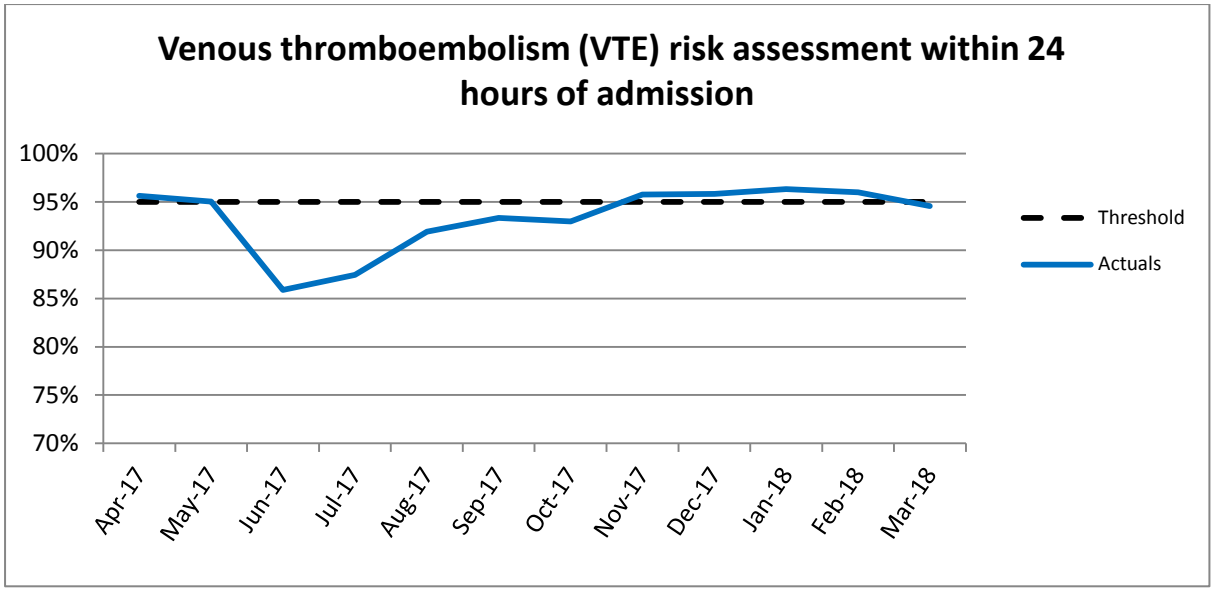


Chart 8 – % of inpatients who received a risk assessment for Venous thromboembolism (VTE) within 24 hours of their admission by month for the period April 2017 – March 2018

2.1.8 Safe: CAS alerts outstanding

The Department of Health Central Alerting System (CAS) is a system for issuing patient safety alerts, public health messages and other safety critical information and guidance to the NHS and others. There are currently no overdue alerts.

2.1.9 Safe: Avoidable pressure ulcers

There was one pressure ulcers recorded for the month of March 2018. This takes the total of avoidable Trust acquired pressure ulcers to 17 compared with 27 in the same period in 2016/2017. Each pressure ulcer is investigated using a root cause analysis and an action plan is then implemented within the clinical area to avoid further ulcers occurring.

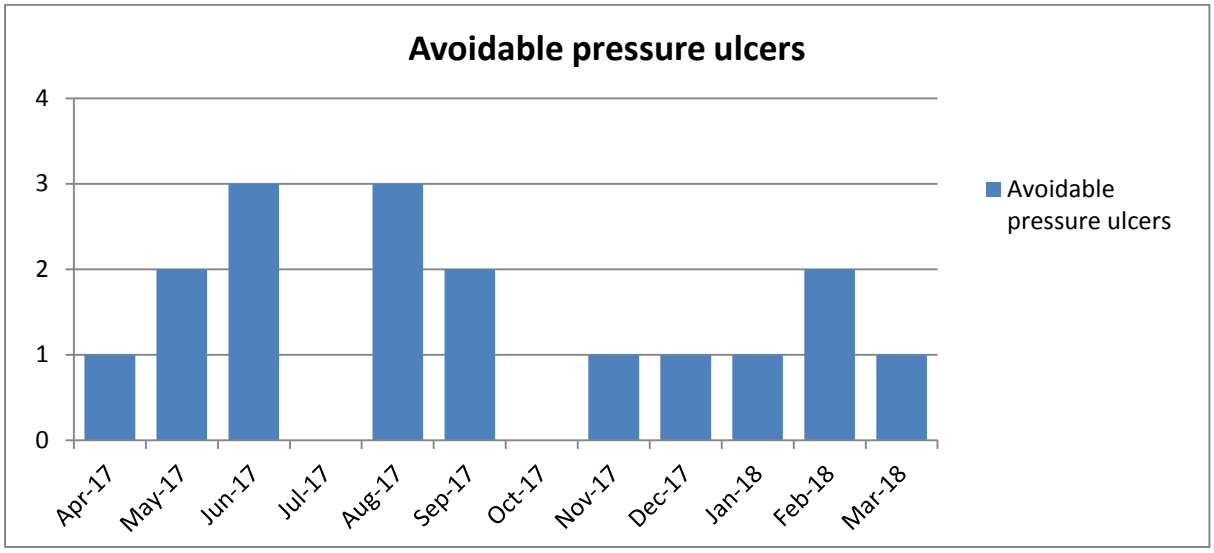


Chart 9 – Number of category 3 and category 4 (including unstageable) Trust-acquired pressure ulcers by month for the period April 2017 – March 2018

2.1.10 Safe: Safe staffing levels for registered nurses, midwives and care staff

In March 2018 the Trust met safe staffing levels for registered nurses and midwives and care staff overall during the day and at night. The thresholds are 90 per cent for registered nurses and 85 per cent for care staff.

The percentage of shifts meeting planned safe staffing levels by hospital site are as follows:

Site Name	Day shifts – average fill rate		Night shifts – average fill rate	
	Registered nurses/midwives	Care staff	Registered nurses/midwives	Care staff
Charing Cross	93.66%	94.89%	97.71%	97.19%
Hammersmith	96.53%	89.74%	98.20%	96.95%
Queen Charlotte's	94.87%	96.37%	97.32%	99.44%
St. Mary's	94.74%	93.46%	96.66%	96.64%
Trust wide	94.79%	93.58%	97.36%	97.05%

The fill rate was below 85 per cent for care staff and 90 per cent for registered staff in the following wards:

<u>Division of Surgery</u>

- A9 Cardiothoracics

  Unfilled special shifts equated to 8 long shifts (94.5 hours). These were coverd by existing staff with no quality or safety issues.

- C8 Cardiology

  Unfilled special shifts equated to 9 long shifts (105.5 hours). These were coverd by existing staff with no quality or safety issues.

- Imperial Surgical Innovation Centre

  Unfilled shits equated to 4 short and 6 long shifts (99hrs). these were covered by the ward manager working in the numbers or a health care support worker with no quality or safety issues.

<u>Division of Medicine</u>

- 7 West Gastroenterology

  Unfilled shifts equated to 15 long shifts (172.5 hours). These were coverd by the ward manager working in the numbers with no quality or safety issues.

- 8 West Geriatric medicine

Unfilled shifts equated to 9 long shifts (103.5 hours). These were coverd by the ward manager working in the numbers with no quality or safety issues.

- 9 South Neurology

  Unfilled special shifts equated to 26 long shifts (264.5 hours). Around 50% of these were relating to vacancy.Seventeen hours were coverd by the ward manager working in the numbers. Staff were redelpoyed to the area and staffing and skill mix monitored twice a day. No quality or safety issues were reported.

- Acute Admissions CXH

  Unfilled special shifts equated to 3 long shifts (34.5 hours). These were coverd by the ward manager working in the numbers with no quality or safety issues.

- John Humphrey Geriatric Medicine

  Unfilled shifts equated to 16 long shifts (184 hours). These were coverd by the ward manager working in the numbers with no quality or safety issues.

- Douglas HSU SMH

  Unfilled shifts equated to 39 long shifts (407 hours). 272.5 hours were for escalation beds opened during March to address capacity issues. 22.5 hours were for Health Care Support Workers. Night duty unfilled shifts equated to 11 shifts (126.5 hours).

- Joseph Toynbee General Medicine

  Unfilled RN night shifts equated to 11 long shifts (126.5 hours) due to vacany ,sockeness and specials. No harm identified as a result of the gap.

- Manvers Respiratory Medicine

  Unfilled Health Care Support Worker shifts equated to 18 long shifts (205 hours). No harm was identified as a result of the gap.

- Witherow Geriatric Medicine

  The gap of 31 RN shifts equated to 252 hours and health care support worker shifts equated to 20 long shifts (230 hours). These shifts were for escalation beds on Grafton ward. Grafton has remained open consistently and shifts are being put out further in advance which has resulted in a better fill rate. Quality and safety is constantly monitored.

During the month of March increased activity across all NHS Trusts continued. As a result many non-urgent elective procedures were postponed to reduce the pressure on bed capacity and increased Emergency Department activity.

In order to maintain standards of care the Trust's Divisional Directors of Nursing, site directors and their teams optimised staffing and mitigated any risk to the quality of care delivered to patients in the following ways:

- Reviewing staffing at the 5 x daily site calls
- Using the workforce flexibly across floors and clinical areas as described and in some circumstances between the three hospital sites.
- Cohorting patients and adjusting case mixes to ensure efficiencies of scale.

In addition, the Divisional Directors of Nursing regularly review staffing when, or if there is a shift in local quality metrics, including patient feedback.

Nursing and midwifery workforce planning continues to be a major focus in the Trust. We are exploring apprenticeships, rotation programmes and nursing asccociate development.

All Divisional Directors of Nursing have confirmed to the Director of Nursing that the staffing levels in March 2018 were safe and appropriate for the clinical case mix.

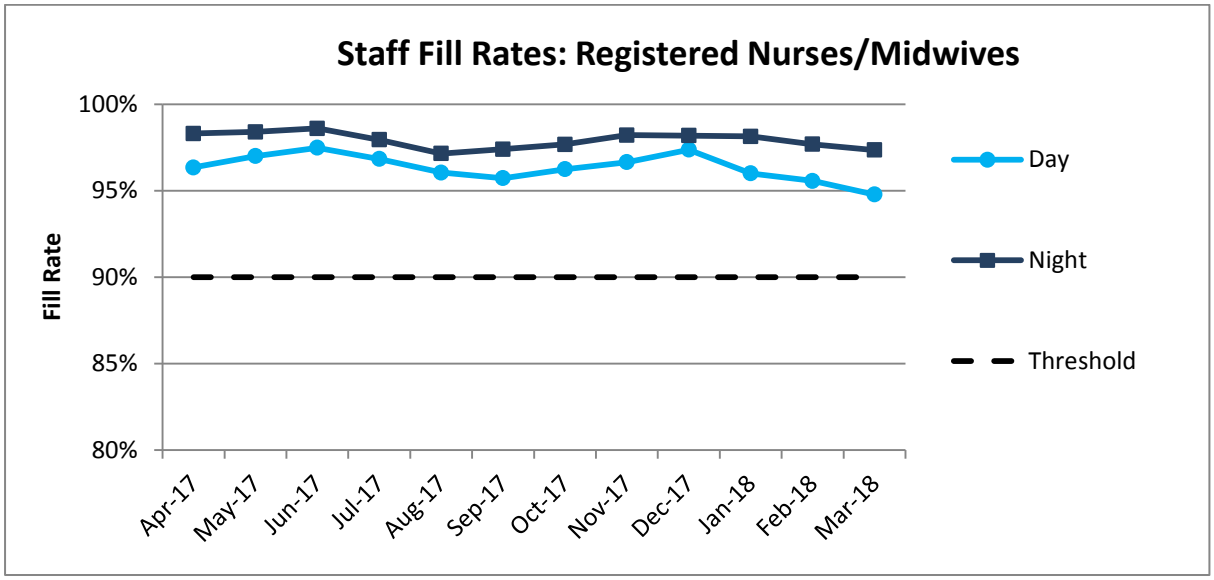


Chart 10 - Monthly staff fill rates (Registered Nurses/Registered Midwives) by month for the period April 2017 – March 2018

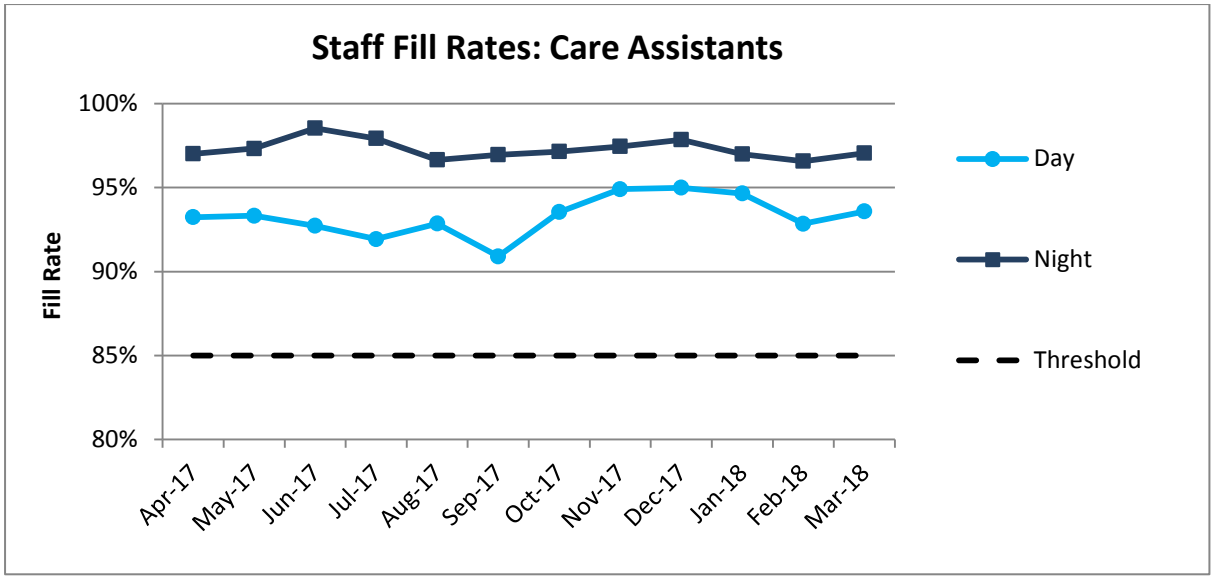


Chart 11 - Monthly staff fill rates (Care Assistants) by month for the period April 2017 – March 2018

2.1.11 Safe: Postpartum haemorrhage

In March the postpartum haemorrhage (PPH) rate was 2.7 per cent (defined as % of women who gave birth at the Trust had a PPH, involving an estimated blood loss of 1500ml or more within 24 hours of the birth of the baby). This met the Trust target of 2.8 per cent or less.

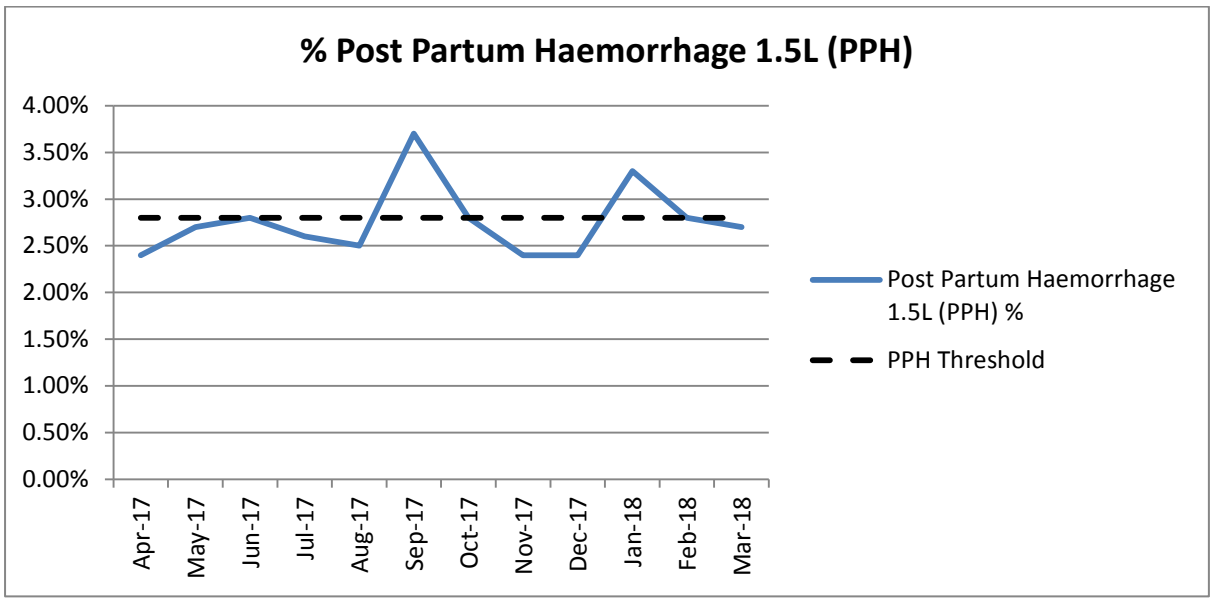


Chart 12 – Postpartum haemorrhage (PPH) for the period April 2017 – March 2018

2.1.12 Safe: Core skills training

Core Skills compliance

The compliance rates continue to improve in all areas. At the end of March, the compliance rate for Doctors in Training/Trust Grade was 75 per cent and for all other staff, 87 per cent.

Core Clinical Skills compliance

At the end of March, the compliance rate for Doctors in Training/Trust Grade was 67 per cent and for all other staff, 86 per cent.

Pilot non-compliance emails – The second phase of the pilot was run within the imaging department to send all staff that are non-compliant an email with details of the subjects that they need to complete. Following the pilot the compliance rate across imaging increased from 92.2 per cent to 93.6 per cent demonstrating this is an effective way to help improve compliance. This will now be followed up with emails to one division per month.

A project plan has been designed to capture all the elements of work that are currently being conducted with a view to improving Core Skills compliance.

The Core Skills team are working to support the RTT training rollout, training admin staff in recording and reporting on completions.

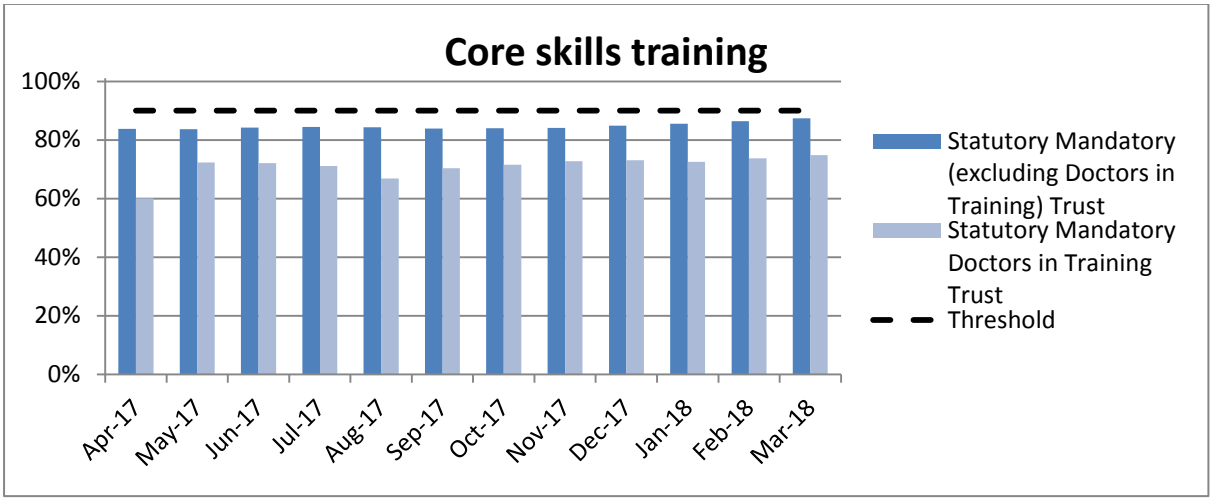


Chart 13 - Statutory and mandatory training for the period April 2017 – March 2018

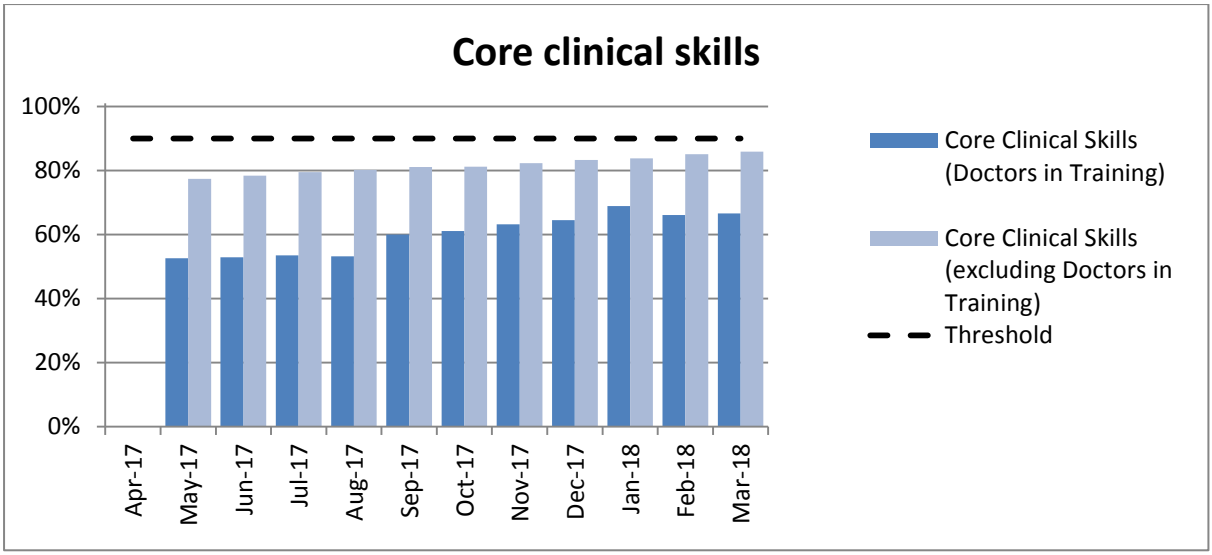


Chart 14 – Core clinical skills training for the period May 2017 (first reported) – March 2018

2.1.13 Safe: Work-related reportable accidents and incidents

There were six (6) RIDDOR-reportable (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) incidents in March 2018.

-The first incident involved a member of staff fracturing a finger whilst lifting a patient and, subsequently, going on sick leave. The incident was reportable to the HSE as an 'over 7 day absence' incident;

-The second incident involved a member of staff slipping whilst walking (due to water on the floor) and sustaining a fracture to his arm. The incident was reportable to the HSE as a 'Specified Injury (fracture)';

-The third incident involved a member of staff sustaining injury from being struck on the head/shoulder by a filing folder that had been left on top of the locker and, subsequently, going on sick leave. The incident was reportable to HSE as an 'Over 7 day absence' incident;

-The fourth incident involved a member of staff having a splash of bodily fluid in her eye whilst removing an ECG cable from a HIV-positive patient. The incident was reportable to HSE as a 'Dangerous Occurrence';

-The fifth incident involved a member of staff having a splash of bodily fluid in his eye from a HEP C-positive patient. The incident was reportable to the HSE as a 'Dangerous Occurrence';

-The sixth incident involved a patient with dementia and no capacity falling from a hospital trolley and, due to apparent shortcomings in the Trust system of work, sustaining injury. The incident was report to HSE as a 'Specified Injury (to public) - Concussion and / or internal injuries'.

In the 12 months to 31st March 2018, there have been 52 RIDDOR reportable incidents of which 21 were slips, trips and falls. The Health and Safety service

continues to work with the Estates & Facilities service and its contractors to identify suitable action to take to ensure floors present a significantly lower risk of slipping.

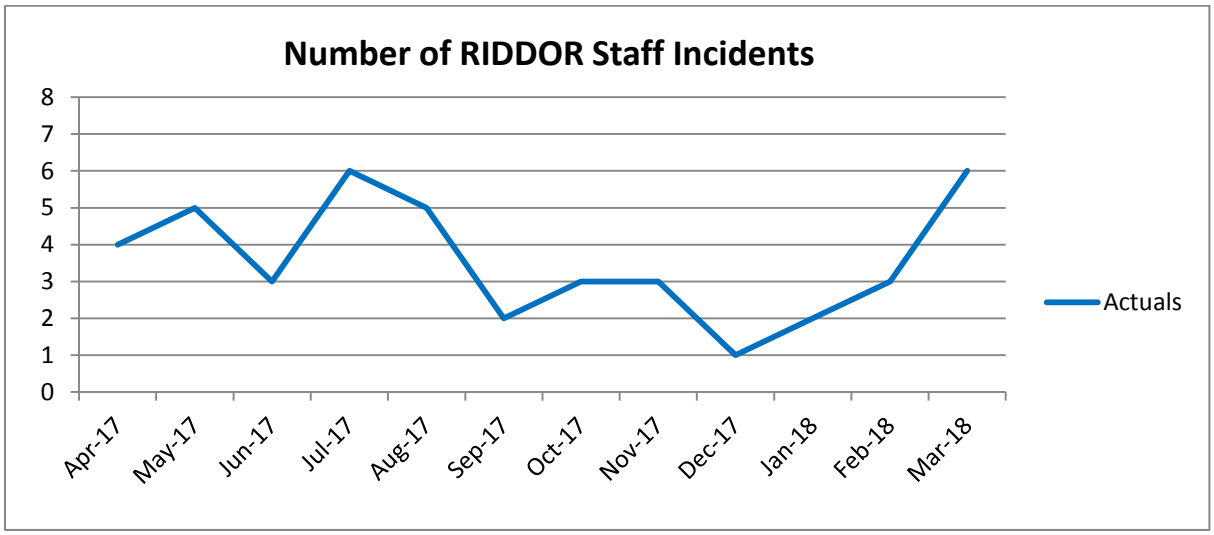


Chart 15 – RIDDOR Staff Incidents for the period April 2017 – March 2018

2.2 Effective

2.2.1 Effective: National Clinical Audits

Since April 2017, a total of 53 relevant HQIP and NCEPOD national study reports have been published. The Trust participated in 49 of these studies and the reports have been issued to the relevant divisions for a full review and are progressing through the specialty and divisional review processes. As reported previously progress is being monitored by the divisional quality and safety committees and reviewed by the quality and safety subgroup. Monitoring has also now commenced at the weekly incident panel meetings to allow greater oversight of progress until the end of the business year.

Twenty four reports have been through the full trust process and levels of assurance agreed by the relevant division/directorate quality and safety committee, compared to nine last month. Action plans are in place for each of these audits.

2.2.2 Effective: Mortality data

The Trust target for mortality rates in 2017/18 is to be in the top five lowest-risk acute non-specialist trusts as measured by the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI).

The most recent HSMR is 69 (November 2017). Over the last 12 months the Trust has had the second lowest HSMR for acute non-specialist trusts nationally. The Trust also has the 2nd lowest SHMI of all non-specialist providers in England for Q2 2016/17 – Q1 2017/18.

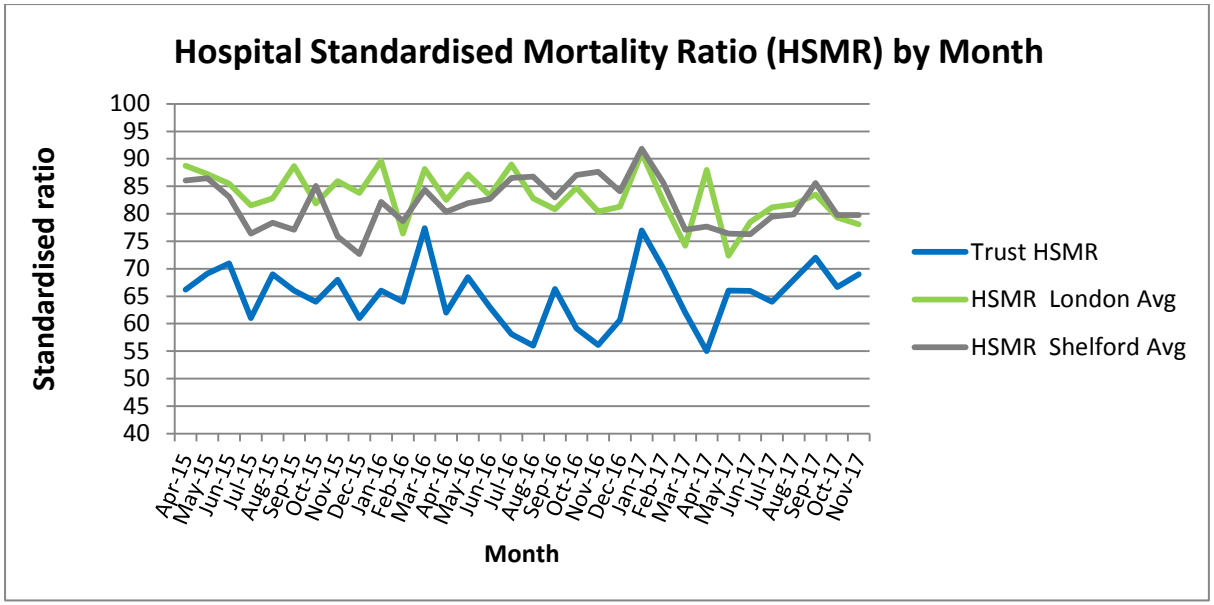


Chart 16 - Hospital Standardised Mortality Ratios for the period April 2015 – November 2017

2.2.3 Effective: Mortality reviews completed

In March 2017 a framework for NHS Trusts on identifying, reporting, investigating and learning from deaths in care was published by the National Quality Board.

The Trust implemented the structured judgement review methodology (SJR) in September 2017, which included deaths from July 2017 onwards. Data is refreshed on a monthly basis as SJRs are completed. 148 completed reports have been received to date, from the 229 requested. Cases are reviewed at the monthly Mortality Review Group (MRG) with a focus on any avoidable factors and learning themes. Early emerging themes map to the 'falls' and the 'responding to the deteriorating patient' safety streams. As more cases are reviewed the group will be able to recommend work streams to be considered as part of the trust improvement programme**.**

To date, the Trust has confirmed thirteen cases of avoidable death. Nine cases have been through MRG, of which five have completed SI investigations, with action plans in place. A further three cases have an SI investigation underway, and one case is undergoing local investigation.

In order to instigate the SJR process at the earliest opportunity the timeframe for local mortality review has been shortened to 7 days (from 30 days). This came into effect from September 2017. A weekly performance report is now reviewed at the MD incident panel and in month compliance is improving.

Mortality reviews (at March 2018)

	Apr 17	May 17	Jun 17	Jul 17	Aug 17		Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	YTD
Total number of deaths (17/18):	120	152	137	138	163		151	161	167	161	191	176	178	1895
No. Level 1 Reviews Completed	120	152	136	138	163		145	158	147	144	177	134	107	1721
Percentage of deaths reviewed locally (Level 1):	100%	100%	99%	100%	100%		96%	98%	88%	89%	93%	76%	60%	91%
Number of SJR reviews requested:	3	3	2	21	29		22	37	19	19	25	26	23	229
Number of SJR reviews completed:	2	3	2	12	23		16	27	14	16	16	14	3	148
Number of confirmed avoidable deaths (Score 1-3):	1	0	0	1	2		1	3	1	0	2	2	0	13

Note: The timeframe for local, level 1 review completion was shorted from 30 days to 7 days, effective September 2017

2.2.4 Effective: Recruitment of patients into interventional studies

We have not achieved our target of 90% of clinical trials recruiting their first patient within 70 days of a valid research application this year. However, validated data for Q3 2017/18 showed performance at 64.3%, which is an improvement on 53.3% in Q2. It is also above the national average of 60.4%.

Historically, much of the delay for ICHT studies has been at the contract negotiation stage. As reported previously we have spent the previous 6-9 months re-staffing the ICHT Joint Research Office (JRO) with new contracting experts and new leadership. As well as now being fully resourced, the team are taking a more pragmatic and proactive approach to contract and cost negotiation (within agreed negotiation boundaries). Weekly team meetings now take place to review all studies in the pipeline, to identify potential issues and escalate. These changes are now starting to impact on performance.

Performance declined nationally following the process and data changes introduced by the DoH in 2016/17, but the national trend is now upward again. An ongoing consultation by NHS England is currently proposing to establish a single set of national clinical trials metrics – agreed by the industry sector – by Q3 2018/19, which are more robust and which are resistant to different interpretations by NHS Trusts as is currently the case.

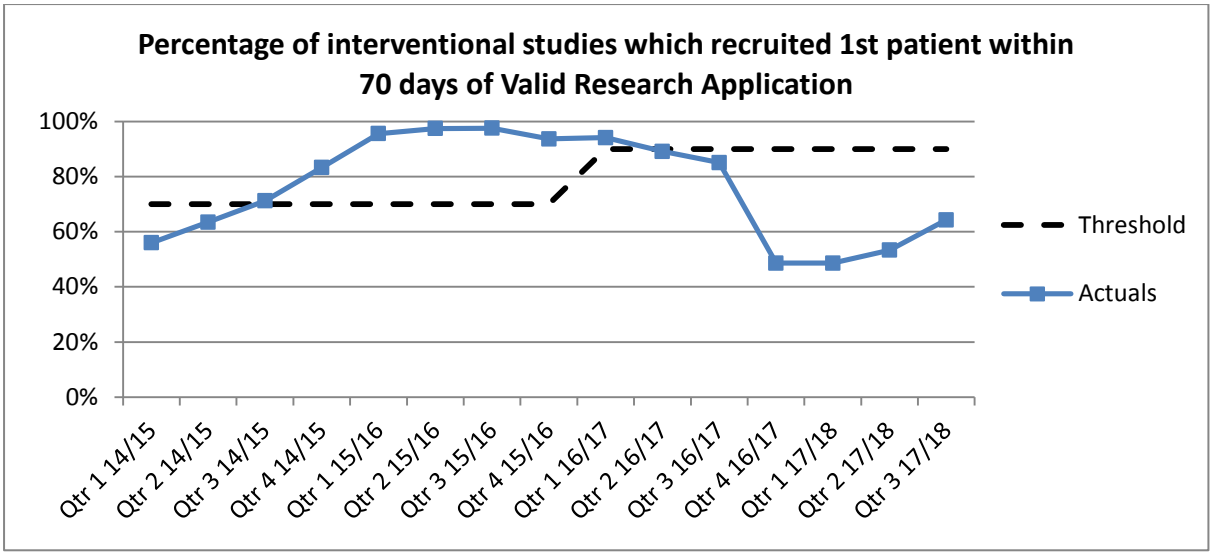


Chart 17 - Interventional studies which recruited first patient within 70 days of Valid Application Q1 2014/15 – Q3 2017/18

2.2.5 Effective: Readmission rates

The most recently reported 28 day readmission rates (through Dr Foster intelligence) continued to be lower in both age groups than the Shelford and National rates.

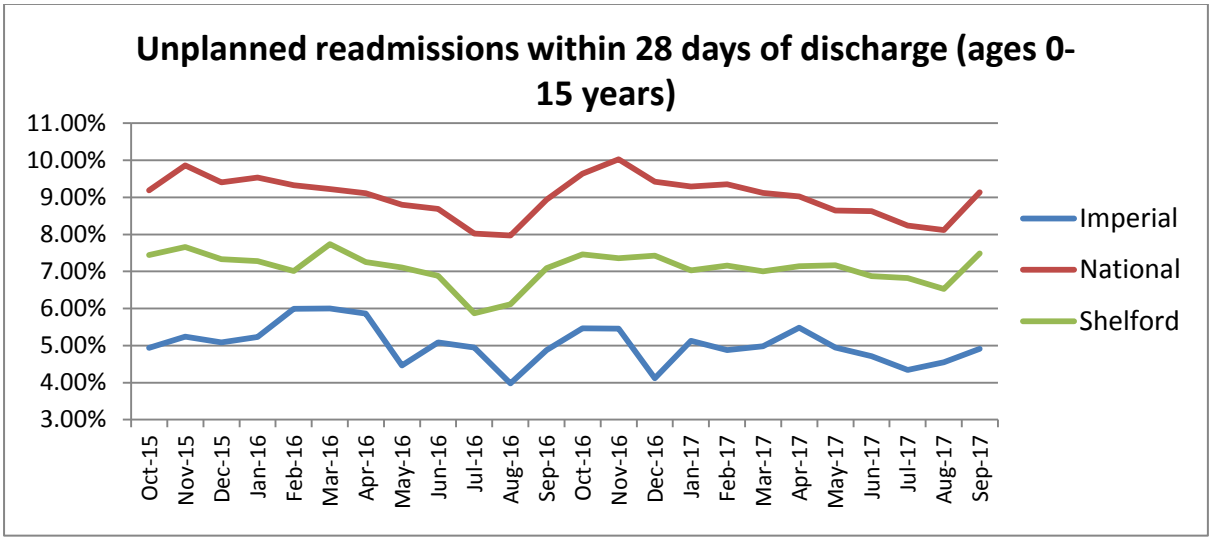


Chart 18 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages -15 years) for the period October 2015 – September 2017 (Source: Dr Foster Intelligence)

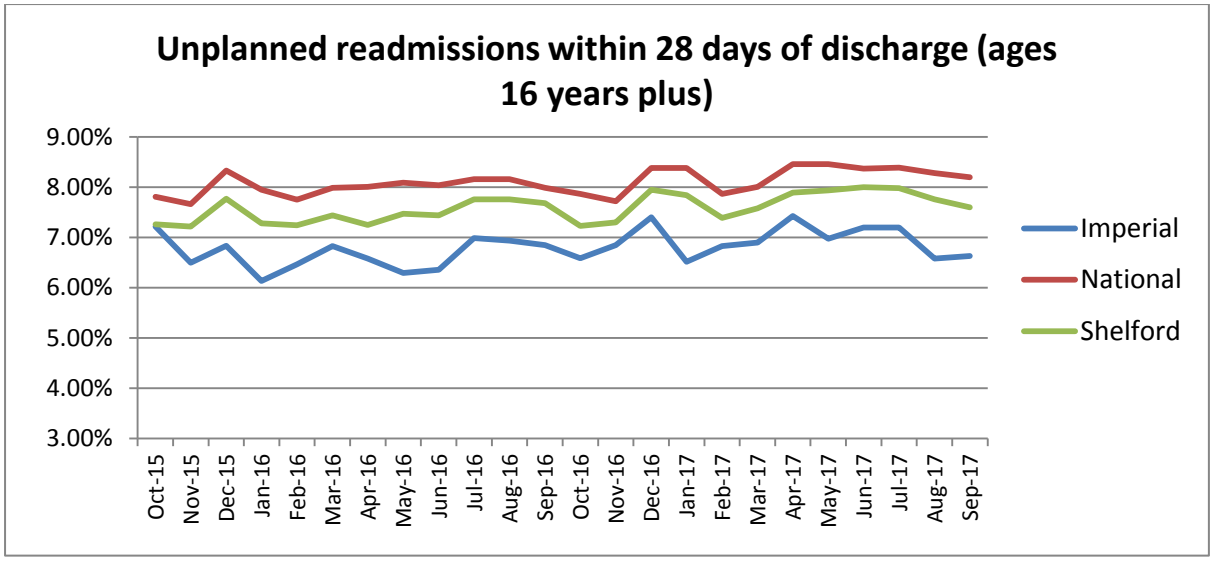


Chart 19 - Unplanned readmissions (to any NHS Trust) within 28 days of discharge from ICHT (ages 16 years plus) for the period October 2015 – September 2017 (Source: Dr Foster Intelligence)

2.2.6 Effective: Diagnostic and surgical orders waiting to be placed on the inpatient waiting list

This is a key data quality indicator in the trust data quality framework. It measures the number of requests for elective admissions (diagnostic or surgical procedure) placed by the clinical team, but these have not yet been processed by the administration team. Processing orders quickly ensures patients are appropriately placed onto the inpatient waiting list and facilitates the offer of timely treatment in line with RTT targets. The Trust operating standard is that orders should be processed within 2 working days of being placed by the clinician. The data quality action group that is being established will include agreeing local plans to address high numbers of orders that are not being processed quickly enough.

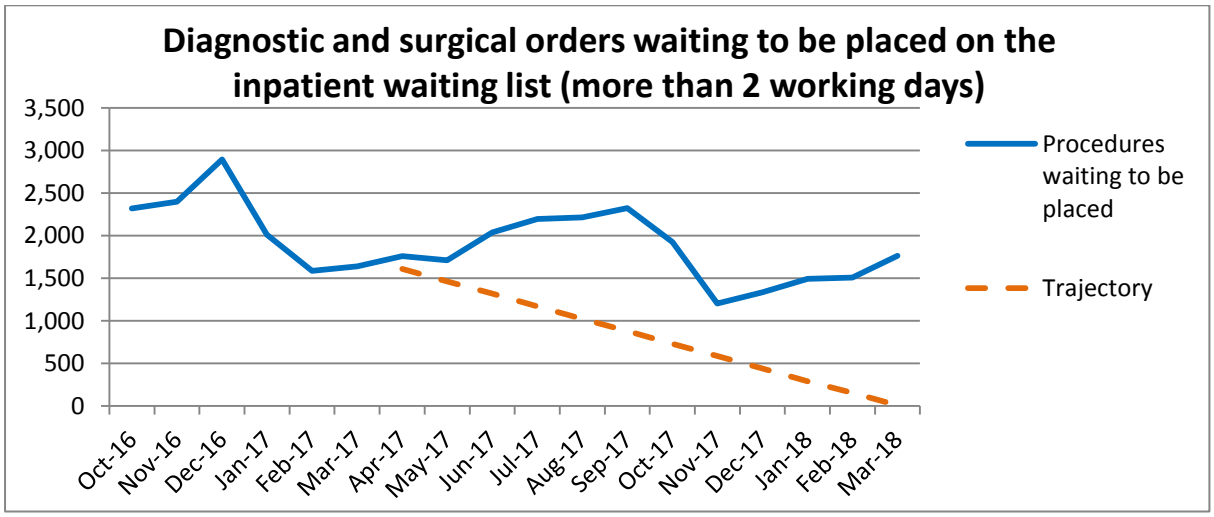


Chart 20 – Number of patients on the Add/Set Encounter request list of more than 2 working days for the period October 2016 – March 2018

2.2.7 Effective: Outpatient appointments checked in and checked out

When patients attend for their outpatient appointment they should be checked-in on the Trust patient administration system (CERNER) and then checked-out after their appointment. This is important so that the record of the patient's attendance is accurate and it is clear what is going to happen next in the patient's treatment journey. The escalation processes to clear appointments on the system in a timely manner continue to be implemented.

There has been an increase in appointments waiting to be cleared on the system and this is being driven mainly from our non-centralised booking areas. This is being discussed at the newly established waiting times data quality group to understand root causes.

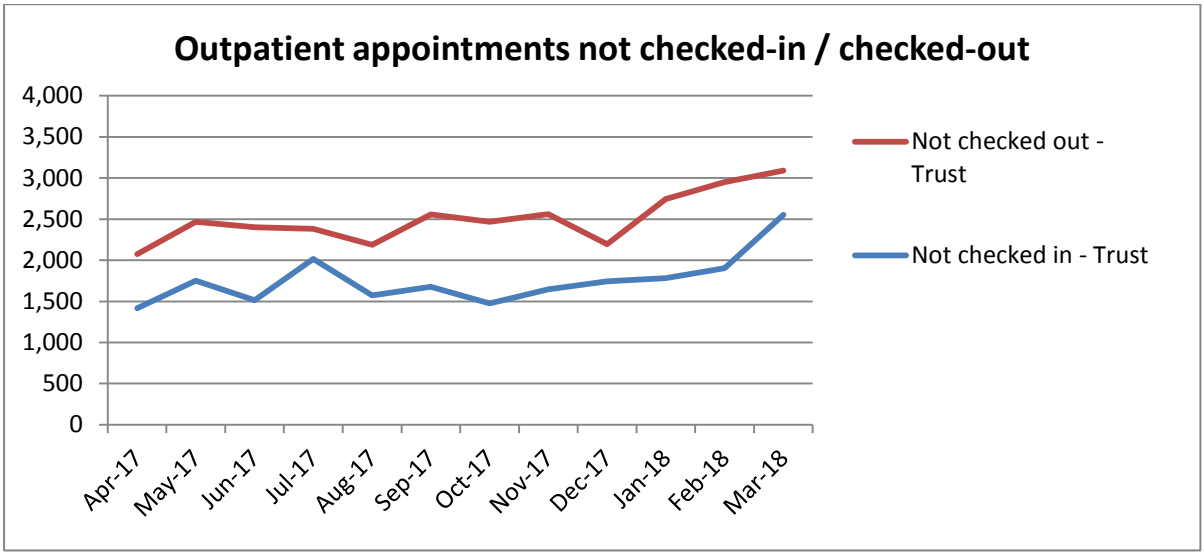


Chart 21 – Number of outpatient appointments not checked-in or DNA'd (in the last 90 days) AND number of outpatient appointments checked-in and not checked-out for the period April 2017 – March 2018

2.3 Caring

2.3.1 Caring: Friends and Family Test

The willingness to recommend remains generally high across all surveys. The dip in A&E response rates was due to one off issue with paper surveys in the urgent care centres, which has now been addressed.

Friends and Family test results

Service	Metric Name	Jan-18	Feb-18	Mar-18
Inpatients	Response Rate (target 30%)	35.00%	35.80%	35.80%
	Recommend %	98.00%	97.50%	97.50%
A&E	Response Rate (target 20%)	16.40%	16.80%	12.90%
	Recommend %	93.70%	92.50%	90.90%
Maternity	Response Rate (target 15%)	28.20%	36.40%	29.60%
	Recommend %	94.30%	94.40%	94.10%
Outpatients	Response Rate (target 6%)	14.30%	15.90%	16.00%
	Recommend %	91.40%	92.90%	92.30%

2.3.2 Caring: Patient transport waiting times

Non-Emergency Patient Transport Service

The metrics for estates maintenance performance are currently under review within the nursing directorate; these will be included as part of the updated integrated performance framework during 2018/19.

2.3.3 Caring: Eliminating mixed sex accommodation

The Trust reported 44 mixed-sex accommodation (MSA) breaches for March 2018. As previously reported the increase in breaches since October 2016 has been mainly attributable to breaches occurring within ITU at Charing Cross. For critical care (level 2 and 3) mixing is acceptable as it is recognised nursing acuity requires gender mixing, however in line with national policy it is not acceptable when a patient in the critical care units no longer requires level 3 or 2 care, but cannot be placed in an appropriate level one ward bed.

The Division of Surgery and Cancer are undertaking a detailed assessment of the situation in discussion with commissioners to understand root causes. This involves gaining an understanding of how other Trusts interpret the policy to report breaches within the context of critical care. The resultant actions with progress will continue to be reported to the Executive Quality Committee.

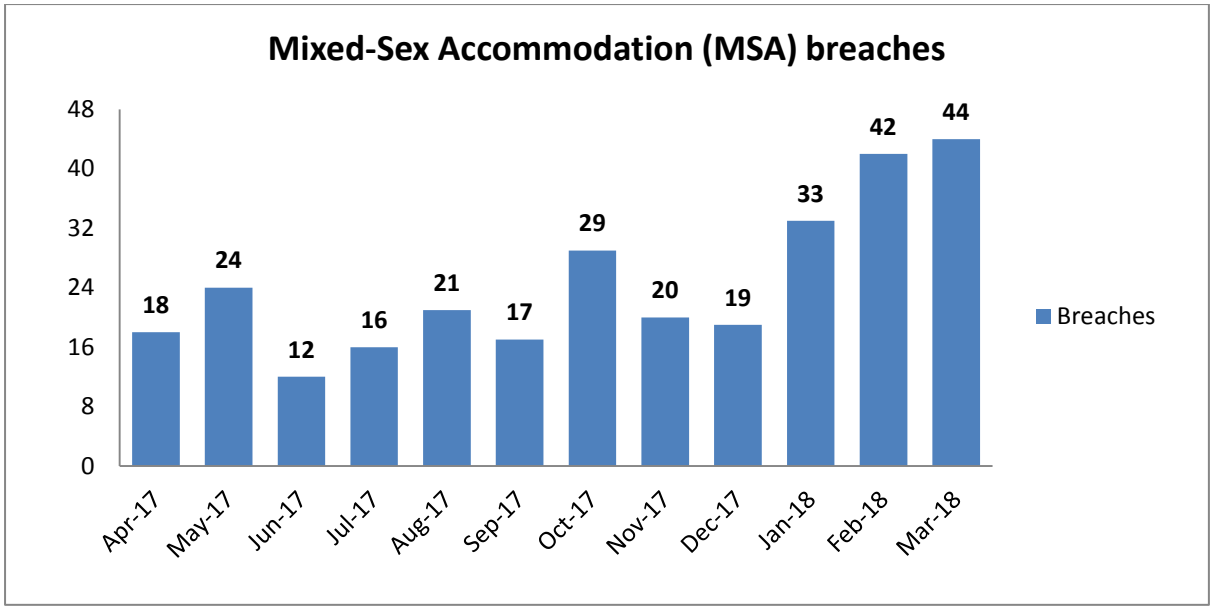


Chart 23 – Number of mixed-sex accommodation breaches reported for the period April 2017 – March 2018

2.3.4 Caring: Complaints

The volume of formal complaints remains consistent, but the proportion related to appointments, delays and cancellations has increased.

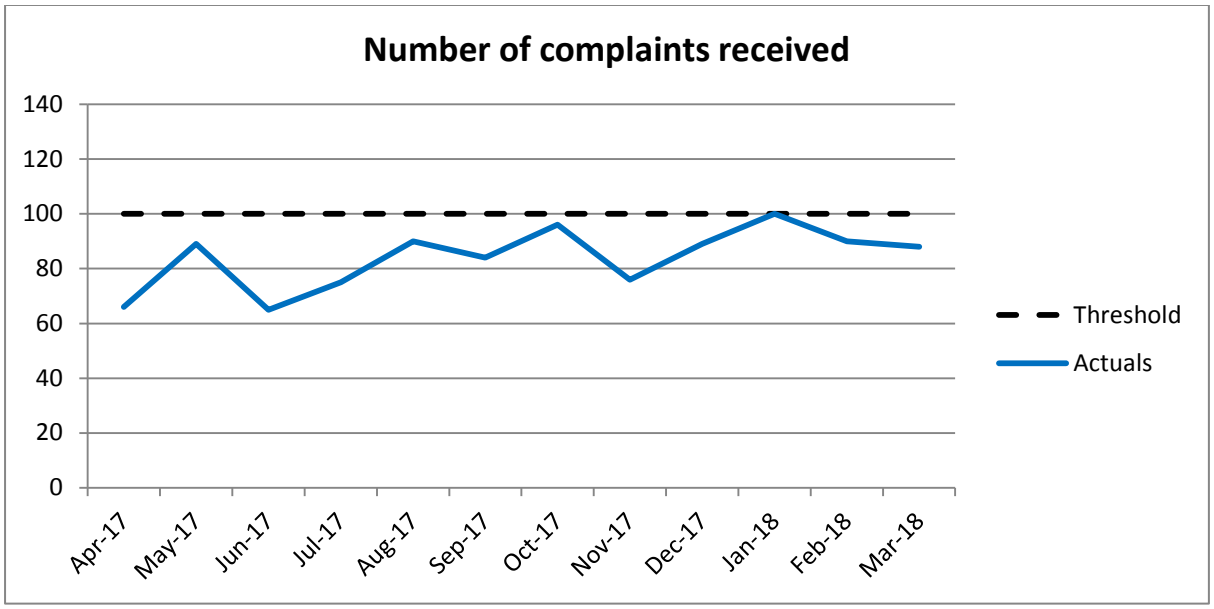


Chart 24 – Number of complaints received for the period April 2017 – March 2018

2.4 Well-Led

2.4.1 Well-Led: Vacancy rate

All roles

At the end of March 2018, the Trust directly employed 9,361 WTE (whole time equivalent) members of staff across Clinical and Corporate Divisions. The contractual vacancy rate for all roles was 12.7 per cent against the target of 10 per cent.

During the month there were a total of 140 WTE joiners and 157 WTE leavers across all staffing groups and the Trusts voluntary turnover rate (rolling 12 month position) stands at 9.1 per cent.

Actions being taken to support reduction in vacancies across the Trust include:

- Bespoke campaigns and advertising are underway for a variety of specialities. Imaging and Radiography are looking to target University Open days and third year students and will be hosting a CPD Open Day/seminar to attract candidates

- A Trust Open Day was held in Charing Cross on 29 March and a further Open Day took place at St Mary's on 18 April to support recruitment for Medicine within acute respiratory and Manvers ward

- A further Acute & Medicine for Elderly Open Day highlighting RRP is planned on 17 May and a Stroke & Neurosurgery Open Day will be held in the next 6 weeks

- An HCA Trust wide Open Day is being held on 27 April and additional HCA assessment centres have been introduced to increase candidate numbers

- Recruitment will be attending RCN nursing and midwifery jobs fair on 20 April and will have a stall at the RCN Congress in Belfast in May

- .A Preferred Supplier List is in place to support with the hard to recruit areas which have already resulted in a number of placements

- The Careers website content is being redrafted and the design is taking an incremental approach. A meeting is being held on 9 May involving Recruitment, Marketing and a number of nursing leads to agree on appropriate careers site content. The new recruitment look and feel is now live and marketing materials have been developed to support recruitment activity. All hard to recruit areas adverts have been redesigned, refreshed and are live to ensure a more compelling and consistent look and feel in the marketplace

All Nursing & Midwifery Roles

At end of March 2018, the contractual vacancy rate for all of the Trusts Nursing & Midwifery ward roles was 14.2 per cent with 725 WTE vacancies across all bands. Within the band 2 – 6 roles of this staffing group, the vacancy rate stands at 15.5 per cent and we continue to work with other London Acute Teaching Trusts to share

information to support a reduction in these vacancies.

Actions being taken to support reduction in our Nursing and Midwifery vacancies include:

- A project group is up and running to address Band 2-6 ward based recruitment & retention. The plan is being refreshed for 2018/2019

- An automatic conditional offer letter was sent out to all of our student nurses who will graduate in February. We have had 39 of our 47 students accept our offer to date. The automatic offer letter has already been sent out to those who complete their qualification in August. There is a 'Student Attraction Strategy' which will build on this activity year on year (including adverts on job boards, attending student fairs and looking at the offer and support we give to newly qualified nurses as part of the Recruitment and Retention plan) to work towards making us an 'employer of choice' for students

- A social media campaign has commenced for Medicine for the Elderly and an Open Day ran on 28th February. A Recruitment and Retention Premium (R&RP) has been agreed for areas which have a vacancy rate above 35% in Medicine. This has been launched for Acute Medicine and Medicine for the Elderly to date and we have seen a boost in applications.

- We continue to pilot a pro-active sourcing tool which holds membership of job boards and databases to source out candidates

- Midwifery will be looking to target specific Midwifery events this year and hosting specific recruitment events to attract Band 6 experienced midwives. They are also looking at creating Band 6 developmental pathway roles that can offer career development

- The volume assessment centres have been revised to make them more efficient, effective and to realise a better candidate experience and conversion rate. This will be an iterative process and further changes will be made as needed

- We have agreed to do monthly Open Days for clinical haematology instead of quarterly and we are also currently putting a case together for an R&R Premium. We will be having an Open Day for 7 North when the refurbishment is finished in early April.

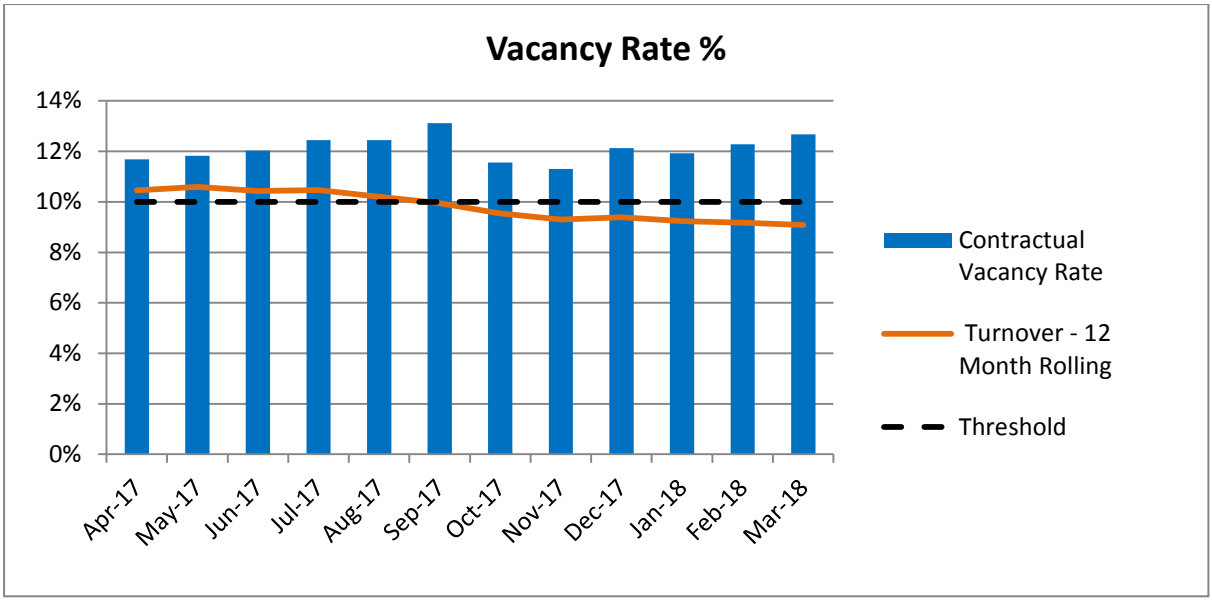


Chart 25 - Vacancy rates for the period April 2017 – March 2018

2.4.2 Well-Led: Sickness absence rate

Recorded sickness absence in March was 3.1 per cent, bringing the full-year Trusts rolling 12 month sickness position to 2.9 per cent, achieving the target of 3.10 per cent or lower.

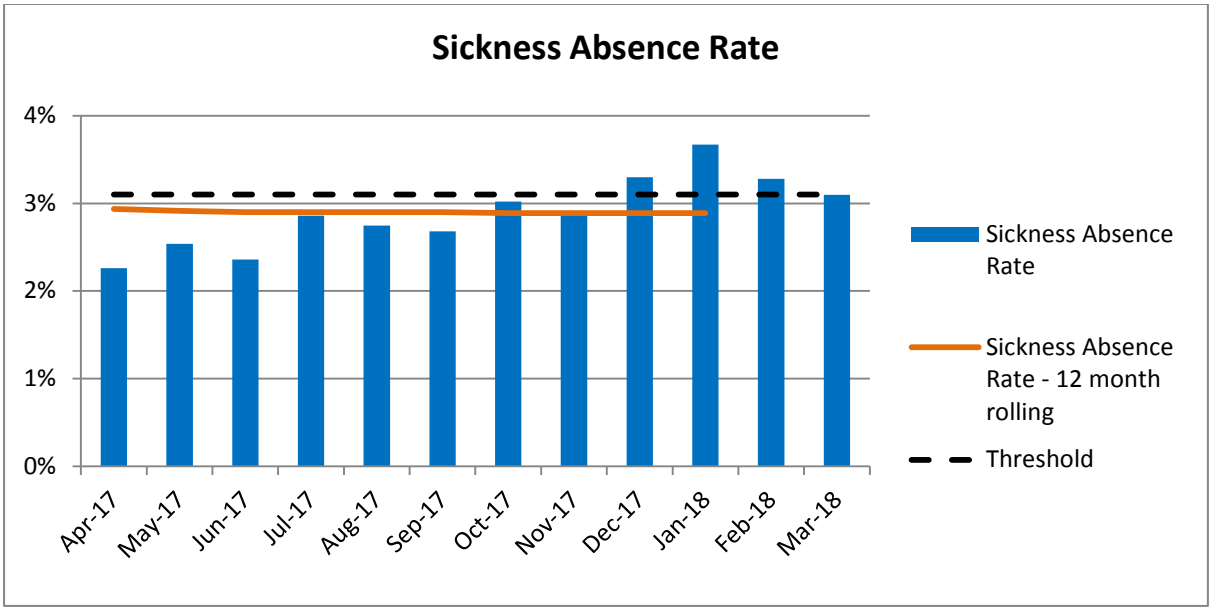


Chart 26 - Sickness absence rates for the period April 2017 – March 2018

2.4.3 Well-Led: Performance development reviews

The PDR cycle for 17/18 began on 1st April 2017 and closed on the 31st July 2017 with 88.5 per cent of staff having completed a PDR with their line manager; reviewing past year performance against objectives and the Trust values, agreeing

personal development plans and setting objectives for the year. The new PDR cycle begins in April 2018.

2.4.4 Well-Led: Doctor Appraisal Rate

Doctors' appraisal rates are 84.53 per cent this month, compared to 88.34 per cent in February. Actions being taken to increase compliance include continuing the Professional Development monthly drop-in sessions across all Trust sites, reviewing the automated reminder emails from PREP and reviewing the system to ensure it is user friendly and easy to navigate by doctors. Individual contact continues with doctors who are overdue with escalation of actions in line with the trust policy. A list of overdue appraisals is being circulated to the divisions each month to allow appropriate management according to the escalation process. There are 66 doctors who are more than eight weeks overdue who are being supported by the professional development team. Appropriate RO intervention is being taken in line with the policy.

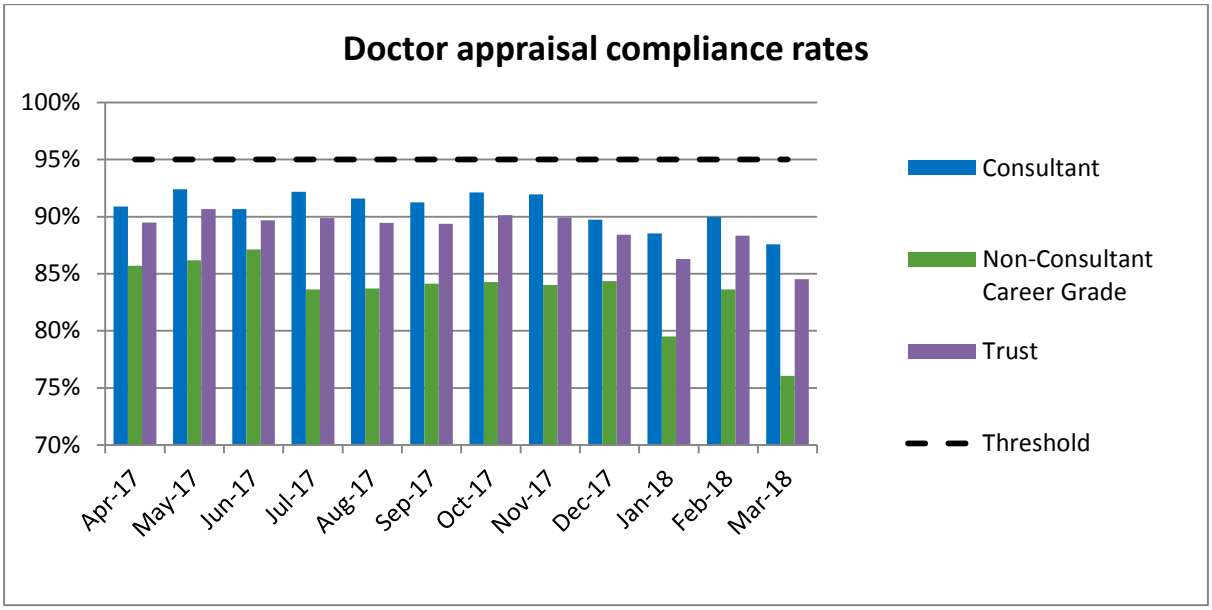


Chart 27 - Doctor Appraisal Rates for the period April 2017 to March 2018

2.4.5 Well-Led: Staff Friends and Family

The overall Engagement score increased from 77% in 2016 to 80% in 2017. The headlines of the Staff Friends and Family test results showed that:

- 86% of staff recommend the Trust as a place for care or treatment
- 72% of staff recommend the Trust as a place to work

The FFT scores were our highest performance to date in the last three years. The Trust has undertaked the 2017 NHS National Staff Survey and the results will be published in March 2018.

2.4.6 Well-Led: General Medical Council - National Training Survey Actions

Health Education England quality visit

The quality visit action plan has now been closed based on the evidence submitted.

2016/17 General Medical Council National Training Survey

The results of the General Medical Council's National Training Survey 2017 were published in July. The 2016 survey demonstrated significant improvements on previous results. The 2017 results indicate that we have maintained our performance overall, with some specialties demonstrating significant improvements, while others either remain challenged or have seen a deterioration in performance. On-going internal monitoring is being undertaken for specialities of concern through education specialty reviews.

In 2015 three specialities were put under enhanced monitoring by the GMC – critical care at Charing Cross Hospital, ophthalmology and neurosurgery. Formal actions plans were put in place with progress monitored at monthly meetings with the Medical Director, and locally through local faculty groups. The 2017 results for both ophthalmology and neurosurgery demonstrated sustained performance and therefore the GMC have removed them from enhanced monitoring. Critical care remains under enhanced monitoring and the recurring red flags triggered a quality review from Health Education England in September which resulted in an additional action plan around developing the workforce, developing MDT simulation opportunities and enhancing supervision.

Health Education England (HEE) requested action plans in response to the survey results with 10 actions remaining outstanding. These are being monitored via the education specialty reviews and local faculty groups and will be reported in this report. A progress report on our actions was submitted to HEE on 19th January 2018.

The General Medical Council's National Training Survey 2018 is now open with results expected in July 2018.

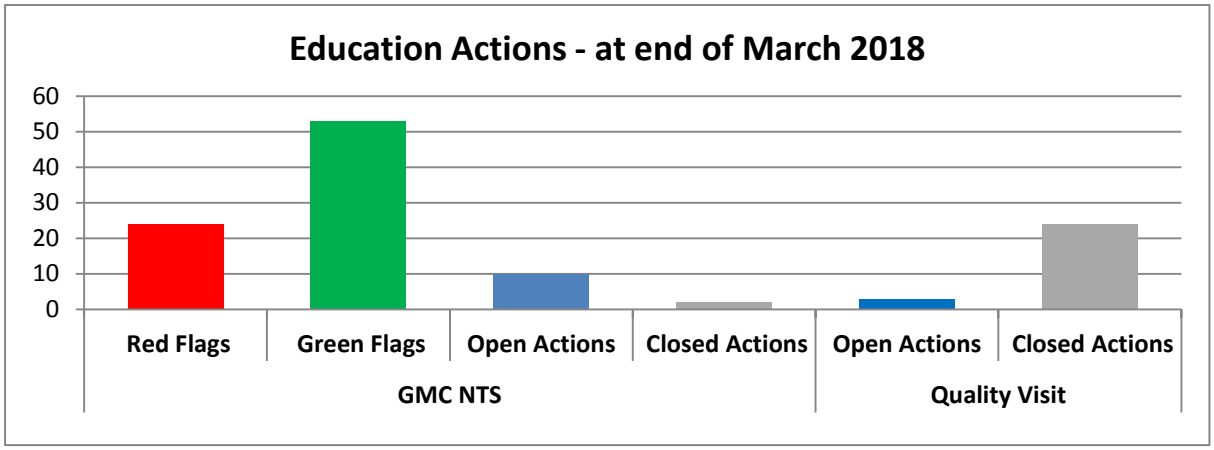


Chart 28 – General Medical Council - National Training Survey action tracker, updated at end March 2018

2.4.7 Well Led: Estates – maintenance tasks completed on time

The metrics for estates maintenance performance are currently under review within the nursing directorate; these will be included as part of the updated integrated performance framework for 2018/19.

2.5 Responsive

2.5.1 Consultant-led Referral to Treatment waiting times

At end of March 2018, 83.3 per cent of patients had been waiting less than 18 weeks to receive consultant-led treatment, against the standard of 92 per cent (February performance was 82.8 per cent). There were 267 patients who had waited over 52 weeks for their treatment since referral from their GP.

The temporary postponement of non-urgent elective activity in January 2018 (to support the emergency pathways as part of the national response), and continued bed pressures in February led to significant numbers of cancellations. This is now feeding through to more long-waiting patients on the waiting list. RTT action plans and recovery trajectories for the most challenged specialties are now in place, and the Trust-level RTT recovery trajectory for 2018/19 is being finalised in line with the updated 2018/19 planning guidance.

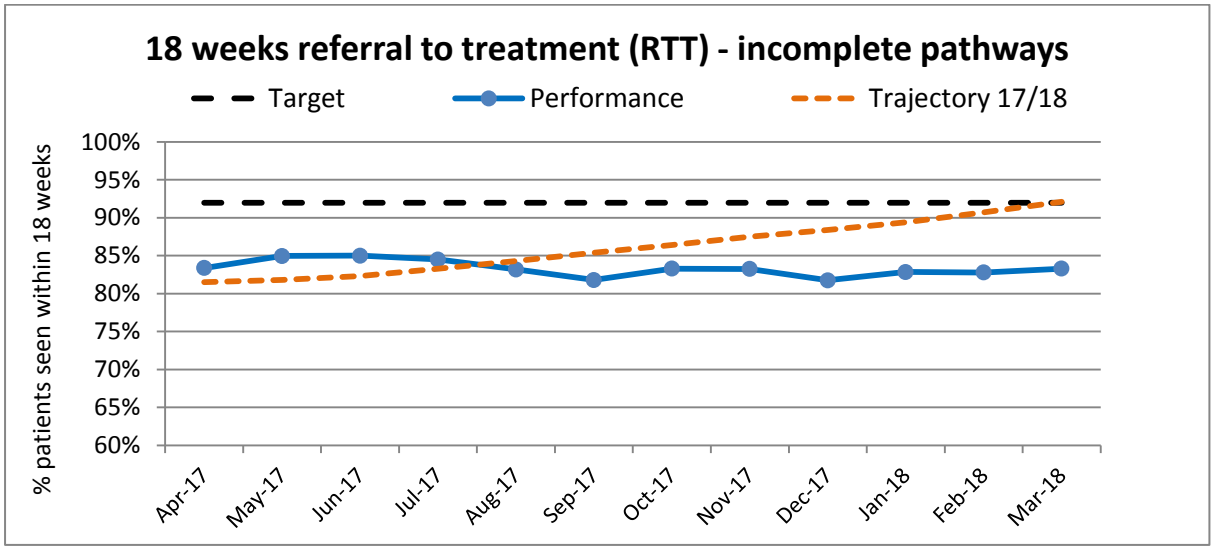


Chart 29 – Percentage of patients seen within 18 weeks (RTT incomplete pathways) for the period April 2017 – March 2018

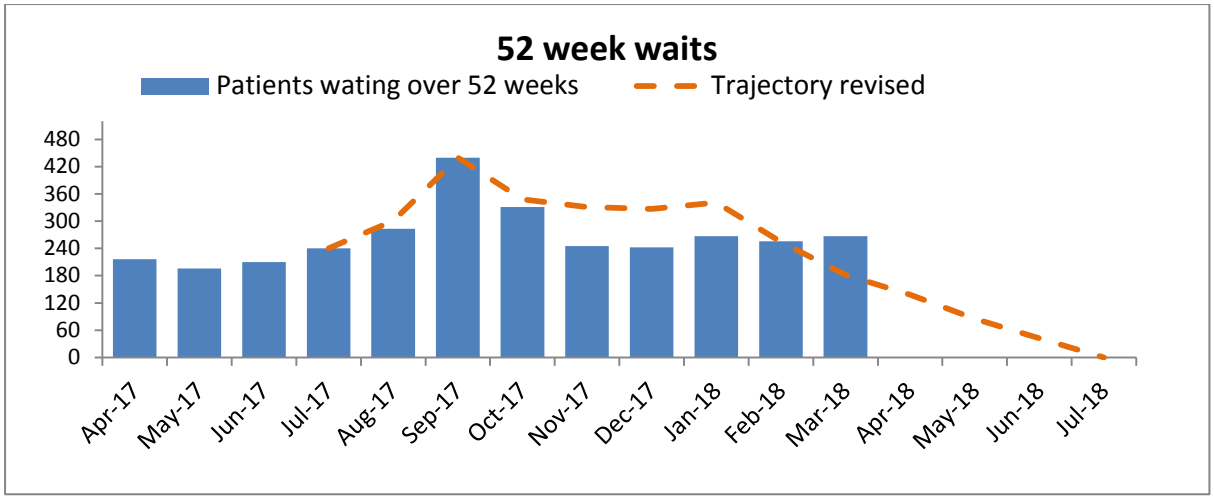


Chart 30 - Number of patients waiting over 52 weeks for the April 2017 – March 2018

2.5.2 Cancer 62 day waits

Due to the timing of submissions cancer performance is reported for February 2018. The Trust achieved the 62-day standard, delivering performance of 88.5 per cent against, above the trajectory target of 85.1 per cent.

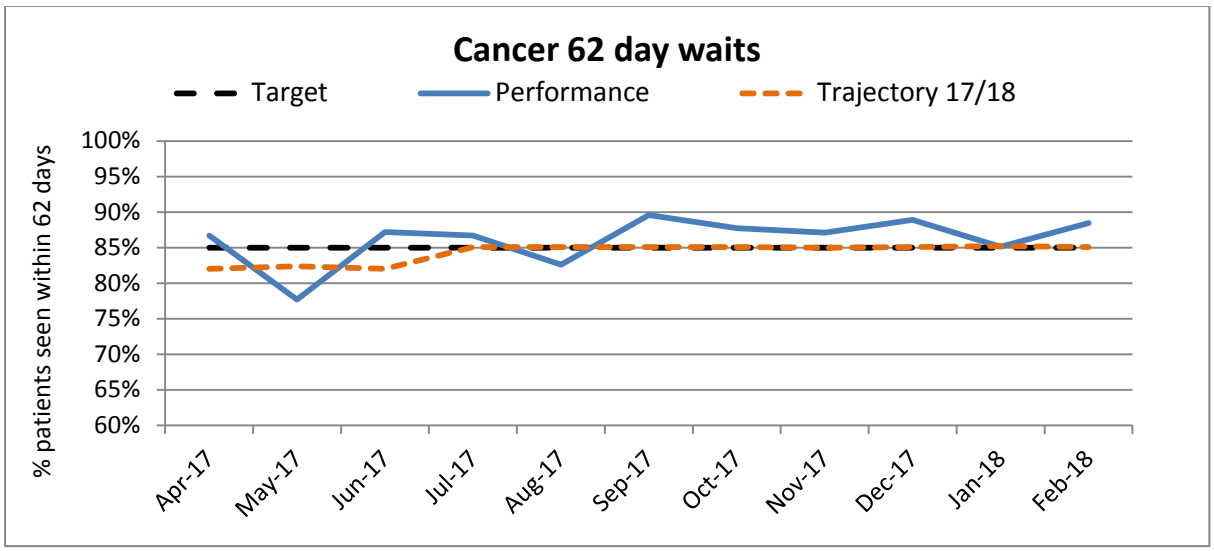


Chart 31 – Cancer 62 day GP referral to treatment performance for the period Apr 2017 – February 2018

2.5.3 Theatre utilisation

Based on the Trust's current methodology for measuring elective theatre productivity the performance in March 2018 was 75 per cent against a target of 85 per cent (includes elective, trauma and waiting list initiative sessions and excludes emergency and private sessions).

The key issues remain as follows:

- On the day cancellations rose significantly across the Trust during March, especially at SMH due to the unavailability of wards beds (General Surgery and

Gynaecology)

- At CXH there was a rise in cancellations due to DNA's and patient unfit for surgery, which were largely the result of continued booking/scheduling issues (T&O and Neurosurgery)
- Significant opportunity[1] exists within Trauma & Orthopaedics and Gynaecology (22 per cent and 28 per cent respectively of the Trust's overall opportunity for March)

Performance is being reviewed within the Trust's weekly Theatres SRO meeting with Four Eyes. Site performance is also monitored at a Divisional level at the monthly Divisional Committee. The Four Eyes productivity programme continues to show signs of improved performance across all areas of focus.

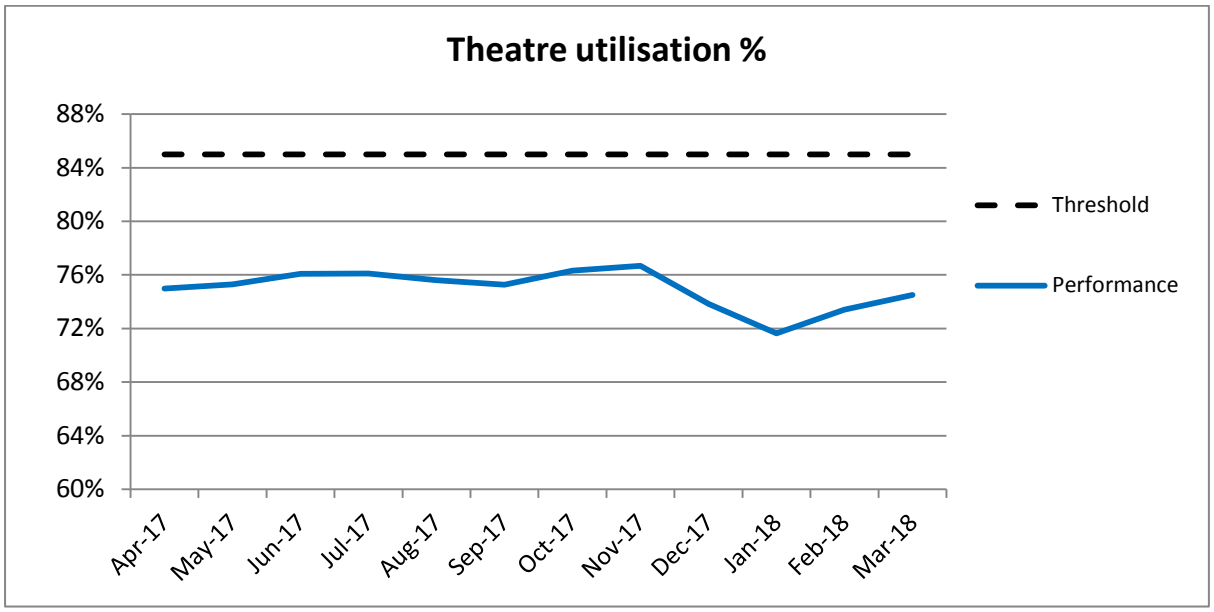


Chart 32 – Average theatre utilisation – elective lists (Trust) for the period April 2017 – March 2018

2.5.4 28-Day Rebookings

Cancelled operations performance is submitted quarterly and a full update will on the trends and impact of the quarter 4 cancellations will be provided in the subsequent report.

2.5.5 Accident and Emergency

Performance against the four-hour access standard for patients attending Accident and Emergency was 83.2 per cent in March 2018. There were eight 12-hour trolley wait breaches for the month (source: monthly A&E SitRep to NHS England).

[1] Opportunity is defined as the sum of late starts, early finishes and overruns in minutes

The Trust continues to experience significant pressures and the key issues remain as follows:

- Increased demand and acuity within type 1 departments
- An increase in arrivals via ambulance and daily trauma presentations at SMH;
- Difficulties with late transfer of patients from the Vocare UCC to the Emergency Department at SMH; &
- High levels of bed occupancy

The Trust continues the programme of patient flow improvements which are overseen by the four-hour Performance Steering Group.

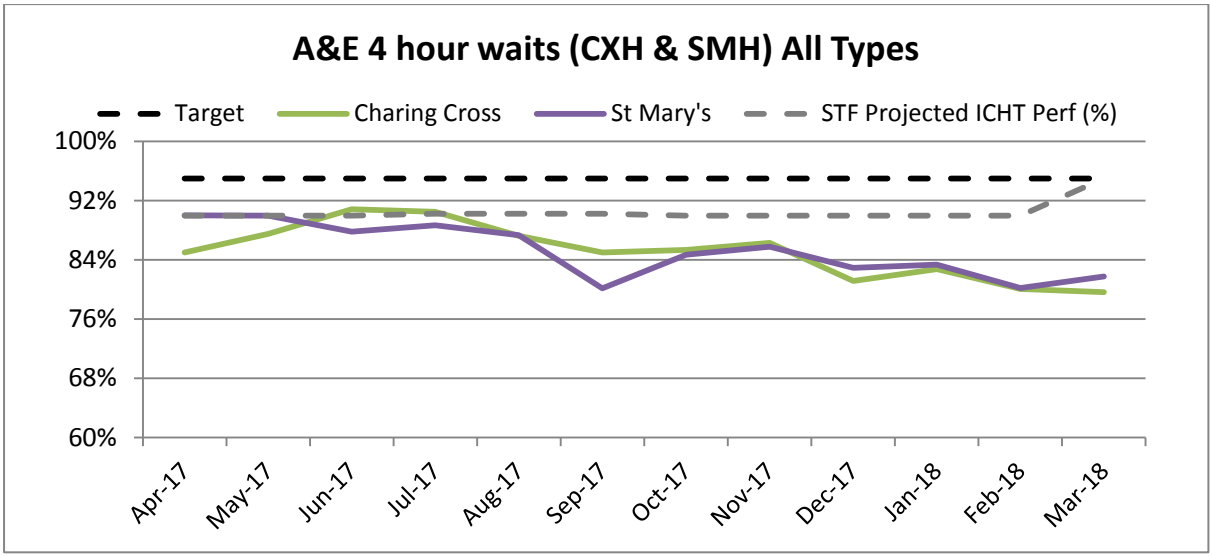


Chart 33 – A&E Maximum waiting times 4 hours (CXH and SMH) for the period April 2017 – March 2018

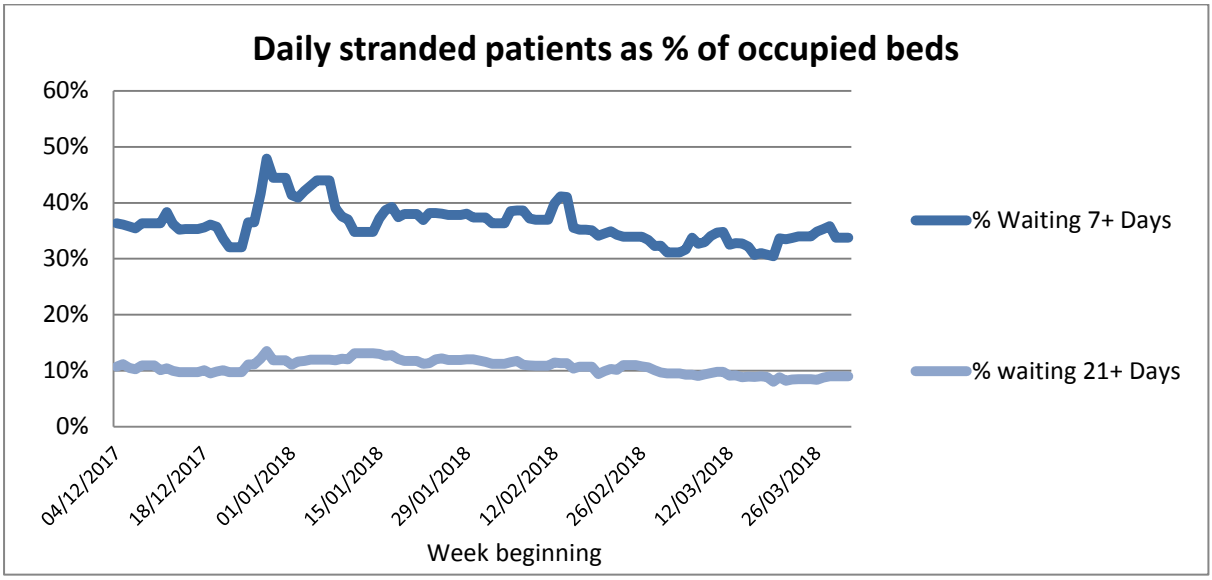


Chart 34 Daily trend in occupied beds that were occupied by patients who have been in hospital 7 days or more (stranded) and patients who have been in hospital 21 days or more (super stranded), from 4 December 2017

The chart shows 'stranded' patients (LOS 7 days or more) and 'super stranded' patients (LOS 21 days or more) (as a subset of the above) as a % of total occupied beds. The source is the daily SitRep report to NHS Improvement.

2.5.6 Effective: Discharges before noon

The Trust is supporting wards to implement the SAFER flow bundle which combines five elements of best practice to improve patient flow and prevent unnecessary waiting for patients. This includes early discharge to make beds available on the wards to admit new patients from A&E. The March performance was 13 per cent of patients discharged before noon. The aim is to achieve the national standard of 33 per cent as set out in the SAFER bundle.

Regular reports on discharge by noon data by ward are being published on the source to show where good patient flow is being achieved and where improvements need to be prioritised. Several wards already have board rounds in place and more are expected to implement these as part of the roll out of SAFER. Multidisciplinary engagement is required from across the Trust to ensure SAFER board rounds are embedded as business as usual.

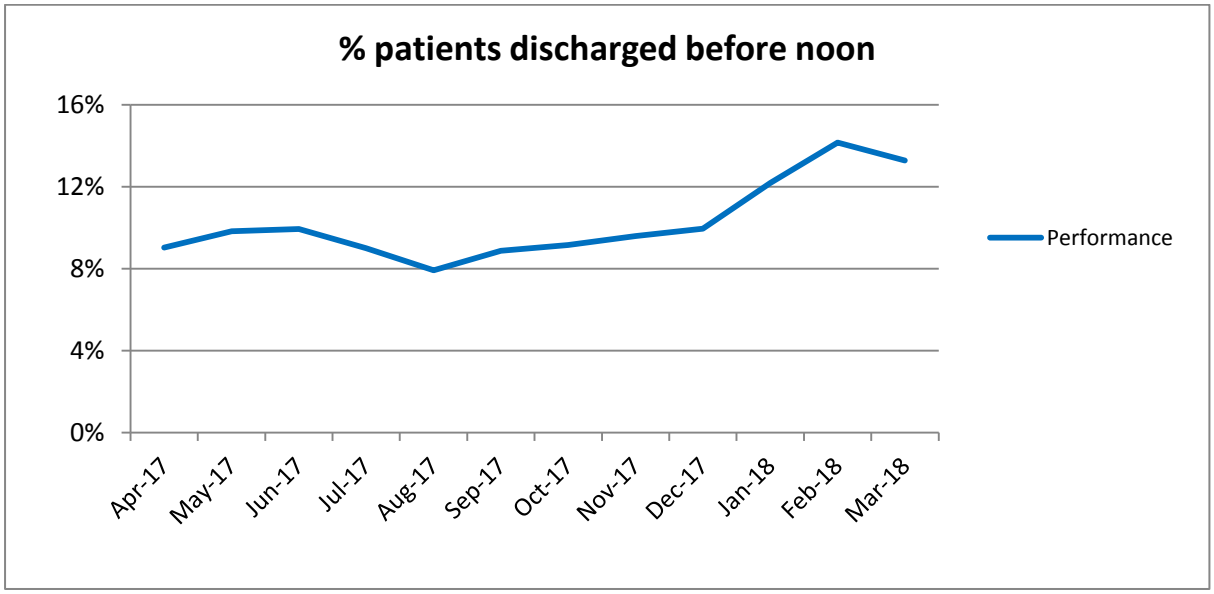


Chart 35 – Patients discharged before noon as a % of total discharges for the period April 2017 - March 2018

2.5.7 Diagnostic waiting times

In March 2018, the diagnostics waiting times performance was recovered to deliver 0.9 per cent of patients who had waited over six weeks for their diagnostic test, meeting the national target of less than 1 per cent.

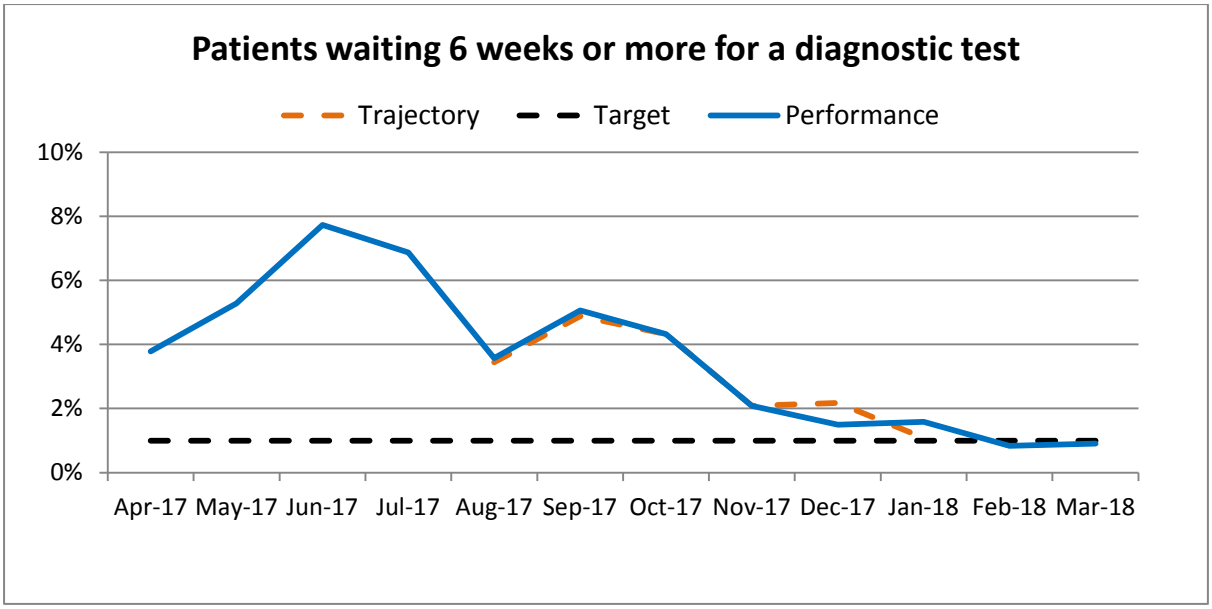


Chart 36 – Diagnostic waiting times for the period April 2017 – March 2018

2.5.8 Outpatient DNA

The overall DNA rate was 11.8 per cent in March 2018. This represented an increase of the 10.8 per cent DNA rate in January and February 2018, for which no root cause has been identified. Analysis of the DNA rate using SPC has showed that the March 2018 DNA rate was within the control limits and did not highlight special cause variation.

The priority is to reduce the numbers of patients not attending their appointments to less than 11 per cent with a target of 10 per cent in 2018/19. Actions include:

- Promoting option for patients to receive appointment letters via email providing instant notification of appointments;
- Deliver a single point of access for appointment handling and queries; &
- Informing patients of the cost to the Trust of missed appointments, through patient communications.

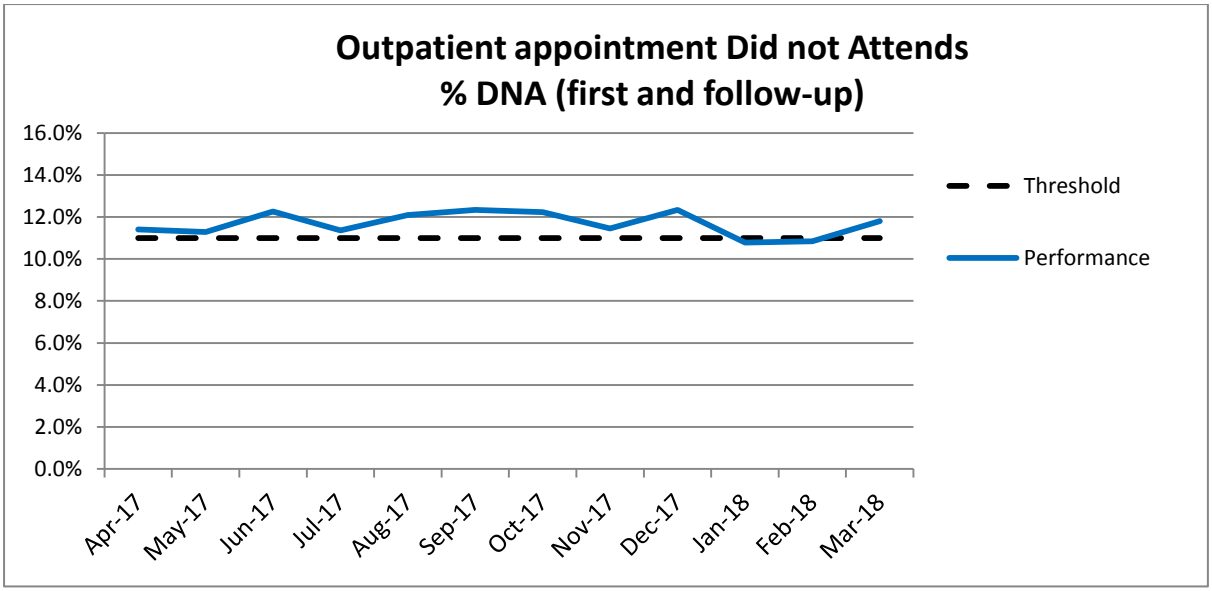


Chart 37 – Outpatient appointment Did not Attend rate (%) first and follow appointments for the period April 2017 – March 2018

2.5.9 Outpatient appointments made within 5 days of receipt

Further improvements are expected with the roll-out of e-vetting as the turnaround time for the vetting processes and turnaround times can be reduced. Further improvements are also expected when the introduction of capacity escalation is added to the e-vetting product.

Outsourcing can have a negative impact on this KPI as we do not routinely book those services that outsource until 14+ days after referral receipt date. This is to give the outsourcing team time to liaise with the outsourcing provider and patient. If a patient is not outsourced, they will return to the outpatient waiting list at 14+ days and are booked in excess of the 5 working day target.

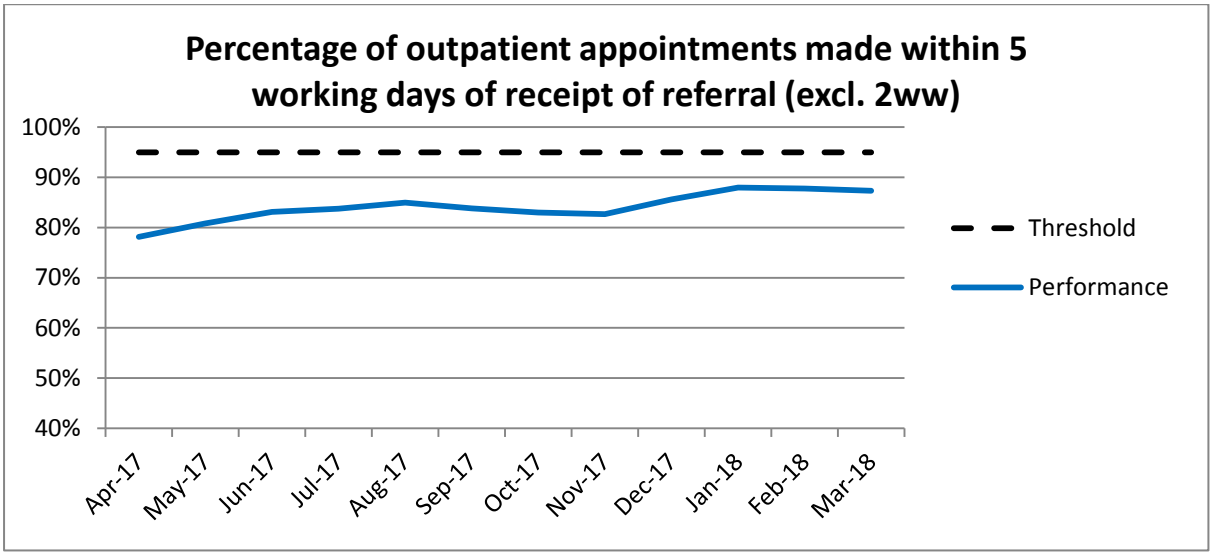


Chart 38 – % of outpatient appointments made within 5 working days of receipt of referral (excluding 2 week waits) for the period April 2017 – March 2018

2.5.10 Outpatient appointments cancelled by the Trust

The hospital initiated cancellation rate (less than 6 weeks' notice) was 9 per cent in March 2018. The division of WCCS is completing a review of the main drivers for hospital cancellations and patient impact with resultant actions to be discussed through the Executive Committee for Operational Performance.

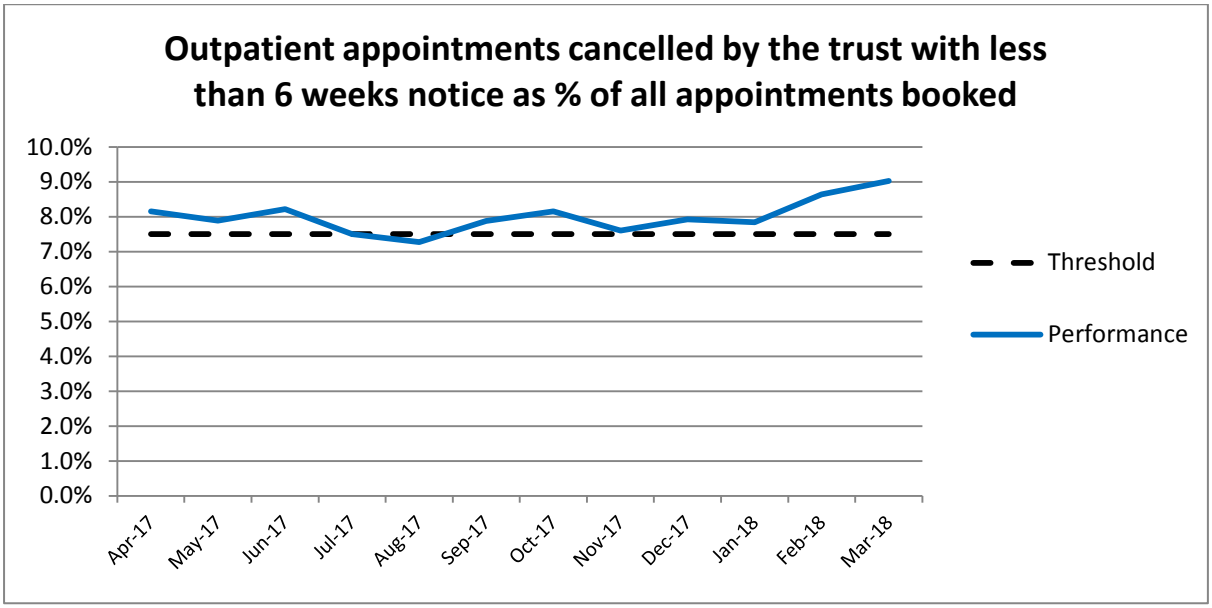


Chart 39 – Outpatient appointments cancelled by the Trust with less than 6 weeks' notice for the period April 2017 – March 2018

2.5.11 Waiting times for first outpatient appointment

A key milestone of the 18 week RTT pathway is the first outpatient appointment. This is where the patient will be assessed by a specialist and decisions on whether further tests are needed and the likely course of treatment are made. This indicator shows the average number of weeks that patients waited before attending their first outpatient appointment following a referral for routine appointments only. The average waiting time in March 2018 was 7.3 weeks to attending first appointment from referral (it was 8.8 in the same period last year). The waiting times vary widely between clinical services, ranging from 4 – 13 weeks.

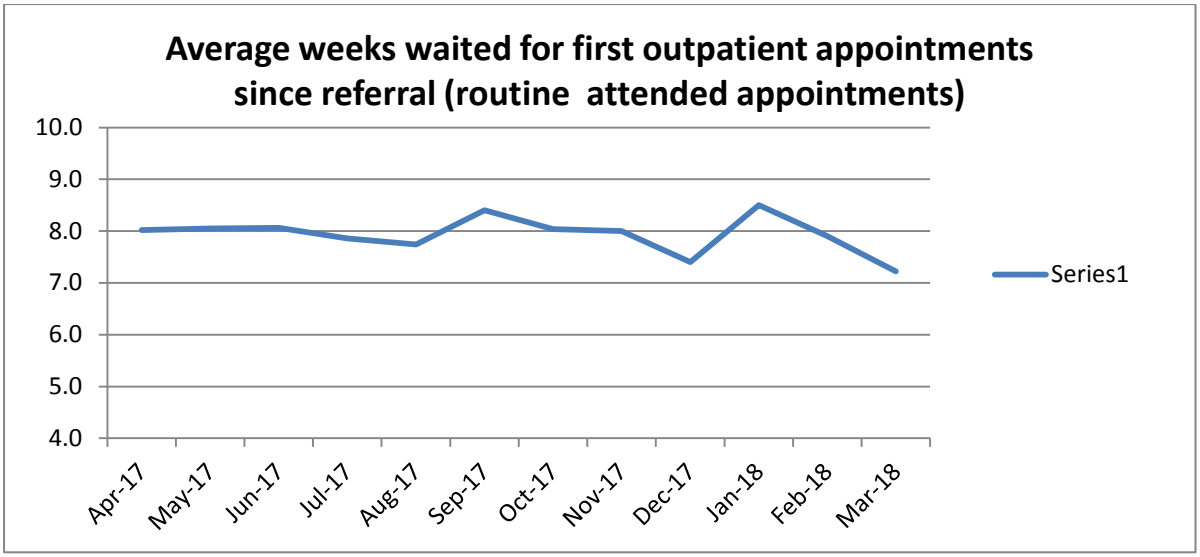


Chart 40 – Average weeks waiting time from referral to first outpatient appointment for the period January 2017 – February 2018 (routine appointments)

3. Finance

Please refer to the Monthly Finance Report to Trust Board for the Trust's finance performance.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	23 May 2018

Finance Report for y/e March

Executive summary:

This report provides a brief summary of the Trust's financial results for the 12 months ended 31 March, subject to audit.

The Trust met the Control Totals and all statutory financial targets set by the Regulator and after the allocation of Sustainability and Transformation Funding (STF) reports a small surplus. Before STF the Trust reports a £2.6m favourable variance to the agreed deficit plan of (£25.2m) of which £0.1m was operational and £2.5m was an adjustment for winter funding. After STF the Trust reported £7.5m favourable to the Control Total as additional incentive and bonus STF were allocated

Financial impact:

The financial impact of this proposal as presented in the paper enclosed:
The 17/18 results attracted additional STF as reported in the paper which has a largely reputational and minor I&E benefit to the Trust

Risk impact:

The reputational risk of missing the Control Total was avoided

Recommendation(s) to the Committee:

The Committee is asked to note the paper, including the risks and issues highlighted.

Trust strategic objectives supported by this paper:

Retain as appropriate:
To realise the organisation's potential through excellent leadership, efficient use of resources, and effective governance.

Author	Responsible executive director	Date submitted
Michelle Openibo, Associate Director: Business Partnering Janice Stephens, Deputy CFO	Richard Alexander, CFO	21 March 2018

FINANCE REPORT – 12 MONTHS ENDED 31st March 2018

1. Introduction

This report provides a brief summary of the Trust's financial results for the 12 months ended 31st March 2018. The financial position of the Trust is in draft until the auditors have completed their audit; this report represents the position as at 16th May 2018.

2. Key External Financial Metrics

- The Trust met the Control Totals and all statutory financial targets set by the Regulator and after the allocation of Sustainability and Transformation Funding (STF) reports a small surplus. Before STF the Trust reports a £2.6m favourable variance to the agreed deficit plan of (£25.2m) of which £0.1m was operational and £2.5m was an adjustment for winter funding. After STF the Trust reported £7.5m favourable to the Control Total as additional incentive and bonus STF were allocated.

- The Trust achieved the Capital Resource Limit (CRL) for the year, the net Trust funded capital plan was £47.5m with Trust outturn spend of £46.7m and the technical underspend was both unavoidable and agreed.

- The Trust achieved its External financing limit (EFL) for the year, the Trust is allowed to be under but not overspent against it. The EFL was £13.9m and the Trust reported £7.6m a headroom of £6.3m.

- As part of the single oversight framework the Trust has a score for Finance and use of resources based on 5 key metrics. The score for each metric ranges from 1 (best) to 4 (worst). On the liquidity metric the Trust scores a 4 and for this reason the Trust cannot score higher than 3 overall. Before this override the average of the 5 metrics is a rating of 1.8.

3. Financial Performance

Before Sustainability and Transformation Funding (STF) and the winter funding allocation the Trust reported a full year favourable variance to plan of £0.1m. Meeting the control total in year reflects a large amount of work in the organisation to identify and deliver savings and mitigate financial risks.

Core STF was £20.7m for the year; this was monitored based achievement of two targets. Financial performance accounted for 70% and A&E 4 hour performance accounted for 30%. The Trust has failed to achieve the A&E target and is therefore showing a £6.2m adverse variance on core STF. The Trust has achieved incentive and bonus STF to reflect achievement of the financial targets, overall the Trust received £11.0m additional STF funding. This brought the total STF to £25.5m against a £20.7m plan.

After STF and winter funding the Trust had a £3.0m surplus against a £4.5m deficit plan, a £7.5m favourable variance. This favourable variance is mainly due to non-recurrent STF and winter income and therefore does not help the Trust to meet its 2018/19 plan.

	In Month			Full Year		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	93.35	100.37	7.03	1,083.60	1,096.70	13.10
Pay	(48.95)	(52.02)	(3.08)	(587.00)	(593.74)	(6.74)
Non Pay	(38.03)	(48.38)	(10.35)	(455.66)	(480.39)	(24.73)
Reserves	0.50	9.15	8.65	(16.53)	(1.53)	15.00
EBITDA	6.88	9.13	2.25	24.41	21.04	(3.36)
Financing Costs	(3.65)	(4.68)	(1.03)	(43.44)	(46.35)	(2.91)
SURPLUS / (DEFICIT) inc. donated asset treatment	3.23	4.45	1.22	(19.03)	(25.30)	(6.27)
Donated Asset treatment	(0.51)	0.13	0.64	(6.12)	(5.52)	0.60
Impairment of Assets	-	-	-	-	5.80	5.80
SURPLUS / (DEFICIT)	2.72	4.58	1.86	(25.15)	(25.01)	0.14
STF Income	2.84	13.07	10.23	20.65	25.54	4.89
Winter Pressures	-	1.25	1.25	-	2.50	2.50
SURPLUS / (DEFICIT) after STF income	5.56	18.90	13.34	(4.50)	3.02	7.52

Year to date income is above plan due to NHS activity based income, mainly in non-elective income where the Trust has seen significant over performance against plan.

Pay and non-pay costs are overspent in the year; this has been due to additional costs of delivering the activity over performance, including the costs of outsourcing. There have also been overspends where cost improvement programmes (CIPs) have not been identified.

3.1. NHS Activity and Income

The summary table shows the position by division

Divisions	Year To Date Activity			Full Year		
	Plan	Actual	Variance	Plan	Actual	Variance
Division of Medicine & Integ. Care	855,804	861,894	6,090	256.89	264.95	8.05
Division of Surgery, Cancer & Cardiov.	709,648	701,842	(7,806)	307.63	313.70	6.07
Division of Women, Children & Clin. Support	2,635,940	2,493,733	(142,207)	159.68	155.32	(4.36)
Central Income				137.59	128.21	(9.39)
Clinical Commissioning Income	4,201,392	4,057,469	(143,923)	861.80	862.18	0.38

Year to date the Trust is slightly over performing on NHS clinical commissioning income; however this consists of a £9.4m underspend on pass through drugs and devices, where the Trust has been working with commissioners to reduce this spend, and a £9.8m over performance on other commissioning income. The largest area of over performance for the Trust is on non-elective. This is offset by underperformance on maternity, community and unbundled diagnostics.

Medicine and Integrated Care (MIC) is over performing driven by non-elective activity. There has also been over performance in Stroke and Neurosciences activity. There is some under performance in renal due to reductions in critical care activity and dialysis sessions

Within Surgery, Cancer and Cardiovascular (SCC) there is over performance within clinical haematology and on critical care activity. There is underperformance in cardiology due to the community activity. There was under performance in surgical directorates including General and Vascular Surgery and Trauma, winter pressures in the year have caused cancelations in surgical areas, especially in January.

Women, Children and Clinical Support (WCCS) underperformance is mainly due to maternity. There has been a reduction in births numbers but an increase in complexity and the service is undertaking a review based on this changed activity. There is also underperformance in pathology income; this activity is undertaken by North West London Pathology but shown in WCCS in year.

3.2. Private Patient Income

This year there has been significant growth in private patient income with an increase of £4.2m over 2016/17. There has been an increase from the introduction of the private IVF service but also a general increase in the income from a number of specialties across the Trust such as Clinical Haematology, Cardiology and Renal. This has been offset by a reduction in Children's Bone Marrow Transplant (BMT) activity due to changes in the referrals to this service.

3.3. Clinical Divisions

The financial position by clinical divisions is set out in the table below. Clinical divisions are favourable to plan in month and adverse year to date.

	In Month			Full Year		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical Divisions						
Income	23.29	25.67	2.38	274.74	281.60	6.85
Expenditure	(17.13)	(18.74)	(1.62)	(210.35)	(218.90)	(8.56)
Medicine and Integrated Care	6.17	6.93	0.77	64.40	62.69	(1.70)
Income	27.32	29.56	2.23	315.01	322.66	7.65
Expenditure	(22.07)	(24.21)	(2.14)	(267.59)	(280.55)	(12.97)
Surgery, Cancer and Cardiovascular	5.26	5.35	0.09	47.43	42.11	(5.31)
Income	15.39	15.57	0.18	182.59	171.24	(11.35)
Expenditure	(18.19)	(17.12)	1.07	(199.30)	(196.46)	2.83
Women, Children & Clinical Support	(2.80)	(1.55)	1.25	(16.71)	(25.23)	(8.52)
Imperial Private Healthcare	1.39	1.61	0.22	13.87	16.04	2.17
Total Clinical Division	10.01	12.34	2.33	108.98	95.61	(13.37)

Within MIC there has been high income over performance with associated costs for delivery, especially in clinical supplies. The adverse expenditure position is due to these costs and undelivered CIPs. SCC has significant NHS income over performance with additional costs of staffing in theatres and outsourced services. There has also been over performance in private income relating to Clinical Haematology. WCCS NHS income underperformance is due to a smaller than expected level of deliveries but the increased acuity has constrained the service's ability to reduce costs. There has also been under performance on the Children's BMT service which sits within the division. IPH shows a positive variance to plan due to income over performance.

4. Efficiency programme

The Trust set a £54.4m cost improvement programme (CIP) in 2017/18 as part of its overall financial plan; this was in line with the value achieved in 2016/17 of £53.8m.

Against this target the Trust has delivered £43.1m in year against identified programs, resulting in a (£11.3m) adverse variance to plan.

A major factor in the under delivery this year has been an extended period of significant winter pressures and RTT work, alongside capacity constraints

5. Cash

The Trust closed Month 12 with a cash position of £21.3m; there has been an overall reduction of £0.7m of cash throughout the year. The Trust continues to develop opportunities to further improve the cash position and avoid additional borrowing.

6. Capital

For the full year the Trust had a net capital spend of £46.7m against the Capital Resource Limit of £47.5m an unavoidable and agreed variance of £0.8m. The Capital Expenditure Assurance Group meets weekly to provide oversight and assurance on capital spend.

7. 2018/19 Plan

On 30th April the Trust submitted a plan to NHS Improvement of a £20.6m deficit before STF. This position requires the trust to make a £48m CIP. This deficit meets the control total set by NHS Improvement. Agreeing this deficit gives the Trust access to £34.2m of STF funding, this will be given to the Trust on achievement of the financial plan and the 4 hour A&E target.

8. Conclusion

Overall the Trust met its key financial duties for the year. The Trust met its financial control total, was within its capital resource limit and was under the external financing limit. The achievement of the financial position gave the Trust access to £25.5m STF funding. The Trust has agreed a £20.7m deficit plan before STF for 2018/19.

9. Recommendation

The Trust Board is asked to note the report.

Appendix

Statement of Comprehensive Income – 12 months to 31st March 2018

	Plan £m	Actual £m	Variance £m		Plan £m	Actual £m	Variance £m
Clinical (excl private patients)	77.3	80.6	3.3		894.9	891.9	(3.0)
Private Patients	4.4	5.0	0.6		50.6	50.7	0.1
Research, Development and education	8.3	10.5	2.3		99.4	105.8	6.4
Other non-patient related income	3.3	4.2	0.9		38.7	48.3	9.6
Total Income	93.3	100.4	7.0		1,083.6	1,096.7	13.1
Pay - in post	(45.0)	(45.1)	(0.1)		(544.6)	(519.8)	24.8
Pay - Bank	(0.6)	(4.6)	(4.0)		(7.3)	(48.9)	(41.6)
Pay - Agency	(3.3)	(2.3)	1.0		(35.1)	(25.1)	10.1
Drugs and Clinical supplies	(22.0)	(23.4)	(1.5)		(250.6)	(250.5)	0.1
General Supplies	(2.8)	(3.3)	(0.5)		(34.3)	(36.2)	(1.9)
Other	(13.2)	(21.6)	(8.4)		(170.7)	(193.7)	(23.0)
Total Expenditure	(87.0)	(100.4)	(13.4)		(1,042.7)	(1,074.1)	(31.5)
Reserves	0.5	9.2	8.6		(16.5)	(1.5)	15.0
Earnings before Interest, Tax, Depreciation and Amortisation	6.9	9.1	2.2		24.4	21.0	(3.4)
Financing Costs	(3.6)	(4.7)	(1.0)		(43.4)	(46.3)	(2.9)
SURPLUS / (DEFICIT) including financing costs	3.2	4.5	1.2		(19.0)	(25.3)	(6.3)
Donated Asset treatment	(0.5)	0.1	0.6		(6.1)	(5.5)	0.6
SURPLUS / (DEFICIT) including donated asset treatment	2.7	4.6	1.9		(25.1)	(30.8)	(5.7)
Impairment of Assets	0.0	0.0	0.0		0.0	5.8	5.8
SURPLUS / (DEFICIT)	2.7	4.6	1.9		(25.1)	(25.0)	0.1
STF	2.8	13.1	10.2		20.7	25.5	4.9
Winter Funding	0.0	1.3	1.3		0.0	2.5	2.5
SURPLUS / (DEFICIT) after STF and winter income	5.6	18.9	13.3		(4.5)	3.0	7.5

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	23 May 2018

Quality Account 2017/18

Executive summary:

This year's trust quality account outlines progress with the third and final year of our current 2015-18 quality strategy which is being delivered through the achievement of our quality goals. These goals are supported by specific annual targets and a number of improvement programmes and are set out in our current strategy under the five quality domains (safe, effective, caring, responsive and well-led).

The quality account also confirms the priority programmes and targets for delivery next year. The trust's new 2018-2023 quality strategy is currently under development and is introduced in the quality account with its launch following later in the year.

This report presents the final draft of the quality account for 2017/18 (appendix A). The draft has been reviewed at all required committees and has undergone all necessary consultation with internal and external stakeholders. It is now ready for presentation to the Board for approval.

The board is asked to delegate the authority of final sign off to the chief executive and chairman once the outstanding stakeholder and external auditor's statements have been incorporated into the document.

Quality impact:

The trust's quality strategy is the plan through which we focus on the quality of clinical care, ensuring that quality is central to all that we do and that we are focused on continuous improvement at all levels of the organisation.

The strategy is designed to deliver improvements in all five quality domains, ensuring our services are safe, effective, caring, responsive and well-led.

Financial impact:

This paper has no financial impact.

Risk impact:

There are numerous risks associated with delivery of the quality strategy goals, programmes and targets, which are described in the trust's corporate risk register. The annual quality account provides assurance to internal and external stakeholders that plans to improve quality in the Trust are robust.

Recommendation(s) to the Board:

The Board is asked to:

- review and approve the content of the final draft quality account;
- confirm that to the best of their knowledge and belief we have complied with the requirements in preparing the quality account;
- delegate the authority of signing the final quality account document to the chief

executive and chairman once the outstanding stakeholder and external auditor's statements have been incorporated into the document.

Trust strategic objectives supported by this paper:

To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
To educate and engage skilled and diverse people committed to continual learning and improvements.
As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care.
To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Author	Responsible executive director	Date submitted
Eleanor Carter, Compliance and Assurance Improvement Lead	Dr William Oldfield, Interim Medical Director	16 May 2018

Quality Account 2017/18

PURPOSE OF THE REPORT

The purpose of this paper is to introduce the final draft of the Trust's quality account 2017/18 (appendix A) for approval.

INTRODUCTION

Quality accounts are annual reports to the public from NHS healthcare providers about the quality of services they deliver. Their primary purpose is to encourage boards and leaders of healthcare organisations to demonstrate their commitment to continuous, evidence-based quality improvement, to assess quality across all of the healthcare services they offer and to explain their progress to the public.

This year's trust quality account outlines progress with the third and final year of our current 2015-18 quality strategy which is being delivered through the achievement of our quality goals. These goals are supported by specific annual targets and a number of improvement programmes and are set out in our current strategy under the five quality domains (safe, effective, caring, responsive and well-led).

The quality account also confirms the priority programmes and targets for delivery next year. The trust's new 2018-2023 quality strategy is currently under development and is introduced in the quality account with its launch following later in the year. The quality account describes the targets and work that we are either doing now or will do in 2018/19, and the metrics are those that will be included in the 2018/19 integrated scorecard.

The quality account was developed using the Department of Health Quality Account toolkit and complies with the mandatory requirements, in the following structure:

- Part 1: statement from the Chief Executive
- Part 2: priorities for improvement in 2017/18 and mandatory statements relating to quality
- Part 3: review of our quality performance in 2016/17 and statements from stakeholders

ENGAGEMENT

As part of the process, the Trust is required to seek engagement from internal and external stakeholders. This includes offering our commissioners, Healthwatch and the local Overview & Scrutiny Committees the opportunity to comment on the draft report.

The first draft was circulated for consultation following approval at executive quality committee in April to our external stakeholders and also internally, to our non-executive and executive directors. Changes were made to the report as a result of the comments received. The second draft was then approved at executive quality committee and quality committee in May. It was circulated to our external stakeholders to allow them to formulate their final statements, which are due to be submitted by the end of May 2018. Once received these will be incorporated into the document in June, prior to publication.

The quality account is subjected to both internal and external auditing, with the external auditors' statement also included in the published document.

References to page numbers will also be included in the final designed version.

RECOMMENDATIONS TO THE BOARD

As part of the legal requirements for the quality account, we are required to include a statement which confirms that to the best of the Board's knowledge and belief we have complied with the requirements in preparing the quality account.

The Board is asked to:

- review and approve the content of the final draft quality account;
- confirm that to the best of their knowledge and belief we have complied with the requirements in preparing the quality account;
- delegate the authority of signing the final quality account document to the chief executive and chairman when the stakeholder and external auditor's statements have been incorporated.

NEXT STEPS

- Final draft to be professionally designed and pictures and graphics included – throughout May 2018;
- Final sign off by CEO and chairman on behalf of the Board – 8th June 2018;
- Publication of quality account – 30th June 2018.

Imperial College Healthcare NHS
NHS Trust

Quality Account 2017/18

Contents

Glossary

We have tried to make this document as straightforward and reader-friendly as possible. A glossary of terms used throughout the document can be found on page xx.

Alternative formats

This document is also available in other languages, large print and audio formation on request. Please contact the communications directorate on 020 3313 3005 for further details.

Este documento encontra-se também disponivel noutros idiomas, em tipo de imprensa grande e em formatoáudio, a pedido.

Waxaa kale oo lagu heli karaa dokumentigaan luqado kale, daabacaad ballaaran, iyo cajal duuban haddii la soo waydiisto.

هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

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Statement from the Chief Executive

Welcome to our quality account which sets out our progress across all five domains of quality. This is an important document as it allows us the opportunity to describe to the public and our stakeholders the progress we are making with our continued focus on providing care that is safe, effective, responsive, caring and well led. The report is transparent, open and honest and shows what we have achieved but also the areas in which we have challenges to overcome. I hope that the document shows how we are working hard to achieve our vision to be a world leader in transforming health through innovation in patient care, education and research whilst recognising the pressures that the NHS is under.

As I have set out in our annual report we face the same challenges as NHS Trusts across the UK in terms of growing demand, changing care needs, developing and making the most of advances in treatment, difficulties in recruiting enough staff and all in the context of financial constraint. Overall, we increased the number of 'contacts' we had with patients last year, compared with the previous one. There was a small increase in urgent and emergency attendances – through our A&E departments and ambulatory emergency care units – but a much larger increase, 7 per cent in emergency admissions, reflecting our sense that we are seeing patients with greater health needs. We also carried out more operations last year, with the main growth in day cases rather than inpatient procedures.

Here at ICHT we have additional local issues including the growing struggle with our ageing estate and the lack of space in which to expand our capacity. We have the biggest backlog maintenance costs in the NHS and this year has seen us having to deal with major estate deficiencies which have impacted negatively on bed capacity as well as patient and staff experience and safety. We continue to invest in our estate and have expanded facilities at all sites with support and investment from our charity for which I am grateful. The longer term solution however requires significant redevelopment and this year we secured planning permission for phase 1 redevelopment of St Mary's, a new, eight-storey building to house ophthalmology services and the majority of the hospital's outpatient services. This will require investment and the business case is moving forward to secure this.

This all contributed to a very pressurised operational environment, especially over the winter months. While we maintained our strong performance against the national cancer care waiting time standards – consistently in the top quartile of trusts nationally – we were not able to meet the four-hour A&E access standard or the 18-week referral-to-treatment waiting time target.

It is clear that to meet demands we must transform our services and change the way we work as our current approach is not sustainable. That means keeping our focus on continuous improvement, further embedding our organisation-wide improvement approach. It also requires us to establish a comprehensive strategic development programme to drive larger-scale change which calls for even more collaborative working and alignment across the north west London sector. Those developments will also inform and be informed by refreshes of a number of key strategies in the coming year, including of our clinical, redevelopment and quality strategies.

The past year has also been defined for us by a series of senior leadership changes. Given that picture, it's especially important to recognise and build on our achievements. This report details a whole range of ways in which we have done more for our patients, local communities and, importantly, our staff, while progressing along the path back to long term sustainability.

I therefore write this with a great sense of pride in what our staff have achieved during this last year and the care they provide to our patients. I will highlight a few examples however I would encourage you to read them in full in this account.

We have the second lowest mortality rates in the UK and with our focus on reduction of avoidable harm for patients have seen reductions in a number of areas including infections and

pressure ulcers. Our improvement programme continues to support us to embed a culture of continued improvement with progress made in training, educating and coaching our staff in improvement methodology and the launch of our imperial flow coaching academy. Using this methodology this year we tripled our flu vaccination rates, have reduced length of stay for patients with diabetic foot problems and have piloted an early alert to clinicians of patients at risk of developing sepsis. This work on sepsis alerts is also part of a much wider programme to develop our safety culture. It is underpinned by awareness-raising, training, improvement rigour and new processes to ensure staff feel confident to raise safety concerns and know how to address potential issues in the workplace. Consequently, we have seen our incident reporting rates increase while maintaining low levels of harm.

As one of 16 global digital exemplar NHS trusts, we continued our ambitious digital roll-out including expanding bed-side monitoring directly into our trust wide electronic patient record system and introducing fetal link to enable real-time, central monitoring of babies' heart rates during labour. Also, for the third consecutive year we have seen improvement in staff engagement scores in the national survey and these are now better than average.

We are disappointed that when the Care quality commission inspected the Trust during the year we had not made sufficient progress overall to improve our rating which remains at requires improvement. The CQC noted some outstanding practice with medical care at Charing Cross rated as such for effective and caring. We made improvements in a number of areas with a net improvement across the quality domain and service level ratings. We're clear that we have to increase our pace and get to 'good' and beyond as soon as possible. We have included the trust wide improvements in our priority plans for 2018/19 and we are reviewing our approach to improvement across the core services against the CQC standards with our top 100 senior leaders in May and will launch this in the summer. There are more details on what CQC found and our approach to improvement throughout the report.

Feedback is important to us and we are using the CQC inspection report as well as the outputs from a listening campaign we have undertaken to inform the development of our new quality strategy which will be published in the autumn. The new strategy will provide a blueprint of how we will get to good and on the road to outstanding over the next five years.

I hope this quality account paints a clear picture of our commitments to continuous improvement, and of how important the safety and experience of our patients are to us all at Imperial College Healthcare NHS Trust. Despite our very significant challenges, we are progressing. I am optimistic that if we can harness the combined expertise and commitment of our staff, patients, partners and communities, we can get there.

We would like to thank everyone who helped us complete the document including members of the public, Healthwatch, local authorities and commissioner colleagues. Much of the work that is described in this document could not have been done without the generosity of our charity, so I would like to extend my thanks for all their support. Finally I would like to thank our staff who work tirelessly every day to better the lives of patients and the community we serve, without this we would not be making the progress that we are.

[insert signature and date]

About this report

Quality accounts were introduced in 2009 by the Department of Health to make healthcare organisations more accountable when it comes to quality of care. They are designed to report on how we have performed against the targets we set for ourselves last year, and to share our targets for next year.

There are a number of inherent limitations in the preparation of quality accounts which may impact the reliability or accuracy of the data reported. These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audit's programme of work each year.
- Data is collected by a large number of teams across the Trust alongside their main responsibilities. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

We have sought to take all reasonable steps and exercised appropriate due diligence to ensure the accuracy of the data reported, but we recognise that it is nonetheless subject to the inherent limitations noted above. We are working to improve data quality across the organisation, as described on page xx. Following these steps, to the board's knowledge, the quality account is a true and fair reflection of the Trust's performance.

We have tried to make this document as straightforward and reader-friendly as possible. A glossary of terms used throughout the document can be found on page xx.

If you have any questions, would like to provide feedback on this report, or to be involved in producing it next year, please email imperial.quality.team@nhs.net.

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare quality accounts for each financial year. The Department of Health has issued guidance on the form and content of annual quality accounts, which incorporates the legal requirements in the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 (as amended).

In preparing the quality account, directors are required to take steps to satisfy themselves that:

1. The quality account has been prepared in accordance with Department of Health guidance and National Health Service Regulations 2010 (as amended) and presents a balanced picture of our performance over the period covered.

2. The content of the quality account is consistent with internal and external sources of information including:
   - Trust board minutes and papers for the period April 2017 to May 2018;
   - Papers relating to Quality reported to the Trust board over the period April 2017 to May 2018;
   - Feedback from Clinical Commissioning Groups;
   - Feedback from local scrutineers, including Healthwatch and local authority overview and scrutiny committees;
   - The Head of Internal Audit's Annual Opinion May 2018;
   - The national inpatient survey 2017;
   - The national staff survey 2017;
   - The General Medical Council's National Training Survey 2017;
   - Mortality rates provided by external agencies (NHS Digital and Dr Foster).

3. There are proper internal controls over the collection and reporting of the measures of performance included in the quality account, and those controls are subject to review to confirm they are working effectively in practice.

4. The data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

The directors have reviewed the quality account at executive quality committee in May 2018 and confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality accounts. The quality account was reviewed at our Trust board meeting held on 23 May 2018, where the authority of signing the final quality accounts document was delegated to the chief executive officer and chair.

By order of the Trust board

[Signatures and date will be inserted once final document is signed off in June]

Chief Executive Officer Chairman

About our Trust

This part of the report provides some background to our organisation and the people we care for. It describes our governance framework and structures, our values and behaviours, vision and objectives and some of the key strategies which are driving improvement in all areas across the organisation.

Imperial College Healthcare NHS Trust provides acute and specialist health care in north west London for around a million and a half people every year. Formed in 2007, we are one of the largest NHS trusts in the country, with nearly 11,000 staff.

We provide care from five hospitals on four sites as well as a range of community facilities across the region. Our five hospitals are Charing Cross Hospital, Hammersmith Hospital, Queen Charlotte's & Chelsea Hospital, St Mary's Hospital and Western Eye Hospital.

Our Trust in numbers

[Infographic: 'Our Trust in numbers' from the annual report will be inserted when available]

Our vision and objectives

Our vision is to be a world leader in transforming health through innovation in patient care, education and research.

To enable us to achieve this, our strategic objectives are:

- To achieve excellent patient experience and outcomes, delivered with care and compassion;
- To educate and engage skilled and diverse people committed to continual learning and improvement;
- As an academic health science centre, to generate world leading research that is translated rapidly into exceptional clinical care;
- To pioneer integrated models of care with our partners to improve the health of the communities we serve;
- To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

The Trust vision and strategic objectives are currently being reviewed as part of the developing future strategic change programme and will be set out in next year's accounts.

We have also developed a set of operational objectives for 2017-19 which will continue to be the focus of our work over the coming year. They are:

- **Improving the way we run our hospitals and services.** We will create care pathways with processes, ways of working and facilities that consistently achieve the best possible outcomes and experiences for our patients and their families, making the most of digital and other new technologies.

- **Developing more person-centred approaches to care.** We will work in partnership with our patients and partner organisations to create sustainable services and

organisational models that help our population stay as healthy as possible and ensure access to the most appropriate care when and where it is needed.

- **Making our care safer.** We will build a culture where all our staff feel safety is key, are able to 'speak up' and understand their responsibilities; and where patients also feel confident to raise safety concerns and believe they will be addressed.

- **Making the Trust a great place to work.** We will create a shared sense of belonging across our organisation, with staff feeling supported, valued and fulfilled, and a compelling 'offer' in terms of reward and recognition, wellbeing and development.

- **Building sustainability.** We will continue to build our organisational culture and strategy that enable us to deliver our promise, effectively and sustainably.

The objectives reflect our commitment to improve quality of care, and to ensure that it is delivered to our patients by a skilled, motivated and diverse workforce as efficiently as possible. They will also support us to improve our CQC ratings.

Throughout the quality account much of the work to deliver these operational objectives is described. However for a full assessment of performance against these in 2017/18, please see our annual report which will be published on our website in August 2018.

Our ethos and values

To help everyone to be as healthy as they can be, we want to look out for the people we serve as well as to look after them.

We look after people by providing care, whenever and however we are needed, listening and responding to individual needs. We look out for people by being their partner at every stage of their life, supporting them to take an active role in their own health and wellbeing.

We are one team, working as part of the wider health and care community. We are committed to continuous improvement, sharing our knowledge and learning from others. We draw strength from the breadth and depth of our diversity, and build on our rich heritage of discovery.

By doing all this, we ensure our care is not only clinically outstanding but also as kind and thoughtful as possible. We are also able to play our full part in helping people live their lives to the fullest. Our promise is better health, for life.

Our values are:

- **Kind** – we are considerate and thoughtful, so you feel respected and included.
- **Expert** – we draw on our diverse skills, knowledge and experience, so we provide the best possible care.
- **Collaborative** – we actively seek others' views and ideas, so we achieve more together.
- **Aspirational** – we are receptive and responsive to new thinking, so we never stop learning, discovering and improving.

Our Governance framework and structures

Management structure

An organisational structure was put in place in July 2016 to devolve more authority to clinical staff providing care to patients and to reduce the number of management layers. Services are

organised into one of 24 clinical directorates, each with its own 'triumvirate' of lead doctor, nurse and manager, with dedicated support from finance, human resources and information and communications technology. These clinical directorates are organised into three clinical divisions, each led by a practising clinician, they are:

- Medicine and integrated care;
- Surgery, cardiovascular and cancer;
- Women's, children's and clinical support.

The three divisional directors are part of the executive management team and report directly to the chief executive.

Imperial Private Healthcare is our private care division, offering a range of services across our sites. Private income is invested back into supporting services across the whole Trust.

The clinical divisions are supported by six corporate divisions:

- Office of the medical director (including quality, improvement, education and research);
- Nursing director's office (including patient experience, estates and quality compliance);
- Finance;
- People and organisational development;
- Information and communications technology;
- Communications (including public and patient involvement)

Governance framework

We regularly review information and feedback about our services and activities at all levels across the organisation. This helps us ensure we are on track to meet our targets and objectives and to deliver our strategic plans, as well as to help us spot and address problems as soon as they arise.

We also contribute to a range of national monitoring programmes, which allows our performance to be benchmarked against that of similar NHS trusts.

Every month, our executive management team reviews a comprehensive set of performance indicators – our 'scorecard'. A scorecard with a core set of indicators is also reviewed by the Trust board at its bi-monthly public meeting. For each indicator, we look at how we are performing against national standards and/or our own targets that flow from our various strategies. In addition to our 'scorecard' we also prepare a monthly quality report which includes each of the indicators that we set out in our quality account in the previous year. In 2018/19 we will produce an expanded and integrated scorecard for use at all committees, more information is included on page xx.

On our website, we publish an easy-to-understand monthly performance summary well as the full scorecard.

There are five board committees overseeing specific aspects of our work:

- Quality;
- Finance and investment;
- Audit, risk and governance;
- Remuneration and appointments;
- Re-development.

Below the board committees is the executive committee which meets on a weekly basis. Sub-groups to a number of our executive committees meet monthly to ensure that there is sufficient time and detailed work being undertaken to deliver improvements. As an example the sub-group

to the executive quality committee considers the minutes from the divisional quality committees and is where divisions come together and trust wide themes and issues are considered.

Our key strategies

Quality strategy

Our current Trust quality strategy ends in 2018 and there are many examples of progress during its lifespan, a number of which are included in this account. The most notable is the launch of our quality improvement programme in 2016 which will be central to the new strategy which is under development and will be published later this year.

The Quality strategy for 2018-23 will be aligned to the CQC domains of quality and will set out our direction and plan for how we will improve to a rating of 'good' in all domains and 'outstanding' where possible. More information on the development of the new quality strategy is on page xx.

Patient and public involvement strategy

In 2016, we developed a Trust-wide approach to increasing and improving patient and public involvement in every aspect of our work. We set out ambitious goals for achieving meaningful involvement in strategic developments, service improvements, service delivery and improving individual health and wellbeing.

Implementation of this strategy is overseen by our strategic lay forum, a group of 12 lay partners plus senior staff from the Trust, Imperial Health Charity and Imperial College. The full forum meets bi-monthly, reports annually to the Trust board, is actively engaged in the Trust's work and plans and, this year, contributed to formal business planning for the first time. Through the expertise and connections of our strategic lay forum members in particular, we are also beginning to develop coordinated involvement approaches across North West London.

People & organisational development (P&OD) strategy

Published in 2016, this strategy is designed to support the changing needs of the organisation, developing skills and capabilities amongst our staff. It encompasses plans to enhance patient and staff experience by focusing on attraction, on-boarding, retention, development and continuous improvement in engagement with our workforce.

Clinical Strategy

Our current clinical strategy[1] sets out how we develop, organise and connect our services and specialties. Over the last year we have been progressing our Trust specialty review programme (SRP) to support us with the development of a new five-year clinical strategy that we plan to publish during 2018. Information on the SRP is included on page xx. The strategy will have been built up from our specialties and will for the first time, give us a roadmap for our specialties and hospital sites. This strategy will take us through our redevelopment programme and beyond, and will be a key tool for continued engagement with our teams.

Estates strategy and redevelopment programme

We have the largest backlog maintenance liability of all trusts (£650m), mostly due to the age of our estate. We therefore have instances where equipment fails and is difficult to repair due to obsolete parts. We have had to close beds and departments to react to structural issues which can have adverse impacts on our staff and can affect patient experience, service provision, and, at times, create a risk to patient safety.

Our estates strategy for 2016 to 2026 provides an integrated approach to the estate with the aim to ensure that the Trust provides safe, secure, high-quality healthcare buildings capable of supporting current and future service needs. Whilst the strategy is being progressed, the Trust

board has prioritised its capital expenditure to support priority backlog maintenance and medical equipment replacement. For further information, please see our annual report.

The redevelopment programme continues to progress with approved planning permission gained during this year for the new outpatient and ophthalmology building (phase one) at St Mary's Hospital. The outline business case for the facility was approved by the Trust in February 2018 and has been submitted to NHS England, NHS Improvement and local CCGs. In addition, Phase two redevelopment of St Mary's Hospital campus planning work is underway.

Digital strategy

The Trust is progressing well with its digital strategy, spanning the five years from 2015 to 2020. The strategy is driving more productive working internally and across the local health system, moving from paper records towards digital data capture and processing. The aim of our programme is that staff and patients can easily and securely access, update, analyse and share information to provide best patient care. The primary drivers are:

- Provide a complete electronic patient record that our staff continuously contribute to so that all relevant information is available when needed;
- Provide the ability to share relevant information to support clinical decision making;
- Enable patients to access, interpret, update and share their record and play a full part in managing their own health;
- Optimise integrated care pathways to reduce unnecessary variation and improve patient outcomes;
- Use information and analytics to support direct care, service improvement, research and population health.

In partnership with Chelsea and Westminster Hospital NHS Foundation Trust we were selected by NHS England to become one of 16 global digital exemplars in acute care with dedicated funding to deliver innovations which other organisations can then use.

Our quality improvement plan

This section of the report describes our approach to quality improvement, progress with developing our new quality strategy and how we monitor our performance throughout the year to ensure we are continuously improving our services. It also sets out the targets and work streams we have chosen to prioritise in 2018/19.

Our approach to quality improvement

As part of developing our 2015-18 Quality Strategy we recognised the need to build a systematic approach to creating a culture of continuous improvement across our organisation. This means having a method for developing, testing and implementing change. We believe we will achieve this aim through focusing on six areas of work (also called our 'primary drivers'). This work is led by our Improvement Team:

1. Inspire staff, patients and partners to participate in the organisation's improvement journey
2. Build improvement capability in our staff & patients
3. Build improvement capacity to spread quality improvement across the Trust and beyond
4. Enable local teams to undertake quality improvement projects through defined consultancy and coaching support
5. Support the design, implementation and evaluation of strategic trust wide improvement & transformation programmes
6. Define and develop how we become a learning organisation

Key to this work is having a consistent and coherent improvement methodology through which we can conduct our improvement work. This methodology can be summarised as:

- Using the model for improvement – incorporating a clear aim, well defined measures and space to think about change ideas, followed by rapid tests of change using multiple Plan-Do-Study-Act (PDSA) cycles
- Using driver diagrams (see glossary on page xx for definition) to articulate why certain work / projects / initiatives will logically lead to achieving the aim
- Moving to 'measurement for improvement' – time series data with control limits, and annotations showing what changes were tried and when
- Using coaching methods to drive improvement & transformation across the Trust
- Co-designing change with patients, staff, carers & our wider communities
- Putting an emphasis on sharing and spreading learning from improvement work.

Enabling quality improvement work

We have established an active engagement programme to inspire staff, patients and our wider partners and communities to participate in our improvement work. Over the last two years we have engaged over 4,000 staff and patients in quality improvement (QI) awareness sessions, with a strong emphasis on making sure that everyone understands the role they can play in quality improvement.

We have designed, tested and implemented a comprehensive quality improvement capability building programme which has involved over 2,500 participants over the past two years. Our QI capability building programme aims to provide all staff at every level with the tools, skills and confidence to carry out and lead improvement work. This ranges from introductory sessions, to

day-long 'Tools for Change' and co-design days, to our award winning Coaching and Leading for Improvement four-day programme, which has run five cohorts and developed over 100 coaches who are now leading improvement work across the organisation. This programme, together with the establishment of a year-long Flow Coaching programme involving nine Imperial clinician-manager pairs, and our Quality Improvement Fellowship are examples of where we have been building the improvement capacity of the organisation.

Through these coaches, and the input of the Improvement Team, we are actively supporting a wide range of local teams in undertaking quality improvement projects. The Improvement Team have also actively supported the design, delivery and evaluation of 39 Trust-wide improvement initiatives this year. Many of these projects and initiatives have already led to significant improvements. Examples include reductions in length of stay (diabetic foot big room), improvements in care pathways (virtual fracture clinic), improvements in patient safety (sepsis big room) and improvements in uptake (for example a near 300% increase in staff flu vaccines in 2017-18). Other improvement work is included throughout the quality account, with more information on big rooms on page xx).

In becoming a learning organisation we aim to be proactive in evaluating impact, sharing and spreading knowledge. In doing so we have actively sought to develop collaborations and networks including:

- Participating in the Institute for Healthcare Improvement's Health Improvement Alliance Europe. This alliance supports leaders and organisations to share and test innovations and improvements from different healthcare systems and to spread successful learning at an international scale;
- A collaborative enterprise with Royal Free London NHS Foundation Trust and NHS Improvement to develop tools and methods to introduce measurement for improvement to show the impact of changes we are making across a range of quality indicators;
- A partnership with Sheffield Teaching Hospitals NHS Foundation Trust and The Health Foundation to run a franchise version of their Flow Coaching Academy as part of introducing a Trust-wide approach to reducing unwarranted variation within clinical pathways;
- Working with the National Institute for Health Research's Patient Safety Translational Research Centre in bringing together researchers and clinicians around key areas of patient safety and innovation.

Improvement methodology is increasingly becoming the way we do things at the Trust and with our emphasis on empowerment and engagement its benefits are starting to be seen. In 2018/19 we will continue to focus on delivery of our primary and secondary drivers as well as improving the communication around the outcomes and impact of the programme.

Developing our 2018-2023 quality strategy

The Trust's new quality strategy is currently under development and will outline our direction and plan for how we get to a CQC rating of 'good', and 'outstanding' where possible, over the next five years. The new strategy will allow us to clearly articulate how our improvement methods are at the heart of our approach to quality and how we plan to further strengthen and develop this going forward. Our CQC rating of 'requires improvement' is a clear message that we must do exactly that - improve. We will use our methodology to do just that.

To strengthen our approach to developing the new strategy we commenced a listening campaign in December 2017 as well as an evidence scan to ensure it is designed to meet a range of national, system-wide and community needs and priorities. The campaign focused on what quality means to different stakeholders with a key principle of inclusiveness: connecting with those who we find hardest to reach, taking steps to overcome barriers to participation and

encouraging everyone to have their say. Through this we have listened to over 700 people face to face and their perspectives are being used to shape our priorities. A measure of success of the new strategy will be whether patients, staff and community groups can recognise their priorities in ours and in how we strengthen their involvement in our improvement journey.

To oversee and coordinate the work we have convened a quality strategy design group involving representatives from across and beyond the organisation including members of our Lay Partners Forum, Healthwatch and Citizens UK. When the strategy is launched we will continue to work together as we deliver the priorities set out as part of the new strategy. At the same time we will work with partners to ensure that patients, staff and community groups are involved in the co-design of improvement initiatives.

The strategy will be published in the autumn of 2018.

Monitoring quality

We work closely with our commissioners (local and NHS England) throughout the year to monitor our performance in all areas of quality management. We monitor progress with delivery of the quality strategy and work collaboratively to develop the annual quality account, acute quality schedule and priorities for the next year through the Clinical Quality Group. This ensures that our quality agenda aligns with local and national priorities.

The Clinical Quality Group is our monthly forum attended by all of our commissioners, and is a key part of our governance structure as set out below.

The governance arrangements for quality in the Trust are led by the medical director who has executive responsibility, and are summarised below. Progress with our quality goals, targets and priorities are reported through this framework, to enable monitoring from ward to board.

A compliance and improvement framework is also in place to ensure we are compliant with regulatory requirements, led by the director of nursing.

To strengthen oversight between our divisions and our executives we are planning to introduce bi-monthly divisional oversight reviews during 2018/19. This will mirror the reviews already in place within the divisions and their directorates with the aim of better supporting trust wide performance improvement.

The executives are also reviewing our approach to CQC compliance management. The proposed approach going forward is to mirror our improvement methodology with a focus on those areas that are trust wide and continue to be challenging as well supporting core services where improvement is required.

Our quality priorities for 2018/19

Our goals: Our new quality strategy will set our Trust goals to match the CQC's current domain definitions. We have therefore amended them in anticipation as follows:

- **Safe:** People are protected from abuse and avoidable harm
- **Effective:** People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
- **Caring:** The service involves and treats people with compassion, kindness, dignity and respect.
- **Responsive:** Services meet people's needs
- **Well-led:** The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

The goals will be supported by specific annual targets and monthly metrics. In 2018/19 the metrics and targets will be monitored through a fully integrated scorecard rather than through the separate performance and quality reports currently produced. The integrated scorecard has been co-designed over winter 2017 following a gap analysis of the main indicator sources, our previous quality account metrics, feedback including from our listening campaign and CQC inspections as well as changes in contractual and regulatory reporting requirements. Although the number of metrics has increased we believe it is all encompassing and will better support us to track performance, emergent risk and prioritise improvement activity. The scorecard metrics and targets are provided in each quality domain in this account.

The scorecard will be accompanied by metrics based variance reporting with clear action/improvement plans using our improvement methodology. The same metrics will be included in directorate and divisional scorecards to ensure a standardised approach.

In March 2018, CQC announced that they would be including 'use of resources' as a sixth quality domain. We will therefore include metrics within this domain in the 2018/19 scorecard.

They are not included in the quality account as they are still being developed. Performance against them will be included in next year's account with our improvement plans.

In next year's quality account all of the integrated scorecard metrics will be used to provide a review of our service performance rather than using a sub-set as is the current practice.

In response to feedback on the need to reduce repetition in the account we have changed the format of the document. Where we already have variance against metrics and actions are known or planned they are described in the section where we summarise our performance during this year. Therefore we have not repeated these in this section.

Using the driver diagrams for each domain, feedback from our listening campaign and CQC inspections as well as our operational objectives we have also identified 13 areas where we want to prioritise our improvement activity over the coming year. These are described in more detail below, setting out our aim, emerging change ideas, and plans so far. They are not described under a quality domain as many of them span multiple domains.

Improvement priority 1	**To reduce avoidable harm to patients**
Rationale for inclusion	Reducing avoidable harm is implicit in our strategic objective to achieve excellent outcomes for patients and is central to our operational objective to make care safer. Although our incident reporting rates and harm profile are good we take avoidable harm seriously and strive to continuously minimise it. In 2017/18 we reported 27 incidents that caused severe/major harm or extreme harm/death, 13 deaths that were avoidable as well as an increasing number of SIs in recurrent categories. We also recognise that the management of patients with sepsis could be improved with a focus on the time between diagnosis and administration of antibiotics being key.
What will we do?	We will: • Support each safety stream with a focus on reducing recurrence of incidents; • Test our approach to implementation of policies across the streams to better understand the behavioural insights work needed to support staff to comply; • Scope and implement the improvement plan for the new stream; • Roll out the sepsis electronic alert across the Trust with targets set for improvement of time to antibiotic; • Launch the Trust sepsis policy; • Evaluate the impact of the safety streams that are continuing in 2018/19 in Q3; • Map the actions from all SIs to the improvement plans for each stream to ensure they continue to address the root causes of our incidents.
Measureable target for 2018/19	We will reduce recurrence of the most commonly occurring SI's which have caused or have the potential to cause patient harm: • Recognition of the deteriorating patient (including sepsis) • Safe mobility and prevention of falls with harm • Fetal monitoring • Safer surgery • Abnormal results

	• Positive patient confirmation • Reducing treatment delays for mental health patients in the emergency departments In addition, once our electronic alert has been rolled out we will ensure that 50% of patients receive antibiotics within 1 hour of diagnosis. We will then set trajectories for further improvement. When combined this work will support us to reduce the number of incidents with the highest harm and those that are avoidable.
Executive lead	Medical Director
Improvement priority 2	**To improve the safety culture across the Trust**
Rationale for inclusion	Safety culture is embedded in our operational objective to make our care safer. We tested our culture during 2016 by inviting staff feedback through the safety attitudes questionnaire. A programme was then set up based on intelligence from research and experience from organisations at national and international level; incident themes; safety culture workshops; staff surveys and qualitative feedback including from work conducted in theatres. This resulted in a list of change ideas which have been prioritised as follows: • Improving our investigations; • Knowing what's reportable, being encouraged and supported to report and making reporting more straightforward; • Learning better from serious incidents; • Sharing information about safety better. In the staff survey we saw an improvement in people feeling able to report incidents, however an increase in the percentage of our staff who said that they had witnessed potentially harmful errors, near misses or incidents in the last month (from 30 per cent in 2016, to 37 per cent in 2017). This is above the national average. Culture is not something that changes quickly so it is important that we continue our focus on this programme.
What will we do?	We will: • Use our live driver diagram to target improvement work; • Explore our approach to "just culture" through an externally supported workshop in the summer (see glossary on page xx); • Complete data analysis of staff survey results by staff group, age profile and gender to understand where to focus support and improvement energy. • Review our approach to supporting staff involved in incidents with a focus on addressing concerns raised following national high profile cases in 2017; • Include an additional question in our internal staff survey to assess whether staff know how to report incidents; • Continue to co-design improvements with staff and patients;

	• Internal communications of the culture work will be given additional focus including taking forward plans to create an Imperial safety campaign and video.
Measureable target for 2018/19	We will aim to improve our incident reporting rates overall. We will expand our work to support specific staff groups with low reporting rates. Improvement targets will be set when appropriate. We will improve staff survey results in questions related to staff reporting incidents and their perceptions of the fairness of processes Evaluation of all improvement interventions will be undertaken and reported during the year.
Executive lead	Medical Director
Improvement priority 3	**To improve permanent nurse staffing levels**
Rationale for inclusion	Feedback from the listening campaign has unanimously reported the importance of having the right number of staff to enable care to be provided, with a specific focus on nursing. Vacancy rates at the Trust are above target with variance across departments. Safe staffing is routinely maintained through the use of temporary staff and cover provided by senior nurses however it is accepted that substantive staffing should be maximised. One of the operational objectives is to make the Trust a great place to work with staff feeling supported, valued and fulfilled. Increasing our permanent workforce and retaining them will be key to this.
What will we do?	A strategy was approved in March 2018 to improve the supply of nurses, this requires significant investment and will be implemented during 2018/19. We will: • Commence overseas recruitment; • Introduce initiatives to improve retention of the existing nursing workforce; • Implement recruitment and retention premiums in the most hard to recruit areas; • Develop our nurse degree and associate apprenticeship programmes to grow our own nurses and associates for the future.
Measureable target for 2018/19	Improve our vacancy rates to target.
Executive lead	Divisional Directors
Improvement priority 4	**To ensure our staff are up to date with the mandatory skills to do their jobs**
Rationale for inclusion	Core skills and core clinical training rates have been below target despite many interventions. This has been identified as one of the priorities for the Trust as we have not managed to reach our target and this has been repeated cited by CQC as an area of concern at their inspections. This is central to our operational

	objective to making our care safer.
What will we do ?	The electronic system for management and monitoring of training is not fit for purpose and not linked to our HR systems. To support improvement by making sure our data is accurate and to ensure the right staff undertake the appropriate training a new learning management system will be procured and introduced in late 2018. We will also review all mandatory training modules, agree the correct portfolio for each staff group and manage staff within this once the new system is in place. Until the new system is in place the current recording system will be used to track compliance with a focus on our medical staff compliance where performance has been most difficult to influence. This will be done by focusing on: • Induction transfer of training for doctors in training; • Linking training to appraisal, excellence awards and study leave/funding; • Line management oversight and follow up.
Measureable target for 2018/19	The target for training compliance will be monitored with trajectories for improvement to reach 85% in the first instance increasing to 90% once the new system is embedded.
Executive lead	Director of people and organisational development
Improvement priority 5	**To ensure our equipment has planned maintenance in line with targets**
Rationale for inclusion	The Trust recognises that the safe and appropriate use of medical devices (see glossary on page xx for definition) is critical to the delivery of high quality patient care. Equipment maintenance oversight and management have been problematic in the past most recently in assuring it is completed within manufacturing recommendations. At the last CQC inspection this was raised as a safety issue and although work was underway our staff were not clear on actions to take when equipment was due for routine maintenance.
What will we do?	We will ensure that our medical equipment has planned maintenance at a frequency determined by the manufacturers instructions or on a risk based strategy by Clinical Technical Services. Medical devices continually move around which can result in devices not being located for maintenance, therefore affecting the scheduled maintenance plan. To address this we are introducing radio-frequency identification (RFID) technology which will replace all of our asset labels on medical devices and enable their locations to be tracked. This will also comply with Globally Recognised Barcodes (GS1) standards (which improve management of assets within the NHS making services safer and more efficient) and assist with the Scan4Safety programme. Labels to indicate high, medium and low risk are also being fixed to all medical devices. An e-Learning package is also being developed to inform staff of essential safety aspects prior to using a medical device and this will be rolled out during 2018.
Measureable target for 2018/19	Targets for planned maintenance will be monitored monthly and are: • high risk = 98 per cent • medium risk = 75 per cent • low risk = 50 per cent

	The percentages for medical device maintenance compliance are based on standard figures from other hospitals and what we consider achievable from current performance.
Improvement priority 6	**To improve the management of medicines**
Rationale for inclusion	Management of medicines has been raised at each of our CQC inspections since 2014. In November 2017 the CQC reported that medicines were not consistently prescribed, given, recorded and stored well and outlined the following additional actions: • The Trust must ensure that control drugs cupboard key is kept securely and access is appropriately restricted. • The Trust must ensure that there are effective checking systems for airway trolleys and emergency medicines stored in the resuscitation bays. • The Trust must ensure that IV fluids are stored appropriately. The CQC report of 2018 identified similar concerns. A new approach is clearly needed to support improvement.
What will we do?	Improvement methodology has been used to identify the aim and drivers for this programme. The resultant plan has three key themes with ideas for change which will be tested and evaluated in 2018/19; • Storage • Temperature • Disposal A new medicines improvement group has been formed to oversee the programme. All training programmes will also being reviewed to ensure they support the improvement priorities and fully equip our staff to manage medicines safely.
Measureable target for 2018/19	• Monthly Fridge Temperature monitoring • Six monthly safe storage audit • Six monthly CD audit Improvement targets will be set once the baseline is agreed.
Improvement priority 7	**To ensure hand hygiene compliance is measured accurately with focused improvement to support staff where risk exists.**
Rationale for inclusion	Monthly hand hygiene audits have been completed by front line nurses for the last 10 years. Results consistently show excellent performance however independent audits do not always give the same results. This and feedback from inspections has raised concerns about consistency of compliance. When research is considered compliance would be expected to be lower than that seen in our point prevalence results.
What will we do?	A new approach to hand hygiene compliance at the Trust was approved in March 2018. A trust wide improvement programme is being implemented, commencing in May 2018 with the launch of a new audit system. This will see us moving from monthly audit to an annual programme for all in-patient areas carried out in partnership with our infection prevention and control team and divisional senior staff. Improvement plans will be implemented for areas of increased risk following these audits.

	Communication, education and engagement will be key focus points of the improvement plan.
Measureable target for 2018/19	Audit results of hand hygiene compliance will be measured however a target will not be set until the Trust baseline audit has been completed. Research results will be used to set targets going forward.
Improvement priority 8	**To continue to define, develop, implement and evaluate an organisational approach to reducing unwarranted variation**
Rationale for inclusion	Variation in care can be unacceptable as it may be harmful or inefficient. This is referred to as "unwarranted variation"; occurring by chance and being characterized by patients not consistently receiving high quality care. One of our approaches to reduce variation is the use of 'flow coaching' within a clinical pathway. Three pilot pathways (Sepsis, Diabetic Foot and Children's Asthma and Wheeze) were used to test the flow coaching approach in 2017/18 (details in section xx) and in March 2018 we launched Flow Coaching Academy (FCA) Imperial to support a further nine pathways. The reduction of unwarranted variation across patient pathways is a key part of how we will improve sustainability and experience for our patients.
What will we do?	In 2018/19 we will define and implement our organisational approach to reducing unwarranted variation including: • How we systematically identify where unwarranted variation exists, linking with existing programmes across the Trust including the 'specialty review programme' (see page xx), clinical audit (see page xx) and GIRFT (see page xx) • Developing skills & capabilities for staff across the organisation for tackling unwarranted variation • With our finance and business intelligence colleagues, start to meaningfully measure outcomes from reducing unwarranted variation linked to the sustainability programme; • Continue to deliver and further develop FCA (Imperial): o Continue to support the three pilot pathways, measuring their impact and learning from their experience; o Support the nine new pathways and eighteen coaches selected from across the divisions; o Provide dedicated space for the weekly "big rooms" (see page for more information see page xx) on each site. The nine FCA (Imperial) pathways are children with acute abdominal pain, perioperative vascular surgery, lower urinary tract symptoms, enhanced recovery, mental health crisis, acute respiratory care, acute kidney injury, adolescence and young people and the maternity pathway.
Measureable target for 2018/19	Each of the twelve pathways has measureable improvement targets for example: • Reduction in length of stay in diabetic foot patients; • Improved time to antibiotics in sepsis; • Improved outcomes for children and young people with asthma or wheeze through increasing use of asthma action plans, education and checking of inhaler technique. Progress will be reviewed through our governance structures throughout the year.

Improvement priority 9	Emergency flow through the hospital
Rationale for inclusion	The 'improving patient flow programme' was launched in early 2017 to improve operational performance across the whole urgent care patient pathway at the Trust and to enable us to meet the trajectory for performance against the four hour A&E wait standard. Significant work was completed against the programme milestones and improvements have been realised in a number of areas, however we have not met our performance target. Achievement of the 4 hour wait standard is a national priority with new targets set for 2018/19 to meet 90% from September and 95 % in March 2019.
What will we do?	Our work will be structured around 6 priorities: **1) Effective emergency department (ED) operations** This work stream will be divided into three sub groups; 1. POCT (point of care testing) in the emergency departments 2. Redevelopment of the emergency department at Charing Cross hospital, creation of additional capacity and reviewing the urgent care centre (UCC) and emergency department pathways. The non-admitted pathway in ED will also be reviewed to reduce breaches. 3. At St Mary's hospital, utilizing improvement methodology to drive efficiency including an emphasis on mental health pathways. **2) Specialist Pathways** A number of discreet projects including the outpatient parenteral antibiotic therapy (OPAT) service, Surgical pathways, and trauma. Following a visit to Addenbrookes Hospital, we will carry out a feasibility study of implementing single medical assessment between ED and acute services. **3) Real Time Bed Management** Given our limited capacity, an effective real time bed management solution is vital. This work will be overseen by a bespoke task and finish group. **4) Improving Ward Flow** This work stream will oversee improvements in discharge processes and use of discharge facilities as well as the rollout of the SAFER bundle across the Trust. **5) External Partners** The work stream will focus on the aspects of inpatient flow that require joint working with external partners for improvement. **6) Infrastructure** This work stream will focus on vital support services that either directly impact on or have effect on both the EDs and ward flow. A helpful review was undertaken by NHSI which will report in April 2018, the recommendations of this will be incorporated into the programme.
Measureable target for 2018/19	The overall target is improvement in 4 hour performance. The existing scorecard will be refreshed to reflect the priorities for 2018/19 with work stream KPIs and improvement targets.

Improvement priority 10	To improve access to services across the Trust through a focus on increasing capacity
Rationale for inclusion	Emergency and RTT performance has been challenged during 2017/18 with deterioration over the winter period. Although elective activity was reduced this was not sufficient to ensure patients were admitted in line with standards. Bed modelling has historically shown that demand does not meet capacity. To achieve these important access targets, additional capacity will be required as well as efficiency improvements.
What will we do?	Bi-weekly capacity management meetings are in place with the CEO and executive team. A full review of demand and capacity will be completed with an options appraisal of bed space opportunities considered internally and externally with commissioners. Bed stock will be reviewed to consider best use of additional space including escalation space by the divisions. We will then review our escalation and full capacity protocols.
Measureable target for 2018/19	If capacity is increased we will measure improvement in: • Number of days where black escalation is in place; • Number of cancelled elective patients; • Occupancy levels
Improvement priority 11	**To improve access for patients waiting for elective surgery**
Rationale for inclusion	Over a sustained period of time, the Trust has encountered a number of data quality & operational performance challenges to delivering a balanced position on elective care. Many of these challenges have been overcome through focused internal interventions and support from external agencies. Despite this the trust has not achieved the RTT standards since 2015 and we are struggling to meet improvement trajectories set for the 92% incompletes target and for the number of patients who are waiting over 52 weeks for treatment. An external review has been commissioned by the CEO to furnish the Trust with a detailed scope of work to support in reviewing those factors that continue to affect compliance with access standards, and evaluate the initiatives in place that will sustain and improve the delivery of RTT 18 weeks. This will report in May 2018 and its recommendations will be taken forward during 2018/19. Performance in March 2018 shows that 83.29% of patients were treated within target and that 267 patients waited over 52 weeks for treatment which is one of the highest reported numbers in the UK. A monthly clinical harm review process is in place with three patients identified as coming to moderate harm however we do not make any excuse for the distress and anxiety that these long waits have on our patients. This is an integral part of our operational objective to improve the way we run our hospitals and is a measure of whether the trust is responsive and well led. We know we need to improve our performance and are committed to continue to do so.
What will we do?	We will fully implement the Trust elective care operating framework (ECOF) which is the change programme redesigning the way we manage elective care. The overall aim of ECOF is that our patients have timely access to elective services which will be delivered through the primary drivers of: • Patient pathways are proactively managed against clear standards • Capacity is planned to meet demand at each stage of a patient's pathway

	• Operational processes are clearly defined and well understood by all staff where SOPs affect their roles • Staff have tools that enable them to effectively manage pathways • Data integrity and quality are proactively managed to provide clarity for all the audiences and staff involved in managing pathways • A comprehensive performance management framework ensures that staff are supported and held to account for their role in managing pathways • All aspects of elective care management are regularly reviewed and updated to meet demands of them and reflect best practice • Potential clinical harm to patients waiting longer than tolerance levels is proactively managed • There is visible senior leadership focus on managing elective care performance Plans are in place for each driver which is overseen through the governance framework. A key focus for 2018/19 is the implementation of training for staff as well as improvements to the data tracking solutions in place. These should support staff to get pathways recorded accurately first time.
Measureable target for 2018/19	Delivery of RTT performance standards as agreed with commissioners: • Ensure at least 92% patients wait for no longer than 18 weeks for non-urgent consultant led treatments at Imperial College Healthcare Trust by March 2020 (TBC). • No patients wait more than 52 weeks for consultant led treatment by July 2018. •
Improvement priority 12	**To improve compliance with equality and diversity standards**
Rationale for inclusion	The equality and diversity system 2 is a tool to help NHS organisations improve the services they provide to local communities and provide better working environments, free from discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. Trusts are expected to self-assess their compliance against four objectives across 18 outcomes for each of the 9 protected characteristics. Although work has been undertaken in this area progress has not been overseen or co-ordinated in a systematic way. A review was undertaken in 2017 and an equality and diversity steering group has been established within the Trust. These standards are central to the operational objective to make the Trust a great place to work. This is also a key element of the CQC well led framework
What will we do ?	The Trust EDS2 compliance assessment will be used as the framework for identifying good practice and areas of improvement. This will be used to inform the trust action plan. Progress with the action plan will be overseen at the trust equality and diversity committee with regular reporting to trust board. A review of the gender pay gap will be undertaken with a focus on the medical consultant workforce in particular the clinical excellence awards. The results of which will also feed into the action plan.

	Governance and reporting will be agreed with the all divisions across the Trust to ensure engagement in this important agenda.
Measureable target for 2018/19	To implement systematic assessment of the EDS 2 goals throughout the organisation with an action plan developed to make improvements where necessary.
Improvement priority 13	**Specialty review and clinical strategy development**
Rationale for inclusion	The Trust specialty review programme (SRP) is our clinically led process to develop a five-year clinical strategy, which is built upwards from specialty level strategic plans (see page xx for more details). The outputs of the SRP will be used to inform the bottom-up development of a refreshed Clinical Strategy. The refreshed clinical strategy will set out how we propose to organise, deliver and develop our services over the next five years, providing excellent high quality care whilst responding to the significant challenges faced by the NHS. The clinical strategy will be a core product of the Trust's wider strategy and, in turn, will influence the development of other Trust-wide strategies. The clinical strategy will also sit within the wider strategic context of the North West London STP. A key feature of the SRP is that the reviews are 'owned' by each specialty, with a focus on MDT input, such that specialty teams recognise the resulting strategies and are able to engage with and buy into them. Specialty specific strategies ensure teams are clear on what they need to do to support the delivery of the Trust clinical strategy.
What will we do ?	All 37 specialties will have completed their 3 workshops by July 2018. The outputs of the SRP will be used to inform the bottom-up development of a refreshed Clinical Strategy. A series of 'wash-up' sessions are in progress to further develop the specialty plans where there are inter-dependencies between specialties and also physical co-adjacencies across our sites. As a result the specialty specific plans will need to be iterated to ensure that they are aligned with the refreshed clinical strategy. This will form part of the continuing programme of specialty review into 2018/19 as part of the wider sustainability and transformation programme. Following on from the refreshed clinical strategy, there will be a continuing programme of specialty review. The review method will be adapted to provide a mechanism for assessing how specialties are progressing their ambitions outlined in the strategy and to allowing us to understand our portfolio of services in even further strategic depth. The frequency of review for each specialty will be determined by needs and risk assessment. Next year we will also ensure opportunities for improvement are mapped and support is prioritised for those areas where capacity/capability is required. We will also continue to iterate the approach to support directorates to make improvements to meet the Trusts objectives and vision as well as further developing our approach to measuring the impact and outcomes. The evolving SRP will become a key part of the wider sustainability and transformation programme in the medium and longer term. The ongoing SRP will inform and be informed by other related trust-wide programmes such as Reducing Unwarranted Variation (see page xx) and GIRFT (see page xx).

Measureable target for 2018/19	• Specialty specific strategic plans developed for all 37 specialties
	• Refreshed clinical strategy published
	• Ongoing series of Specialty Reviews
	  o Define of adapted methodology & approach
	  o Begin reviewing specialties as part of the adapted approach

Scorecard quality metrics

Each quality domain has an aim and a suite of metrics as described above. The metrics are set out in turn in the following pages and will be included in the monthly scorecard. The Trust Board have approved these and are assured that they include all of the mandatory requirements as well as being reflective of our ambitions.

A driver diagram is included for each domain which sets out the drivers and ideas for change and improvement which will support delivery of the metrics.

Quality Domain 1: Safe

Aim/CQC Definition: People are protected from abuse and avoidable harm

[Some targets are still under development and will be included in the final version where available]

Area	Description	Target
Patient safety – incidents and reporting	To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing extreme harm/death	Below national average
Patient safety – incidents and reporting	To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing severe/major harm	Below national average
Patient safety – incidents and reporting	We will maintain our incident reporting numbers and be within the top quartile of trusts	Top quartile
Patient safety – incidents and reporting	We will have zero never events	0
Patient safety – incidents and reporting	We will ensure all patient safety alerts and medical devices alerts issued through the national central alerting system are reviewed and acted on in the specified timeframes	0 outstanding
Patient safety – incidents and reporting	We will ensure 100% compliance with duty of candour requirements for every appropriate incident graded moderate and above	100%
Infection control and cleanliness	We will achieve a 10% reduction in healthcare-associated BSIs caused by E. coli	10% reduction (n=65)
Infection control and cleanliness	We will have no healthcare-associated BSIs caused by CPE	0
Infection control and cleanliness	We will ensure we have no avoidable MRSA BSIs and cases of C. difficile attributed to lapse in care	0
Infection control and cleanliness	We will ensure our cleanliness audit scores meet or exceed the required standards	Being developed
Infection control and cleanliness	We will meet flu vaccination targets for frontline healthcare workers as part of the national seasonal flu campaign	National target
Medicines management	We will ensure standards for monitoring fridges used to store medicines so that temperatures remain at safe levels and we will ensure controlled drugs are checked every day	Being developed
VTE	We will assess at least 95% of all patients for the risk of VTE within 24 hours of their admission, and maintain zero cases of avoidable harm	95% 0
Sepsis	We will ensure at least 50% of our patients receive antibiotics before the sepsis alert or within one hour of a new sepsis diagnosis	50%
Maternity standards	We will maintain the ratio of births to midwifery staff at 1 to 30	1:30
Maternity standards	We will reduce postpartum infections (Puerperal	Being developed

Area	Description	Target
	sepsis)	
Safe staffing	We will maintain the percentage of shifts meeting planned safe staffing levels at 90% for registered nurses	90%
Safe staffing	We will maintain the percentage of shifts meeting planned safe staffing levels at 85% for care staff	85%
Estates and facilities	We will improve medical devices maintenance compliance according to risk categorisation	98% high risk;75% medium risk; 50% low risk.
Estates and facilities	We will ensure lifts are kept in service to minimise disruption and inconvenience	Being developed
Estates and facilities	We will improve the number of reactive maintenance tasks completed within the allocated timeframe	Being developed
Estates and facilities	We will ensure that planned maintenance tasks are completed within the allocated timeframe	Being developed
Estates and facilities	We will ensure that compliance with statutory and mandatory estates requirements	Being developed
Staff training	We will achieve compliance of 85% with core skills training	85%
Staff training	We will achieve compliance of 85% with clinical skills training	85%
Staff training	We will ensure that 90% of eligible staff are compliant with level 3 safeguarding children training	90%
Workforce and people	We will have a general vacancy rate of 10% or less	10%
Workforce and people	We will have a nursing and midwifery vacancy rate of 12% or less	12%
Health and safety	We will ensure we have no reportable serious accidents, occupational diseases and specified dangerous occurrences in the workplace	0

Goal	Primary Driver	Secondary Driver
Safe: People are protected from abuse and avoidable harm.	1. We follow best practice standards (clinical, professional, safeguarding, Information governance and operational) to provide the safest possible patient care	The appropriate standards/ policies/ contracts are in place
		The standards/ policies/ contracts are being implemented or part of a quality improvement initiative
		We have oversight of whether the standards/ policies/ contracts are having the intended effect and we are sharing learning
	2. We have oversight of risks and issues affecting the safety of patients & staff and proactively learns from mistakes & best practice	Systems and processes for recording safety related risks and issues are in place and being used
		There is strong quality governance arrangements from board to ward
		We are managing and learning from safety risks and issues that occur internally and externally to the organisation
	3. There is a culture where safety is our number one priority	There is a safe space to speak up when things go wrong and listen and respond to all
		Share patient and staff stories related to safety when things go wrong and when they go right
		Collective leadership is promoted in which everyone takes responsibility for the safety of patients
		Staff are aware and trained in safety culture concepts, practices and responsibilities
		We are exploring how to embed a “just” culture
	4. There are always enough staff on duty with the right skills, knowledge and experience and equipment	There are safe staffing levels across all professions
		Staff are appropriately trained and competent
		We have equipment and supplies in place to provide safe care
		Staff health and wellbeing is supported

Quality domain 2: Effective

Aim/CQC Definition: People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Area	Description	Target
Mortality indicators	We will improve our mortality rates as measured by HSMR (hospital standardised mortality ratio) to remain in the top five lowest-risk acute trusts	Top five lowest-risk acute trusts
Mortality indicators	We will improve our mortality rates as measured by SHMI (summary hospital-level mortality indicator) to remain in the top five lowest-risk acute trusts	Top five lowest-risk acute trusts
Mortality indicators	We will ensure that palliative care is accurately coded	100%
Mortality reviews	We will ensure structured judgement reviews are undertaken for all relevant deaths in line with national requirements and Trust policy and that any identified themes are used to maximise learning and prevent future occurrences.	100% of relevant cases
Readmissions	We will reduce the unplanned readmission rates for patients aged 0-15 and be below the national average	Better than national average for 2017/18
Readmissions	We will reduce the unplanned readmission rates for patients aged 16 and over and be below the national average	Better than national average for 2017/18
Clinical trials	We will ensure that 90% of clinical trials recruit their first patient within 70 days	90%
Clinical audit	We will participate in all appropriate national clinical audits and evidence learning and improvement where our outcomes are not within the normal range	100%
Patient reported outcomes	We will increase PROMs participation rates to 80%	80%
Patient reported outcomes	We will improve PROMs reported health gain to be better than national average	Better than national average
Data quality	We will improve data quality by reducing diagnostic and surgical orders waiting to be processed on our system in line with trajectories	0
Data quality	We will improve data quality by reducing outpatient appointments not checked-in on our system in line with trajectories	0
Data quality	We will improve data quality by reducing outpatient appointments not checked-out on our system in line with trajectories	0

Goal	Primary driver	Secondary driver
Effective: People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence**.**	1. Supporting self-care and self-management of conditions and promote a healthy lifestyle	Self-care: Partner with patients to recognise, treat and manage their own health
		Self-management: Encourage and enable patients to protect their own health, choose appropriate treatments and manage long-term conditions
		Promote healthy lifestyles and every interaction with patients
	2. Produce and translate the latest advances in research and technology for better patient outcomes	Collaborate with research partners
		Promote pioneering research ito diagnostic methods and treatments
		Ensure timely and appropriate participation of patients in clinical trials
		Introduce new care bundles
		Support improvements to patient care through innovation
	3. Systematically review outcomes and clinical practice to identify improvement opportunities and implement evidence based practices	Undertake audits to understand where there is scope for improvement
		Review services to develop forward-looking clinical strategies and workforce
		Regular internal inspections of wards to promote safer patient care and spread good practice
		Regular internal inspections of core services
		Regular review of health outcomes to identify areas for improvement
		Review and standardise practices, ensuring they are in line with national standards, guidelines and policy
	4. Reduce unwarranted variation to provide consistently good services	Ensure clinical teams own and use their own data to drive improvements
		Use rigorous improvement methods to design, test and implement changes
		Improve the quality of patient records through the increased use of structured data
	5. Making sure care is coordinated to meet patient need	Support transitions of care between different services and settings of care within the organisation
		Support transitions of care between different organisations

Quality domain 3: Caring

Aim/CQC Definition: The service involves and treats people with compassion, kindness, dignity and respect.

[Some targets are still under development and will be included in the final version where available]

Area	Quality account description	Target
Friends and family test	To maintain the percentage of inpatients who would recommend our trust to friends and family to 94% or above	94%
Friends and family test	To maintain the percentage of A&E patients who would recommend our trust to friends and family to 94% or above	94%
Friends and family test	To maintain the percentage of maternity patients who would recommend our trust to friends and family to 94% or above	94%
Friends and family test	To increase the percentage of outpatients who would recommend our trust to friends and family to 94% or above	94%
Friends and family test	To maintain the percentage of patients using our patient transport service who would recommend our trust to friends and family	Being developed
Mixed sex accommodation	We will have zero mixed-sex accommodation (EMSA) breaches	0

Goal	Primary Driver	Secondary Driver
Caring: The service involves and treats people with compassion, kindness, dignity and respect	1. Patients are looked after in a caring environment	Ensure our sites are easy to access
		Identify opportunities and plans for refurbishing and redeveloping our sites
		Ensure our patient facing services have patient experience at their heart
		Ensure patients are treated in a clean and infection free environment
		Improve patient nutrition
	2. Patients have access to the most up-to-date and accurate information to make decisions about their own care	Promote openness and honesty at all times
		Support patients to have access to medical records
		Provide patient information that is clear, consistent and accessible to all
	3. Staff recognise and treat every patient as an individual	Improve feedback and learning from events, complaints and compliments
		Embed the Trust values into all interactions between staff, patients and the public
		Recruit and develop team leaders based on their values
		Provide emotional and social support for staff

Quality domain 4: Responsive

Aim/CQC Definition: Services meet people's needs

[Some targets are still under development and will be included in the final version where available]

Area	Description	Target
Referral to treatment – elective care	We will reduce the percentage of patients waiting over 18 weeks to receive consultant-led treatment in line with trajectories	92%
Referral to treatment – elective care	We will reduce the percentage of patients waiting over 52 weeks to zero in line with trajectories and implement our agreed clinical validation process	0
Cancer	We will maintain the percentage of cancer patients who are treated within 62 days from urgent GP referral at 85% or more	85%
Theatre management	We will increase theatre touchtime utilisation to 95% in line with trajectories	95%
Cancelled operations	We will reduce cancelled operations as a percentage of total elective activity	Below national average
Cancelled operations	We will ensure patients whose elective operations are cancelled are rebooked to within 28 days of their cancelled operation	Below national average
Critical care admissions	We will ensure 100% of critical care patients are admitted within 4 hours	100%
Accident and Emergency	We will admit, transfer or discharge patients attending A&E within 4 hours of their arrival in line with trajectories	95%
Accident and Emergency	We will reduce the number of A&E patients spending >12 hours from decision to admit to admission to zero	0
Bed management	We will reduce the percentage of patients with length of stay over 7 days and 21 days as a percentage of occupied beds in line with national planning assumptions	Being developed
Bed management	We will maintain the average number of delayed beds in the month as a percentage of occupied beds in line with national planning assumptions	3.5% of beds
Bed management	We will discharge at least 33% of our patients on relevant pathways before noon	33%
Diagnostics	We will maintain performance of less than 1% of patients waiting over 6 weeks for a diagnostic test	1%
Outpatient management	We will reduce the average waiting times for first outpatient appointment	8 weeks or below
Outpatient management	We will reduce the proportion of patients who do not attend outpatient appointments to 10%	10%
Outpatient management	We will reduce the proportion of outpatient clinics cancelled by the trust with less than 6 weeks' notice to 7.5% or lower	7.50%

Outpatient management	We will ensure 95% of outpatient appointments are made within 5 working days of receipt of referral	95%
Complaints management	We will maintain numbers of PALS concerns at less than 250 per month	Less than 250 per month
Complaints management	We will maintain the numbers of formal complaints at less than 90 per month	Less than 90 per month
Complaints management	We will ensure that we respond to complaints within an average of 40 days	40 days
Complaints management	We will ensure that at least 70% of complainants are satisfied with the overall handling of their complaint	70%
Patient transport	We will improve pick up times for patients using out non-emergency patient transport service	Being developed
Patient transport	We will improve drop off times for patients using out non-emergency patient transport service	Being developed

Goal	Primary Driver	Secondary Driver
Responsive: Services meet people's needs	1. Care and treatments are designed to meet individual patient needs	Have accurate and clear information covering patients' past and present condition/ Improve the availability, quality and sharing of medical records in line with guidelines
		Patients are able to access and control their information
		Patients (with long term conditions) have and are support to design their own care plans
		Patients, families and carers are at the centre of decision-making about their care
		Develop proactive relationships with healthcare professionals in primary, community and mental health settings.
	2. Promote equality and equity in access to our services	Make adjustments to care to take account of age, disability, gender, gender identity, race, religion or belief and sexuality
		Improve transport services to and from hospital
		Support physical and mental health in a more integrated way
		Understand care needs for specific patients groups
	3. Patients have timely access to our services	Patients have access to timely planned care (from pre-referral advice and outpatients, to diagnostics to patient admissions)
		Patients have access to timely acute, emergency and urgent care
	4. Listen to and act on feedback from patients and the public	Improve mechanisms for capturing patient feedback
		Improve feedback and learning from events, complaints and compliments.
		Empower teams to act on patient feedback data
		Support co-production of improvement work
		Ensure we consult, listen to and involve patients and the public in decisions about our services

Quality domain 5: Well led

Aim/CQC Definition: The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Area	Description	Target
Workforce and people	We will have a voluntary staff turnover rate of 12% or less	12%
Workforce and people	We will have a general staff retention rate of 80% or more	80%
Workforce and people	We will maintain our sickness absence rate at below 3%	3%
Workforce and people	We will achieve a performance development review rate of 95%	95%
Workforce and people	We will achieve a non-training grade doctor appraisal rate of 95%	95%
Workforce and people	We will have a consultant job planning completion rate of 95% or more	95%
Health and safety	We will have a departmental safety coordinator in 75% of clinical wards, clinical departments and corporate departments	75%
Health and safety	We will ensure at least 10% of our staff are trained as fire wardens	10%
NHSI segmentation	We will maintain or improve NHSI provider segmentation	-

Goal	Primary Driver	Secondary Driver
Well-led: The leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.	1. Build improvement capacity and capability at all levels	Design and deliver a comprehensive quality improvement education programme accessible to staff at all levels
		Develop multiple cohorts of improvement coaches and leaders
		Support staff to have the capacity to undertake and lead improvement work
	2. Recruit, develop and retain a highly motivated and expert workforce	Effective recruitment, attraction and onboarding strategies are in place
		Prioritise professional development opportunities and networks
		Focus on talent management
		Ensure effective staffing levels and working patterns are in place
		Prioritise staff mental and physical wellbeing
		Promote equality and diversity
	3. Become a learning organisation	Listen to and act on patient feedback
		Listen to and act on staff feedback
		Maximise learning capacity by developing skills in staff
		Share and celebrate stories across and beyond the organisation
	4. Develop strategic and operational plans to meet current and future needs of our population	Develop strategies with our partners in North West London to improve the health of our communities
		Ensure our estates are fit for purpose
		Emergency preparedness plans

Statements of assurance from the Trust board

In this section of the quality account, we are required to present mandatory statements about the quality of services that we provide, relating to financial year 2017/18. This information is common to all quality accounts and can be used to compare our performance with that of other organisations. The statements are designed to provide assurance that the board has reviewed and engaged in cross-cutting initiatives which link strongly to quality improvement.

A review of our services

In 2017/18, Imperial College Healthcare NHS Trust provided and/or sub-contracted 86 NHS services.

We have reviewed all the data available to us on the quality of care in all of these NHS services through our performance management framework and assurance processes.

The income generated by the NHS services reviewed in 2017/18 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2017/18.

Participation in clinical audits and national confidential enquiries

Clinical audit drives improvement through a cycle of service review against recognised standards, implementing change as required. We use audit to benchmark our care against local and national guidelines so we can put resource into any areas requiring improvement; part of our commitment to ensure best treatment and care for our patients.

National confidential enquiries investigate an area of healthcare and recommend ways to improve it.

During 2017/18, 41 national clinical audits and 3 national confidential enquiries covered NHS services that Imperial College Healthcare NHS Trust provides. During that period Imperial College Healthcare NHS Trust participated in 98 per cent national clinical audits and 100 per cent national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Imperial College Healthcare NHS Trust was eligible to participate in during 2017/18 are included in the table below alongside the number of cases submitted to each audit or enquiry as a percentage where available.

National Clinical Audit and Clinical Outcome Review	Host Organisation	Eligible	Participated	% Submitted
Acute Coronary Syndrome or Acute Myocardial	National Institute for Cardiovascular Outcomes	√	√	Ongoing data collection
Adult Cardiac Surgery	National Institute of Cardiovascular Outcomes	√	√	Ongoing data collection
BAUS Urology Audits:	British Association of	√	√	N/A

Bowel Cancer (NBOCAP)	Royal College of Surgeons of	√	√	100%
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes	√	√	N/A
Case Mix Programme (CMP)	Intensive Care National Audit Research Centre	√	√	Ongoing data collection
Child Health Clinical Outcome Review Programme	The National Confidential Enquiry into Patient Death	√	√	N/A
Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes	X	X	Service decommissio
Coronary Angioplasty/National Audit of	National Institute for Cardiovascular Outcomes	√	√	100%
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health	√	√	100%
Elective Surgery (National PROMs Programme)	NHS Digital	√	√	Ongoing data collection
Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons	√	√	N/A
Falls and Fragility Fractures Audit programme	Royal College of Physicians	√	√	Ongoing data collection
Fractured Neck of Femur	Royal College of Emergency Medicine	√	√	Ongoing data collection
Head and Neck Cancer Audit (HANA) (TBC)	Saving Faces - The Facial Surgery Research	√	√	Ongoing data collection
Inflammatory Bowel Disease (IBD) programme	Inflammatory Bowel Disease Registry	√	X	Did not participate
Learning Disability Mortality Review	University of Bristol	√	√	N/A
Major Trauma Audit	The Trauma Audit & Research	√	√	97.2%
Maternal, Newborn and Infant Clinical Outcome	MBRRACE-UK, National Perinatal Epidemiology Unit,	√	√	N/A
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome And Death	√	√	N/A
National Audit of Breast Cancer in Older Patients (NABCOP)	Clinical Effectiveness Unit, The Royal College of Surgeons of England	√	√	N/A
National Audit of Dementia	Royal College of Psychiatrists	√	√	100%
National Bariatric Surgery Registry (NBSR)	British Obesity and Metabolic Surgery Society (BOMSS)	√	√	N/A
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre (ICNARC)	√	√	100%
National Chronic Obstructive Pulmonary Disease	Royal College of Physicians	√	√	N/A
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	London North West Healthcare NHS Trust	√	√	N/A

National Comparative Audit of Blood Transfusion programme	NHS Blood and Transplant	√	√	100%
National Diabetes Audit - Adults	NHS Digital	√	√	100%
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	√	√	Request for data only
National End of Life care audit	TBC – to be commissioned by HQIP in 2017	√	√	Ongoing data collection
National Heart Failure Audit	National Institute for	√	√	N/A
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership	√	√	Ongoing data collection
National Lung Cancer Audit	Royal College of Physicians	√	√	91%
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	√	√	100%
National Neonatal Audit	Royal College of Paediatrics and	√	√	100%
National Ophthalmology Audit	Royal College of Ophthalmologists	√	x	Did not participate
National Vascular Registry	Royal College of Surgeons of	√	√	79%
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	√	√	N/A
Oesophago-gastric Cancer (NAOGC)	Royal College of Surgeons of England	√	√	100%
Paediatric Intensive Care (PICANet)	University of Leeds	√	√	100%
Pain in Children	Royal College of Emergency	√	√	N/A
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists	N/A	N/A	N/A
Procedural Sedation in Adults (care in emergency departments)	Royal College of Emergency Medicine	√	√	N/A
Prostate Cancer	Royal College of Surgeons of	√	√	100%
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians	√	√	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Serious Hazards of Transfusion	√	√	100%
UK Parkinson's Audit	Parkinson's UK	√	√	N/A

The reports of twenty four national clinical audits and confidential enquires were reviewed by the provider in 2017/18. The majority of these have provided a satisfactory level of assurance, however the exceptions are listed in appendix A with the actions required to improve the quality of healthcare provided. All other reports are under review by our divisions with assurance reporting planned in line with our governance framework.

The reports of 365 local clinical audits were reviewed by the provider in 2017/18 and the actions we intend to take to improve the quality of healthcare provided can be found in appendix B.

Participation in clinical research

In partnership with Imperial College London, the Trust is at the forefront of developing and delivering world-class biomedical and clinical research, collaborating with partners in industry, government, the NHS, and the charity sector to apply new knowledge to clinical problems.

Through the Imperial College Academic Health Science Centre (AHSC) partnership, and with significant infrastructure funding from the NIHR Imperial Biomedical Research Centre (BRC), Clinical Research Facility (CRF) and other NIHR infrastructure awards, we are committed to encouraging innovation in everything that we do. Part of this involves carrying out pioneering research into novel diagnostic methods and treatments across a broad spectrum of specialities and for some of the most complex illnesses, with benefits for patients everywhere. Our clinical staff keep abreast of the latest possible treatments – active participation in research leads to more successful patient outcomes – and work closely with academic staff in Imperial College in order to translate research findings into improved treatments and diagnostics in the healthcare setting.

Last year, following a competitive application and review process, the NIHR Imperial BRC – a major programme of experimental medicine in partnership with Imperial College London – was renewed and awarded £90m over the next 5 years. The funding has allowed the BRC to continue its world-class research into cancer, heart disease, brain sciences, immunology, gut health, infection and anti-microbial resistance, surgery, metabolic and endocrine diseases, health informatics, genomics, imaging and molecular phenotyping.

Since starting in April 2017, the new NIHR Imperial BRC programme has implemented more than 150 individual research projects in experimental medicine. In total, 580 new clinical studies were initiated within the Imperial partnership in 2017/18.

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 20,238.

17,202 patients have been recruited into 422 NIHR Portfolio studies in 2017/18. This included 487 patients within 97 studies sponsored by commercial clinical research and development organisations.

Through joint working with its academic partner, the Trust has continued to make significant scientific advances in 2017/18. Recent translational research highlights are included below. In addition the Paediatric Clinical Research Facility (PRCF) at ICHT was recently relocated to the Clarence Wing and refurbished. The PCRF's research activities focus on children with problems such as allergy, asthma, sickle cell anaemia, hepatitis, tuberculosis (TB), acute infections and sleep disordered breathing. The Facility has already attracted capital funding of £500k from the Charles Wolfson Charitable Trust and, following a recent public nomination, it has been selected by an independent judging panel to be the winner of Allergy UK's Hospital Clinical Heroes Awards in 2018.

Translational research highlights:

- BRC investigators demonstrated a new class of experimental drugs which reduced hot flushes in menopausal women by almost three-quarters in just three days. The hope is that these types of compounds may provide an alternative to Hormone Replacement Therapy (HRT), which is a risky treatment for many women due to possible side effects;

- As part of a multi-centre collaborative study, Imperial BRC researchers are developing new techniques which allow the brains of foetuses and babies to be scanned, thus helping doctors and scientists to understand how the brain grows and how problems may arise;
- The launch of 'gripAble™' as a commercial product, which aims to make the training of arm and hand functions more accessible and improve physical rehabilitation following strokes, for example;
- RAPID, a one-stop-shop for men with suspected prostate cancer, is being trialled at Charing Cross Hospital, aiming to reduce diagnosis times from six weeks to just one week;
- Cardiovascular clinical academics developed a software 'learning algorithm' that can more accurately predict when the heart may stop in patients with pulmonary hypertension. In addition to accurate disease risk prediction, these artificial intelligence (AI) techniques can help clinicians tailor their treatments to better suit individual patients, without the need for invasive procedures;
- A joint initiative between the Trust and Imperial College academics, funded by NIHR infrastructure, analysed group B streptococcus infections in neonates, providing new understanding more about how such infections may be transmitted in a hospital setting.

More detail on each of these examples, as well as well other translational research work can be found on the NIHR Imperial Biomedical Research Centre website [insert hyperlink: https://imperialbrc.nihr.ac.uk/research/].

Our CQUIN performance – CQUIN framework

Commissioning for Quality and Innovation (CQUIN) is a payment framework that allows commissioners to agree payments to hospitals based on agreed quality improvement and innovation work.

A proportion of Imperial College Healthcare NHS Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals through the CQUIN framework.

In 2017/18 the value of the schemes was 2.8 per cent of the contract value for NHS acute healthcare services as agreed with NHS England. This equated to £5,697,799 of our planned income from NHS England.

A summary of the 2017/18 CQUIN goals and achievements for Q1 to Q3 are provided in the table below. The figures for Q4 will not be validated until the end of June 2018.

NHSE 2017-19 CQUIN schemes	Description of scheme	Full year Plan value £	Achieved % (Q1 – Q3)
BI1 HCV Improving Treatment Pathways through ODNs	ICHT is an HCV ODN lead provider. The CQUIN requires prioritisation of patients with highest clinical need and supports the sustainability of treatment. The outcomes anticipated from this CQUIN are: • Improvement in patient engagement • The planned roll-out, of new clinical treatment guidance to improve outcomes through multi-disciplinary team treatment plans • Improved participation in clinical trials	£3,357,631	Q1 – 100% Q2 – 100% Q3 – 100%

	• Enhanced data collection to demonstrate the effectiveness and equity of this way of working and the availability of new treatments		
GE3 Hospital Medicines Optimisation	This CQUIN is to support Trusts and commissioners to realise agreed targets and metrics that will unify hospital pharmacy transformation programme (HPTP) plans and commissioning intentions. This CQUIN also includes year 2 of the antiretroviral drug switches scheme. The outcomes anticipated are: • Faster adoption of best value medicines with a particular focus on the uptake of best value generics, biologics and CMU frameworks as they become available. • Improved drugs data quality in the drugs MDS and outcome registries as well as to meet the requirements of the ePharmacy and Define agendas. • The consistent application of lowest cost dispensing channels. • Compliance with policy/ consensus guidelines to reduce variation and waste.	£1,017,464	Q1 – 100% Q2 – 95% Q3 – 95%
IM4 Complex Device Optimisation	Clinical decision making around device selection varies between implanting units. This scheme seeks to ensure that device selection remains consistent with the commissioning policy, service specification, and relevant NICE guidance while new national procurement and supply chain arrangements are embedded. The outcomes anticipated are: • Enhancement and maintenance of local governance systems to ensure compliance • Development of sub-regional network policies to encourage best practice including minimum standards for patient consent to ensure optimal device selection. • To improve timely access to all patients. • To ensure that referral pathways and robust MDT decision making processes are developed for appropriate cases.	£223,842	Q1 – 100% Q2 – 100% Q3 – 100%
CA2 Nationally Standardised Does Banding Adult Intravenous	This CQUIN is to incentivise the standardisation of doses of SACT in all chemotherapy units. The outcomes anticipated are: • Have the principles of dose banding accepted by local teams. • Have the drugs and doses approved by	£203,493	Q1 – 100% Q2 – 100% Q3 – 100%

SACT	local formulary committees. • Have SACT prescribed in accordance with the doses of drugs listed in the national dose-banding tables. • Agreement and adoption of standardised product definitions		
WC5 Neonatal Community Outreach	To improve community support and to take other steps to expedite discharge, pre-empt re-admissions, and otherwise improve care such as to reduce demand for critical care beds and to enable reduction in occupancy levels. Babies receiving specialist neonatal care would have their health and social care plans coordinated to help ensure a safe and effective transition from hospital to community care.	£284,890	Deliverables not due until Q4
WC4 Paediatric Networked Care	This scheme aligns to the national PIC service review and aims to gather information which allows the demand across the whole paediatric critical care pathway to be considered. PICUs will be asked to review the delivery of activity undertaken by the acute hospitals in their usual catchment that trigger the Paediatric Critical Care Minimum Data Set. The outcomes anticipated are: • work with local acute hospitals to collate data over a six month period in 2017. • provide a summary report by February 2018 • oversee the review of each of the referring acute hospitals in their usual catchment against the Paediatric Intensive Care (PICS) standards	£203,493	Deliverables not due until Q4
STP Renal	This CQUIN is to encourage working across the primary and secondary care pathways to review and improve renal replacement therapy efficiencies and to implement the findings of the recent London Peer Review. The outcomes anticipated are: • To support patients to be more pro-active in the management of their care through the use of self-management tools. • To support the management of renal patients across the whole pathway by supporting primary care and providing rapid assessment and diagnosis. • To increase home dialysis uptake • Increase rate of haemodialysis with AV Fistulas	£406,986	Q1 – 95% Q2 – 95% Q3 – 95%

	• To improve rates of pre-emptive transplantation as a therapy of choice for those suitable with chronic kidney failure.		

In addition to these national schemes, we also agreed with our local NW London commissioners to work to all best endeavours to achieve nationally set CCG CQUINs. This agreement was made on the basis of achieving sector wide control totals while still demonstrating substantial quality outcomes within these areas. The value of the schemes would normally amount to 2.5% of the contract value, though in meeting the financial obligations of the local health economy this was reduced to 1.7%; equating to £6.71m of our planned CQUIN income from NW London CCGs. A brief summary of what we achieved in 2017/18 is as follows:

CQUIN scheme	**Description of scheme**	**Achievements**
1. Improving staff health and wellbeing	Improvement of health and wellbeing of NHS staff, health food for NHS staff, visitors & patients, and improving the uptake of flu vaccinations for front line staff	The overall staff FFT engagement score increased from 77% in 2016 to 80% in 2017. 86% of staff recommend the Trust as a place for care or treatment, and 72% recommend the Trust as a place to work. This is the highest performance to date in the last three years. Attendees at our Schwartz rounds increased dramatically in 2017, and it gives our staff to opportunity to share personal reactions to clinical cases, allowing staff to reflect on and connect with stories. The final submission has been made to NHS England showed that 60.5% of our HCWs were vaccinated against flu in 2017/18. This is a significant 39.9% increase in uptake compared to 2016/17. By the end of 2018 we have also agreed to better promote healthy eating and drinking at our on site retail outlets by removing price promotions and advertising of all sugary drinks and food high in fat, salt and sugar, as well as removing them from checkouts.
2. Reducing the impact of serious infections	Timely identification and treatment for sepsis in emergency departments and acute inpatient settings Reduce antibiotic consumption and improve antibiotic review	We introduced a Cerner sepsis alert designed to help identify adult patients who are at high risk of sepsis. The alert is based on a similar algorithm to the NICE guideline and has been validated in a number of hospitals across the US and UK and pulls in data from various sources including patient biochemistry and observations to identify patients who are at risk and require urgent clinical review. The number of sepsis alerts increased over the winter period, conversely confirmed cases decreased. 50% of patients with a sepsis alert in our EDs and acute inpatient wards received antibiotics within one hour. As part of the flow programme ICHT has developed a weekly sepsis ‘big room’ which allows us to design, test and implement changes across the Trust to improve identification and treatment of sepsis.

		The latest bi-annual antibiotic point prevalence survey has found that all indicators of antibiotic prescribing quality are in excess of the target level of 90%. Overall there has been a 1% decrease in the antibiotic consumption from 2016/17 to 2017/18.
4. Improving services for people with mental health needs who present to A&E	Identify cohort of frequent A&E attenders that could benefit from input from specialist mental health staff, sharing data with key system partners, and work to reduce attendances	Reviews of frequent attending mental health patients arriving in our EDs at the St Mary's and Charing Cross Hospital sites are conducted on a monthly basis. The ICHT Frequent Attender service seeks to identify and support repeated users of UEC services. To reduce attendances to ED and subsequent hospital admission we work intensively with these patients. The service has undertaken collaborative working with a core cohort of 15 patients on each site. This involves bespoke MDT case working providing up to six 1:1 sessions and developing long term clinical relationships with the patients. We have introduced an escalation process with our partners at CNWL for both In and Out of Hours The CNWL CRHT (Crisis Team) Model of Care review has proposed to stop duplication of LPS assessments for those cases referred for community follow up.
6. Advice and guidance	Provide good quality A&G services to GP Practices	ICHT maintains its GP advice service for 19 specialties, all of which are easily located on the Trust's website. The e-mail addresses are manned by clinical leads who aim to respond to queries within 24 hours. Phone lines also exist for elderly medicine, maternity, microbiology, ophthalmology, paediatrics, pathology, and stroke and neurosciences. As part of our joint outpatient transformation programme we hold with commissioners, we have agreed on a model where there are templates for referral, smart information and guides for GPs.
7. E-referrals	Primary care referrals to Outpatient First attendance to be received through e-RS	e-RS Steering Group formed with local commissioners, RFSs, and GP colleagues to increase the number of Primary Care referrals received via e-RS; dedicated project team established to map all specialties and sub-specialties to the DoS and upload to e-RS. Training and presentations have been given in Practices and GP Members Forums. We anticipate achieving paper switch-off by 1st August 2018, in advance of the 1st October 2018 deadline.
8. Supporting proactive and safe discharge	Map existing discharge pathways and produce credible plan to achieve submission of the Emergency Care Dataset	ICHT meets with our partners Vocare, CNWL, WLMH, LAS, 111, and other commissioned services such as Home First Rapid Response and CIS on a monthly basis as an escalation point for bottlenecks to be resolved. Mapped discharge pathways have been developed jointly

		with CCGs to improve inpatient bed flow. We have developed a standardised operating procedure to accurately report DToCs**.** The plan to implement ECDS was produced earlier in the financial year. The Safer Patient Flow Bundle has also been introduced to facilitate a reduction in length of stay and improve patient flow and safety from admission to discharge.

Care Quality Commission registration status

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It makes sure health and social care services provide people with safe, effective, caring, well-led and responsive care that meet fundamental standards.

The Trust is required to register with the CQC at all of our sites and our current registration status is 'registered without conditions'.

The CQC has taken enforcement action against Imperial College Healthcare NHS Trust during 2017/18. This was in the form of Requirement Notices, which relate to regulatory breaches identified during inspections carried out in 2016/17 and 2017/18, and were set during 2017/18. Summary of findings and actions being taken in response are summarised below.

CQC Requirement Notice	Summary of related findings	Summary of action being taken
Regulation 12: Safe care and treatment	Medicines management policies were not always being adhered to in: • Maternity at St Mary's Hospital • Medical care at St Mary's, Charing Cross and Hammersmith hospitals • Urgent and emergency services at Charing Cross Hospital	Changes were made to the Trust's Medicines Management Quality Improvement Programme, including a shift to focusing on human factors in why medicines policies / procedures are not followed in practice
	Statutory and mandatory training was not always completed as required, with completion rates below the Trust target: • In Maternity at St Mary's Hospital • In Medical care at St Mary's, Charing Cross and Hammersmith hospitals • Among medical staff in Surgery at St Mary's Hospital	• Introduction of a core skills group to oversee Trust-wide improvement activities • Development of a Trust-level business case to improve the IT systems used for recording completion of training • Additional actions were taken in Maternity, specifically in relation to CTG training
	Airway and emergency trolleys were not always appropriately checked in Urgent and emergency services at Charing Cross Hospital	• All trolleys now have checklists attached for daily completion • Completion of checklists is audited weekly •
	Clinical and hazardous waste management guidelines were not always adhered to in Surgery at St Mary's Hospital	Training is being delivered to staff to alert them to finding and improve awareness of the guidelines / requirements
	Daily cleaning requirements were not always being completed and checks	• Documented cleaning schedules are now in place

	were not being undertaken to identify this in Surgery at St Mary's Hospital	• Weekly cleaning audits will be jointly carried out by the Trust's cleaning team and theatre staff (these are currently carried out by the cleaning team only), monitored by the Theatre Manager • Completion and outcomes of audits will continue to be monitored at monthly meetings with the Trust's cleaning subcontractor, and will be reported by exception to the Trust's cleaning sub-group
	Deep cleaning of theatres were not taking place in line with Trust policy in Surgery at St Mary's Hospital	• A deep cleaning schedule was in place at the time of the inspection; action is being taken to ensure the schedule is communicated to all relevant staff • Completion of deep cleans and outcomes of cleaning audits will continue to be monitored at monthly meetings with the Trust's cleaning subcontractor
	The poor state of repair of seven theatres is reflected in an infection control risk in Surgery at St Mary's Hospital	The scope of theatre refurbishment has been agreed and works will be undertaken between April and December 2018, one theatre at a time.
Regulation 15: Premises and equipment	Portable equipment (medical devices) did not always having safety tests and planned preventative maintenance completed when these are due, in urgent and emergency services at St Mary's and Charing Cross hospitals	The Trust has a planned preventative maintenance programme in place which is overseen by the Medical Devices and Management Group, Chaired by the associate medical director. Following the CQC's findings the timeframe for the current year's programme was accelerated.
Regulation 17: Good governance	Performance was not always monitored against agreed standards in Urgent and emergency services at St Mary's Hospital	The inspection findings are being taken account of as part of the Trust's annual review of the performance framework and related governance arrangements

We have not participated in any special reviews or investigations by the CQC during 2017/18. All trusts are captured in CQC patient surveys, of which three, carried out during 2016 were published during 2017/18: children's services, A&E departments, and maternity. The Trust's performance in the children's and maternity surveys was similar to previous results, and the Trust was not identified as an outlier in either of these. However, the Trust was identified as an outlier for poor performance in the A&E survey. Responses to survey outcomes are managed by the division responsible for the service, with support from the Trust's Patient Experience team.

During 2017/18, two of the Trust's core services were inspected: Urgent and emergency services at St Mary's and Charing Cross hospitals, and Surgery at St Mary's, Charing Cross and Hammersmith hospitals. The Trust also had its first inspection of the well-led domain at Trust level, a new type of inspection introduced by the CQC this year.

- The Trust's overall rating for the well-led domain, which is based on findings from the trust level inspection of the well-led domain and performance of core services during inspections in the year preceding the well-led inspection, was 'Requires improvement'.
- Urgent and emergency services was rated overall as 'Requires improvement' at St Mary's and Charing Cross hospitals. This reflects no change in overall rating at St Mary's Hospital, and a worse overall rating at Charing Cross Hospital where the service was previously rated overall as 'Good'.
- Surgery was rated overall as 'Requires improvement' at St Mary's and Charing Cross hospitals, and Good' overall Hammersmith Hospital.
- The Trust's overall ratings for each domain and for the Trust overall, remain the same as they were in 2014.

Our data quality

High quality information leads to improved decision making which in turn results in better patient care, wellbeing and safety. There are potentially serious consequences if information is not correct, secure and up to date.

We continued to experience challenges with data quality in 2017/18 which we are working to improve through our data quality framework which we introduced this year.

Key data quality indicators are reported every week and are also included within our monthly performance scorecards to ensure data quality governance is aligned with our Performance Management Framework.

An executive-led Data Quality Steering Group is in place and meets every month. It provides leadership and oversight of the development and delivery of all aspects of our Data Quality Framework.

There are over 100 data quality indicators in total in use across the Trust, which are available via a data quality dashboard tool (Cymbio). New data quality indicators continue to be developed in response to requirements.

NHS number and general medical practice code validity

The Trust submitted records during 2017/18 to the Secondary Users Service for inclusion in the Hospital Episode Statistics (see glossary on page xx for definitions) which are included in the latest published data. The percentage of records in the published data to month 9 2017/18 (most recent available) which included the patient's valid NHS number was:

- 97 per cent for admitted patient care;
- 98 per cent for outpatient care;
- 91 per cent for accident and emergency care .

The percentage of records in the published data which included the patient's valid general medical practice code was:

- 100 per cent for admitted patient care;
- 100 per cent for outpatient care;
- 100 per cent for accident and emergency care .

Information governance toolkit scoring

Information governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The information governance toolkit is the way we demonstrate our compliance with information governance standards. All NHS organisations are required to make three annual submissions to Connecting for Health in order to assess compliance.

Our information governance assessment report overall score for 2017/18 was 67 per cent and was graded 'satisfactory'. The satisfactory rating was achieved by a minimum level 2 assessment against all standards. The information governance toolkit return was subject to an independent audit conducted in October 2014 and again in March 2018. The final audit report gave the Trust 'reasonable assurance' of the self-assessment.

Clinical coding quality

Clinical coding is the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised. The use of codes ensures the information derived from them is standardised and comparable.

The Trust was not subject to the Payment by Results clinical coding audit by NHS Improvement during 2017/18. There are no Payment by Results audits currently planned.

National Outcomes framework indicators 2016/17

The NHS Outcomes Framework 2017/18 sets out high level national outcomes which the NHS should be aiming to improve. For full information about our performance, please see pages xx-xx.

A review of our quality progress 2017/18

This part of the report shares the quality improvement priorities that we set ourselves for 2017/18 and reports our progress against each of these. It also outlines our performance against the NHS Outcomes Framework 2017/18, the Quality Schedule agreed with our commissioners and national targets and regulatory requirements.

Our quality account improvement priorities for 2017/18 reflected the goals and targets defined in our 2015-18 quality strategy. They were outlined in our quality account last year following consultation with our clinical and management teams and with our external stakeholders, through the quality steering group.

Our progress with these goals and targets is described below under each quality domain. Where additional actions are required for 2018/19 these are included here to avoid repetition.

This page shows some of our quality highlights over the last year. These are explained in further detail throughout the following section.

[Infographic to be included in final designed version illustrating some of the quality highlights]

Safe

We want to ensure our patients are as safe as possible while under our care and that they are protected from avoidable harm. We are committed to continuously improving the safety of our services for patients and staff. We do this through delivering improvements in key areas of safety as well as by understanding and improving our safety culture.

Safety culture programme

Culture is "the ideas, customs and social behaviour of a particular people or society" which defines how people behave and interact with others. Safety culture is about the attitudes, values and behaviours that staff share about safety, often described as the "the way we do things around here to keep patients and staff safe". The safety culture programme was launched in 2016, is led by the medical director and is in place to ensure that safety is a universal priority for all staff groups. It is designed to support the development of a culture in which all staff can describe their contribution to safety, are aware of the potential for things to go wrong, are supported to learn from mistakes, take action to put things right and are confident in speaking up if they have concerns. In line with our approach to quality improvement, this is a programme that encourages staff to identify local issues, plan improvements and test them with a focus on continuously improving safety.

The programme has been designed using intelligence from research and learning including from our staff informally through workshops and formally through the staff survey and the safety attitudes questionnaire which was used in 2016 as well as through analysis of incidents. A number of pieces of work were planned this year and our progress is described.

Incident reporting improvement work-stream

In May 2017, we launched an incident reporting reference group (IRRG) to plan, develop and oversee improvements to our reporting and management processes. Plans were developed using staff feedback obtained from engagement events where staff expressed the need to make reporting as simple and efficient as possible and shared their fears of the consequences of reporting incidents. In response we have:

- Simplified the Datix reporting fields to minimise the time taken to complete;
- Launched a range of communication tools to widen the learning for key safety improvement messages including a monthly safety briefing;
- Supported a number of areas with low reporting rates to understand the barriers and explore their local "trigger lists" which should be reported;
- Amended the incident management workflow to provide more timely feedback to reporters by removing an unnecessary management approval step;
- Introduced anonymous reporting;
- Developing an app based reporting tool with the Patient Safety Translational Research Centre (see glossary on page xx) with a pilot planned in the coming months;

This work will continue to develop and evolve in 2018/19 with a focus on evidencing change as a consequence of reporting, improving communication and reducing the administrative burden on our clinical managers. We will also introduce positive reporting.

Serious incident improvement programme

A serious incident (SI) was declared in May 2016 following the death of a baby at St Mary's Hospital. An internal review and an external review by the Royal College of Obstetricians and Gynaecologists were commissioned which took place in March and April 2017. A number of the recommendations from these reviews helped inform our serious incident improvement programme and we have worked hard this year to improve the quality of our serious incident investigations. An end to end review of our processes revealed many areas

for improvement including candour, compliance with the national framework, education and training, support for staff and patients/families when things go wrong. A number of tests of change have already completed including changes to the management of duty of candour, new report templates and the introduction of new training for those involved in investigating and assurance.

Feedback on the training has been excellent and we are seeing improvements in the quality of the investigation reports being presented to the review panels. Embedding these changes and focusing on the experience of those involved will continue to be key going forward.

Duty of Candour

As well as being a requirement under the duty of candour legislation, the Trust recognises the importance of being open with patients when things go wrong. This involves giving patients accurate, truthful and prompt information as well as providing an apology.

Concerns were raised in February 2017 about compliance with the duty of candour (DoC) for incidents that had been declared as serious. These concerns originated from a retrospective compliance audit in September 2016 (limited assurance) and also from a serious incident where the candour process was not sufficient. A full review of processes across the Trust was completed and compliance is now monitored through the weekly medical director's incident review panel. The duty of candour policy was refreshed this year, and a mandatory online training module for consultants and appropriate nurses was implemented. We have seen a measurable improvement in compliance. Work to continue improving compliance and therefore experience will be an on-going priority.

Safety improvement programmes

Sepsis

Sepsis is an inflammatory response triggered by infection, with the risk of in-hospital mortality. Early recognition and intervention can reverse the inflammatory response and improve clinical outcomes. Whilst clinical outcomes for patients with sepsis at the Trust are within the national average, the condition can be fatal and therefore is a high priority for continued improvement.

During this year we began to use an electronic decision support module in our electronic patient record designed to improve the identification of adult patients at high risk of sepsis. The alert has been tested and is live in a number of in-patient areas. The sepsis alert has a reporting functionality and we are now able to use real-time analytics to drive improvements in care through using this report. Work to improve sepsis identification and management is being supported by one of three "big rooms" aimed at reducing unwarranted variation across care pathways through multidisciplinary working. The roll out and standardisation of this work will be a key priority for 2018/19 and will be taken forward as part of the deteriorating patient safety stream.

Safety Streams

The safety streams were established in 2016 to focus and target work to drive improvements in patient safety in nine well-recognised areas of clinical risk. Progress is summarised in the table below. Each stream is chaired by an experienced clinical lead with dedicated support from an improvement team lead.

The safety streams will continue into 2018/19 with the exception of pressure ulcer reduction which will be managed as part of business as usual following sustained reductions.

Safety Stream	Rationale	Progress to date	Key areas for improvement
	The trust previously reported a number of serious incidents which related to the management of abnormal results. Immediate action was taken in response to these serious incidents including escalation of unsuspected abnormal results to the clinician and to the appropriate multidisciplinary team; however it was recognised that the issue of endorsement of results was a key risk area.	• A large amount of background work has been undertaken to understand the difficulties and variations in practice; • Engagement of the Information Governance team to provide data from the electronic patient record to identify clinical teams who perform endorsement well; • An evidence scan and investigation into other trusts process and procedures; • Abnormal ranges of results agreed which once implemented into the electronic patient record will lead to all normal results being automatically endorsed; • A Standard Operating Procedure has been agreed by the Trust.	The key priority is to start working with teams to support change and ensure sustainability; Once teams with most variation identified engagement will begin to understand problems, barriers and key tests of change. A pilot with the division of medicine to understand and develop a process to support junior doctor rotations. Building capability and providing staff with training to support the information technology process and understand the importance of endorsement from a safety perspective. Our potential measures include: • Increase in endorsement of results • Reduction in incidents • Potential reduction delays in activation of treatment • Potential reduction in length of stay
	National Institute of Clinical Excellence (NICE) updated existing guidance on falls prevention in 2013. This emphasised the prevention of falls in hospital and highlighted that all patients aged 65 or older and those judged by	• Policy refresh • Quality sprint • Embedding falls assessment and care plans in the electronic patient record (EPR) • Staff engagement in identifying falls as a trigger for incident reporting • Undertaking the national Royal College of Physicians (RCP) audit in	To support this programme of work across the Trust, we have engaged with the divisions to identify six wards to pilot a six month programme of work to support staff to drive small tests of change. This will comprise of improvement training to build capability and provide facilitation in practice to understand

	a clinician to be at higher risk of falling because of an underlying condition are regarded as being at risk of falling and that their care be managed according to a number of evidence based recommendations. The aim of the safety stream is to support patients to mobilise safely and to reduce the rate of inpatient falls with harm.	2017 • Local divisional action plans agreed, the delivery of which will be supported by the improvement team	tests of change utilising measurement for improvement. Our measures will focus around compliance of the three key areas of the RCP data including: • Lying and standing blood pressure • Assessment of medications that increase fall risk • Objective assessment of vision And also • Staff and patient experience • Reduction in falls with harm • Continued and potential increase of falls reporting
	This safety stream aims to reduce the number of fetal monitoring related incidents resulting in clinical harm and litigation. The stream intends to reduce the risk of incidents through improved training and improved clinical performance.	A central monitoring IT system, 'Fetal Link', and the day-to-day use and training for it has been delivered (e.g. induction training, multidisciplinary team meetings). The 'Fetal Link' system provides a mechanism to monitor key clinical metrics (including fetal heart rate or cardiotocography) and escalate any issues quickly.	Our measures include: • Reduction in intrapartum still births or neonatal intensive care (NICU) admissions relating directly to CTG interpretation • Reduction in incidents, complaints and claims relating to CTG • CTG used in all appropriate cases • Intermittent fetal monitoring done as per protocol • Converted to CTG from intermittent fetal monitoring at the correct point and in a reasonable time • Unexpected neonatal admissions to NICU due to CTG concerns • Time between classification of CTG as pathological to definitive action taken We are investigating the use of a

			dashboard to monitor fetal monitoring outcomes and process.
	Our hands are the principle route by which cross-infection happens, and hand hygiene is the single most important factor in the control of infection. The aim of this safety stream is to improve adherence to recommended hand hygiene procedures realised through a strong communication and education campaign and a new audit process that promotes awareness and supports bespoke ward level engagement and improvements.	• A steering group has been formed • Initial 'five moments' (hand washing technique – see glossary on page xx) audit tested and rolled out • Baseline audit data collected • Ward champions identified and test wards identified to pilot new approach • Communications plan developed • Establish a hand hygiene awareness week identified and follow up launch activities in planning stages • Hand hygiene champions to attend an improvement sprint	• Audit redevelopment to be launched in April 2018 • Hand hygiene communication campaign and key messaging • Development of education packages/bundles to roll out with new audit • Hand hygiene week • Ensuring robust hand hygiene stock management and consumables in place Our measures include the number of ward champions, improvements as a result of audit, engagement with staff and quantity of consumables used
	Ensuring that patients are correctly identified every time care or treatment is given including where samples are taken and processed is central to the safe delivery of care.	A steering group to address positive patient confirmation within the Trust has been established and a new policy is due to be published in June 2018. Regular reporting of patient identification errors within the Trust has been established for the group, to assist in identifying themes and clinical areas requiring improvement support.	Pilot an innovative new way to launch policies in the Trust to ensure staff understand their responsibilities with regards to positive patient identification. Thematic analysis of patient identification errors has highlighted areas of practice with the higher levels of patient identification errors. These relate to: 1. Pathology including blood gases and wrong blood in tube 2. Major trauma pathways 3. Imaging and interventional radiology IR(ME)R (see glossary

			on page xx) incident reporting Pilot projects to reduce reported patient identification errors have been planned for these areas, each with bespoke measures.
	Pressure ulcers cause pain, discomfort and distress to patients and can delay recovery and discharge from hospital. Whilst many patients are at risk of pressure ulcers they remain largely avoidable; therefore pressure ulcer prevention remains a key patient safety priority for the Trust.	Patients in the intensive care at the highest risk of pressure ulcers due to the complex nature of their underlying condition. Implementing a care bundle based on evidence based practice standards has delivered a reduction in pressure ulcers – particularly the most severe grade of pressure damage -in this group of patients. We have not reported a Trust acquired category 4 (the most severe pressure damage) since March 2014.	We will continue to measure rates of pressure ulcers by grade, and also monitor which clinical areas have the highest incidence of pressure ulcers in order to target improvement work. Actions we are currently undertaking : • A nominated champion in each clinical area disseminating education from the in-house tissue viability study days • Exploring the data into device related pressure damage, • Further work in our intensive care areas to look at pressure damage to the ears • Review of the mattress contract and piloting of a new hybrid mattress in high risk areas • Communications campaign to improve the use of the pressure ulcer prevention app • A regular newsletter

 **Responding to the deteriorating patient**	Failure to detect, respond and escalate the care of an acutely unwell patient may result in further avoidable clinical deterioration, impairment or in extreme cases, death. This safety stream's primary focus is to enable clinical staff to identify those patients at risk and prevent clinical deterioration through accurate and robust observation, using data to identify patients at risk at safety briefings and encourage effective escalation conversations between clinical staff.	• A large amount of diagnostic work was completed to identify key issues • A steering group with consistent membership from all clinical divisions has been established. • Relational communication workshops engaging frontline staff tell us what works and co-design resources that encourage good escalation conversations • Undertaking of Adult In-patient National Warning Score Audit across all inpatient beds with paediatrics and private patients on-going • Piloting data collection reporting at safety briefings in a small number of clinical areas to identify and increase awareness at local level. • Engagement with close partners to improve surveillance using national tools e.g. National Early Warning Score 2 (NEWS 2), alerts on the electronic patient record (EPR)	Actions which we are currently looking to improve: • Continue to test and spread the communication tools once developed from the relational workshops to other areas • Resolve electronic patient record documentation variation of the Trust escalation tool (SBAR), NEWS (see glossary on page xx) totals and adjusted parameter values • Develop an implementation plan for NEWS 2 • Continue to test and spread the data collection charts to improve observation compliance and awareness of deterioration risk • Develop a Deteriorating Patient guideline and appropriate monitoring strategy, which will include defining our measures • Include sepsis management with the roll out of the electronic alert and improved time to antibiotics We are working with the PSTRC who have a dedicated research theme on deteriorating patients.

	Our own audits and the Care Quality Commission have identified the need to improve our medicines management processes. There is variation in practice across wards and sites, often driven by our complex estate.	We have focused on four key topics to date (storage, security and disposal of medicines) and held five engagement events with staff (32 in total from nursing, pharmacy and estates) to understand the issues staff face in undertaking best practice, and their ideas for improvement.	Our focus is on pulling out the key messages from policies and making these messages easy to follow and available at the point of need. This will be a co-designed process with staff to ensure any products are fit for purpose Also establishing the staff roles and responsibilities to enable and empower staff to do the right thing. A communication strategy is being developed. Our measures will include monitoring our existing audits of compliance with policy and practice,
	Following a series of surgical 'never events' we aim to create a culture of safety in our theatres and areas where we carry out invasive procedures to reduce avoidable harm and improve performance and outcomes. We are doing this by seeking to improve the use of the five steps to safer surgery which has been evidenced to improve teamwork, communication and safety.	Work has focused on strengthening the framework for the practice of safe surgery in the Trust, including: • Review of policies to align them with national standards • Review of all interventional checklists • Commencing 'no brief, no start' in operating theatres across the Trust • Establishing an annual trust wide audit and divisional monthly audit programme, supported by divisional action plans to provide assurance • Strengthening education and training (including mandatory module) • Interviews with staff to understand cultural barriers in theatres Significant progress has been made with no surgical 'never events' declared since November 2016.	Work to date has focused on setting clear expectations. Key areas for improvement moving forward are reviewing our measurement strategy to focus on the quality of the checks rather than the ticking of the boxes. Observational measurement has begun, and the plan is to accompany this with peer to peer feedback and coaching in situ, focusing on good practice as well as areas for improvement. Sharing stories will form a large part of the work moving forward to share learning and improve culture. Our measures will include monitoring for an improvement in our existing audits of compliance with the checklist.

The table below sets out our performance against the targets set. We have made excellent progress against a number of these with six fully achieving our targets and one partially achieving. Of the seven where the target has not been achieved we have still made progress including a reduction in never events.

Goal/Target	National Target / National Average	Performance in 16/17	Target for 17/18	Outcome in 17/18	Target achieved?
To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing severe/major harm	0.28% (Apr 17 – Sept 17)	0.1% (7 incidents) (April-Sept 16)	Below national average	0.07% (14 incidents)	Yes
To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing extreme harm/death	0.11% (Apr 17 – Sept 17)	0.0% (2 incidents) (April-Sept 16)	Below national average	0.08% (13 incidents)	Yes
We will maintain our incident reporting numbers and be within the top quartile of trusts	41.68 (Apr 17 – Sept 17)	42.3 (April-Sept 2016 as published by NRLS) 44.85 (full year)	Over 46.76	48.97 (Apr 17 – Sept 17)	Yes
We will have zero never events	0 never events	4 never events	0 never events	1 never event	No
We will promote safer surgery by ensuring 100 per cent compliance with all elements of the WHO checklist in all relevant areas	N/A	Element 1: 100% Element 2: 100% Element 3: 100% Element 4: 100% Element 5: 92%	100% compliance	Briefing: 100% Sign in: 97% Time out: 98% Sign out: 96% Debrief: 100%	No
We will have no serious incidents where failure to follow the WHO checklist properly is a factor	N/A	2	0	1	No
We will have a general vacancy rate of 10 per cent or less	N/A	11.6%	10% or less	12.1%	No
We will have a vacancy rate for all nursing and midwifery staff of 12 per cent or less	N/A	19%	10% or less	14.7%	No
We will maintain the percentage of shifts meeting planned safe staffing levels at 90 per cent for registered nurses and 85 per cent for care staff	90% for registered nurses 85% for care staff	97% for registered nurses 95% for care staff	90% for registered nurses 85% for care staff	97% for registered nurses/midwives 95% for care staff:	Yes
We will ensure we have no avoidable MRSA BSIs and cases of *C. difficile* attributed to lapse in care	N/A	12 (3 MRSA BSIs, 9 *C. difficile* lapses in care)	0 avoidable infections	10 (3 MRSA BSI, 7 *C.difficile* lapses in care)	No

We will maintain 90 per cent for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams	N/A	89%	At least 90%	91.5%	Yes
We will reduce avoidable category 3 and 4 Trust-acquired pressure ulcers by at least 10 per cent	N/A	27	Less than 24 (at least 10% reduction)	17	Yes
We will assess at least 95 per cent of all patients for risk of venous thromboembolism (VTE), complete root cause analysis (RCAs) for all potentially avoidable Trust acquired cases within the agreed timeframe and prevent avoidable death as a consequence	over 95% 0 avoidable deaths	95.33% 0 avoidable deaths	over 95% 0 avoidable deaths	Q1: 92.71% Q2: 91.63% Q3: 95.53% Q4: 95.64% 93.87% (full year data) 0 avoidable deaths	No Yes
We will ensure that we comply with duty of candour and being open requirements for every incident graded moderate and above	N/A	New target not previously measured	SIs: 100% Other incidents: 50% by end of Q2	SIs: 98% Level 1: 89% Moderate: 79% (Apr 17-Feb18)	No

Safe quality highlights & challenges

Our incident reporting rate has continued to increase and the number of incidents that cause severe or extreme harm to patients continues to be less that the national average: A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. Incidents are categorised by degree of harm, from near miss to extreme harm.

We investigate all patient safety incidents which are reported on our incident reporting system, Datix. In addition, those graded moderate and above are reviewed at a weekly panel chaired by the medical director. Incidents that are deemed to be Serious (SIs) or never events undergo an investigation which involves root cause analysis (see glossary on page xx for definitions).

According to the latest data published by the National Reporting and Learning Service (NRLS) the number of incidents we have reported which cause the most harm to patients is below average when compared to our peers, and we are in the top quartile of reporters nationally.

Our HSMR and SHMI results triangulate well with our harm profile from incident reporting as both show a positive picture of outcomes for patients in our care. More information on our HSMR and SHMI results are included on page xx.

An important measure of an organisation's safety culture is its willingness to report incidents affecting patient safety to learn from them and deliver improved care. A high reporting rate reflects a positive reporting culture. Our work in 2018/19 will focus on areas who have the lowest reporting rates and where recurrent issues exist.

To reduce the administrative burden on frontline managers in managing incidents we are trialling a new administrative support function. The pilot will be evaluated in Q1 2018/19 and rolled out if successful. This will support clinical staff to focus on trends, themes and areas for improvement.

We reduced our never events: Although we did not meet our target, we reported one never event this year, compared to four in 2016/17. Never events are defined as serious, largely

preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The incident reported this year was a 'wrong route medication' incident where an epidural line was connected to a peripheral cannula. There was no clinical harm caused to the patient. Mitigation actions are in place and are being monitored through audit. A national patient safety alert has since been released outlining the actions trusts should take to introduce connections that prevent incidents like this one. However these products are still not yet fully available. A task and finish group has been established to review the available devices and manage the roll out across the Trust.

We reported no peri-operative never events and one SI related to WHO checklist failure: In 2016/17 the Trust reported four never events related to practice in surgery, and two serious incidents due to a failure to follow the WHO safer surgery checklist (see glossary on page xx for definition). Focussed improvement work commenced in 2016 under the safer surgery stream.

We maintained safe staffing levels: Although our vacancy rates remain higher than our targets, we have ensured staffing meets planned safe levels this year. Where shifts were not filled, staffing arrangements were optimised and any risk to safe care minimised by the senior nurses taking the following actions:

- Using the workforce flexibly across floors and clinical areas;
- The nurse or midwife in charge of the area working clinically and taking a case load;
- Specialist staff working clinically during the shift to support their ward based colleagues.

Our divisional nurse directors regularly review staffing at ward level alongside local quality metrics to ensure there are no quality or safety concerns regarding safe staffing levels.

We have achieved a thirty-seven per cent reduction in the number of category 3 and 4 pressure ulcers: A pressure ulcer is a type of injury that affects areas of the skin and underlying tissue when the area is placed under too much pressure. Pressure ulcers are graded from one to four to indicate their severity, with one indicating less damage and four indicating serious damage. All avoidable pressure ulcers are subject to an incident investigation and an action plan put in place.

We met our VTE assessment target in quarter 3 and quarter 4: Venous thromboembolism (VTE) is a blood clot within a blood vessel that blocks a vein, obstructing or stopping the flow of blood. The risk of hospital acquired VTE can be reduced by assessing patients on admission. The Trust moved to assessment for VTE at drug prescription on admission rather than at discharge at the end of March 2017 in response to limited assurance on accuracy of data from auditing. There was an initial drop in performance across the Trust which we had anticipated and a Trust-wide action plan that included sharing performance data locally was implemented. As a result we met our 95 per cent target in quarter 3 and quarter 4.

We reported 10 avoidable infections: In 2015 we began to report 'avoidable' infections of MRSA blood stream infections (BSI) and *Clostridium difficile* infections. For how we define 'avoidable infections' please see the glossary on page xx. Although we did not meet our target, we saw a decrease in avoidable infections in 2017/18, reporting 10 compared to 12 last year.
We reported the same total number of cases for both infections as we did last year.

In March 2018, the Trust also received a letter from NHS Improvement commending our contribution to reducing *Escherichia coli* bloodstream infections. The Trust was one of 59 who achieved a 10 per cent or greater reduction in hospital-onset infection.

We have not fully met our targets for compliance with duty of candour:. Although we have not met our target there has been a marked improvement in our duty of candour compliance for all incident levels.

[Insert infographic] Supporting Programme: QIA CIP

A cost improvement programme (CIP) is the identification of schemes to increase efficiency or reduce expenditure. The most successful CIPs are often those based on long-term plans to transform clinical and non-clinical services that not only result in a permanent cost saving, but also improve patient care, satisfaction and safety.

Our medical director and director of nursing review all proposed CIPs for their impact on quality of care using a quality impact assessment process that has been approved by our Trust Board. The process considers risks of implementing the CIP by considering any impact against the five CQC domains of safety, effectiveness, caring, responsive and well-led. This process ensures that any risks are identified and plans are in place to mitigate these. It also ensures that any efficiencies we implement will have either a positive or neutral effect on the quality of care we provide to our patients.

Effective

We want to ensure the outcomes for our patients are as good as they can be using best available evidence to continuously improve care and treatment. We are pleased that CQC increased our overall rating in this domain to 'good' following their inspections in 2017 which reflects the progress we have made over the last few years.

In this section we describe our progress with the targets under the effective domain during 2017/18 as well as with our key priority improvement work streams.

Mortality review programme
In March 2017 the National Quality Board published a framework for NHS trusts on identifying, reporting, investigating and learning from deaths in care. This included the need to use structured judgment review (SJR) in selected cases and mandated new reporting requirements from quarter 3 2017/18. Although the Trust had an established mortality review process and associated policy, we have now transitioned to this new process and the framework has been fully implemented. We published our new learning from deaths policy in September 2017, engaged a number of our staff in structured judgment review training and are now submitting quarterly data externally through the learning from deaths dashboard (see appendix C).

Cases are reviewed monthly by our Mortality Review Group, focussing on any avoidable factors and learning themes. Early emerging themes map to our 'falls' and the 'responding to the deteriorating patient' safety streams. As more cases are reviewed the group will recommend work streams to be considered as part of the Trust improvement programme.
In 2018/19 we will:

- Continue to train, coach and support our cadre of reviewers;
- Streamline the process between SJR and serious incident investigations;
- Implement the national recommendations on how best to engage families in SJR and how to comply with duty of candour;
- Improve learning and sharing of improvements from the reviews.

Clinical audit programme
Audits and service evaluations are important assurance and governance tools, producing data which can be used for improvement. Our Clinical Audit and Effectiveness Group oversee the Trusts participation in national clinical audits and the action plans for improvement as a result. In addition they also coordinate a trust wide audit plan to provide assurance that we are providing healthcare in line with appropriate standards, and to allow identification of areas where improvements can be made.

The Trust priority audit programme continues to evolve with examples of trust wide improvement being taken forward as a result which are included in section xx. In 2018/19 it will be expanded to include an assessment of performance against the updated never event list. We will also continue to make links between this programme and the safety improvement streams ensuring that audit is driving improvement.

Clinical guidelines programme
Our aim is to ensure that we have no out of date clinical guideline documents (recommendations on how healthcare professionals should care for people with specific conditions) at any time. Processes are in place in divisions to manage this however we are currently reviewing our approach with a plan to re-launch in the first quarter of 2018/19.

Quality surveillance programme
In July 2015 it was announced that the National Peer Review Programme Team would become the Quality Surveillance Team (QST). The role of the QST is to improve the quality and outcomes of clinical services by delivering a sustainable and embedded quality assurance

framework for all NHS England (NHSE) specialised commissioned services and all cancer services irrespective of how they are commissioned. This is done through a programme of provider self-assessment and targeted peer review.

The annual self-assessment process was completed at the end of June by our clinical teams. All 66 services required to self-report did so. Action plans for services which were non-compliant with the quality indicators were developed.

Local and NICE Guidance
Although we have made improvements in processes in these areas it remains challenging to review and ensure compliance with the volume of guidance across the Trust. In 2018/19 we will therefore:

- Complete a review of all Trust clinical guidelines, linking them to national guidance where it exists and reducing the number of truly local documents;
- Review progress with audit of guidance with divisions;
- Review the policies including a scan of other hospitals and relaunch our approach;

Getting It Right First Time (GIRFT)
Getting It Right First Time (see glossary on page xx for definition) is a national programme designed to improve clinical care within the NHS by reducing unwarranted variations in quality, outcomes and costs. GIRFT reviews are being conducted nationally across 30 clinical specialties. GIRFT is led by frontline clinicians who are expert in the areas they are reviewing. This means the data that underpins the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services on a daily basis. The GIRFT team visit every trust carrying out the specialties they are reviewing, investigating the data with their peers and discussing the individual challenges they face.

The Trust has started to use the outcomes from the GIRFT reviews through the specialty review process. However processes for sharing and learning need to be further developed. Contact has been made through the medical director's office with the regional GIRFT director and supportive work is planned for 2018/19 where we will:

- Centralise the process for oversight of the outcomes from GIRFT;
- Work collaboratively with the GIRFT team to learn from other test bed organisations;
- Involve directorate teams who have been involved in reviews to test and implement a new approach to using the GIRFT resources;
- Define how GIRFT data will systematically inform the trust wide approach to reducing unwarranted variation and conduct thematic analysis to identify priorities for improvement interventions.

Seven Day Services
The seven day services programme is designed to ensure patients that are admitted as an emergency receive high quality consistent care, whatever day they enter hospital. Significant progress has been made to deliver against the four core national standards. The Trust participated in a national audit in Autumn 2017 which demonstrated that whilst weekend performance has improved overall, there remains a difference between Saturday and Sunday performance. We will continue our work to reduce this variation next year.

West London Genomic Medicine Centre
The Trust is the lead for the West London Genomic Medicine Centre (GMC), one of 13 NHS centres delivering the 100,000 Genomes Project. The GMC has four partners: The Royal Marsden NHS Foundation Trust, Royal Brompton & Harefield NHS Foundation Trust, Chelsea & Westminster Hospital NHS Foundation Trust and West London Mental Health NHS Trust.

The project was established to sequence all the genes of patients and their families with rare diseases as well as patients with certain common cancers, with a view to sequencing 100,000

genomes by 2017. These areas were selected due to their strong link to changes in the genome with the aim to transform diagnosis and treatment for patients.

In 2017, a collaboration between the GMCs in West London and North Thames was agreed in order to enhance the delivery of the 100,000 Genomes project and to inform working towards a Centralised Genomics Hub as part of the reconfiguration of genetics services in England.

In October 2018 the 100,000 Genomes Project will move into routine clinical care as part of the new Genomic Medicine Service where laboratory services for genetic testing will be centralised and all DNA based testing will be centrally commissioned by NHS England.
Below are some examples of where exemplar pathways for genetic testing have been happening at Imperial College Healthcare Trust.

Rare Diseases

- Genetic testing for hereditary haemorrhagic telangiectasia at Hammersmith Hospital;
- Genetic testing for different types of diabetes at St Marys Hospital;
- Genetic testing for retinal disorders at Western Eye Hospital.

Cancers

- Commenced routine genetic testing for some patients in the Haematology Department at Hammersmith Hospital;
- Genetic testing for prostate patients at Charing Cross Hospital;
- Genetic testing for Upper GI, Colorectal, Thyroid and Oesophagus at St Mary's Hospital;
- Sequenced results for cancer are discussed at a weekly tumour sequencing board.

The table below sets out our performance in 2017/18. Where applicable, it presents national targets and averages and information relating to our performance against these indicators in 2016/17. Site level data is described where available and appropriate.

Goal/Target	National Target / National Average	Performance in 16/17	Target for 17/18	Outcome in 17/18	Target achieved ?
To show continuous improvement in national clinical audits with no negative outcomes	N/A	We have not been able to fully report against this goal	All show continuous improvement No negative outcomes	Not measurable. The target has been revised for 2018/19	N/A
We will improve our mortality rates as measured by SHMI (summary hospital-level mortality indicator) to remain in the top five lowest-risk acute trusts	100	75.54 2nd lowest risk	Top 5	74.29 (Q2 16/17 – Q1 17/18) 2nd lowest risk	Yes
We will improve our mortality rates as measured by HSMR (hospital standardised mortality ratio) to remain in the top five lowest-risk acute trusts	100	64.17	Top 5	67.37 (Jan – Dec 17) 2nd lowest risk	Yes
We will ensure that palliative care is accurately coded	N/A	100% (for all reviewed deaths)	100%	100% (for all reviewed deaths)	Yes
We will ensure mortality reviews are carried out in all cases and report specified information on deaths in line with national requirements, including those that are assessed as more likely than not to be due to problems in care, and ensure learning	N/A	91% (Feb 2016 – March 2017)	100%	91%	No

and action as a consequence.					
We will increase PROMs participation rates to 80 per cent	Groin hernia: 0% Hip replacement: 42.8% Knee replacement: 21% Varicose vein: 29% (April 2017 – Sept 2017)	Groin hernia: 4.5% Hip replacement: 90.8% Knee replacement: 113.5%* Varicose vein: 71.9%	80%	Groin hernia: 7.3% Hip replacement: 67% Knee replacement: 70% Varicose vein: 80.6% (April 2017 – Sept 2017)	Yes – varicose vein No – groin hernia, hip replacement & knee replacement
We will improve PROMs reported health gain to be better than national average	See table on page xx for full results	Health gain was unable to be calculated for groin hernia, and hip replacement due to insufficient Part forms returned. **Knee replacement:** EQ-5D: 0.298 EQ VAS: 4.572 Oxford Knee score:16.742 **Varicose Veins:** EQ-5D: 0.080 EQ-VAS: -1.177 Aberdeen: -1.282	Over national average	See table on page xx for full results	No - Health gain below average for varicose veins Health gain unable to be calculated for groin hernia, knee and hip replacement
We will review all out-of-ICU/ED and coronary care unit cardiac arrests for harm and deliver improvements as a result	N/A	Cases reviewed from December 2016	All cases reviewed	100%	Yes
We will ensure that 90 per cent of clinical trials recruit their first patient within 70 days	54% (Q1 – Q3 2017/18)	85.4%	More than 90%	55.5% (Q1 – Q3 2017/18)	No

**Data from completed part A (pre-surgery) forms can sometimes arrive with NHS Digital after the closure of the annual reporting year; also non-NHS patients who may not appear on the Trust's information system may complete PROMS forms and these factors can result participation rates in excess of 100%*

Effective quality highlights & challenges

Our mortality rates remain consistently low and we have a system in place to review all deaths that occur in the Trust: As part of our drive to deliver good outcomes for our patients we closely monitor our mortality rates, using two indicators, HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator), which enable us to compare our mortality rates with our peers. Both of these have remained low, with our Trust being amongst the top five lowest risk acute Trusts in the country throughout the year. This year we have also moved up to have the second lowest SHMI of all non-specialist providers in England. As part of this, we also monitor the percentage of deaths with palliative care coded as this may affect the data (for definitions see glossary on page xx). Although our palliative care coding rates are high, we are confident that they are accurate with a clinical coding review process in place.

The Trust participated in 40 out of 41 relevant national clinical audits, and action plans have been implemented where required: We review all national clinical audit reports in which we participate through our divisional governance structures and through the Clinical Audit and Effectiveness Group. The new CQC insights report displays national audit outcomes in a useful format which we are looking to incorporate into the Trust reports going forward.

In 2018/19 we will ensure our processes are expedited to evidence actions to variance in results, use the CQC insights report to target areas for improvement and continue to learn from the audit results, sharing outcomes and stories of where we have done well and where we have not.

For the full list of audits we participate in, and the actions we are taking in response to the reports we have received so far this year, please see appendix A.

We are reviewing all cardiac arrests which occurred outside the intensive care unit (ICU), emergency department (ED) or coronary care unit for harm: When cardiac arrests occur outside these departments it can be because patients are not being monitored properly, or their deterioration has not been recognised. The Trust now has an increasingly robust process in place to review each of these cardiac arrests for care or service delivery issues. Two cases have been found to have resulted in harm this year, compared to one last year.

Patient Reported Outcome Measures (PROMs): PROMs measure quality from the patient perspective and seek to calculate the health gain experienced following four surgical procedures: surgery for groin hernia, varicose veins, hip replacement and knee replacement. Patients who have these procedures are asked to complete the same short questionnaire both before and after surgery. The Trust is responsible for ensuring completion of the first questionnaire (part A) pre-surgery. The number of pre-surgery forms sent to NHS Digital are compared to the number of surgical procedures performed at the Trust and it is this which provides the Trust's participation rate.

An external agency, Capita, is responsible for sending patients the second questionnaire (part B) post-surgery. Analysis of any differences between the first and second questionnaires are used to calculate the overall health gain. If insufficient Part B questionnaires are returned to Capita, and in turn to NHS Digital who publish the results, they will not publish an organisation's health gain score.

At Imperial our health gain data could not be measured for groin hernia, hip and knee replacement procedures due to insufficient numbers of forms being returned. The Trust has recognised that there are issues with data collection from Capita and are pursuing alternative providers for PROMS data.

As of 1st October 2017 NHSE discontinued mandatory varicose veins surgery and groin hernia surgery PROMs collection.

We did not meet our target to ensure that 90 per cent of clinical trials recruit their first patient within 70 days this year however we are above national average: We are committed to encouraging innovation in everything that we do. Part of this involves carrying out pioneering research into diagnostic methods and treatments across a broad spectrum of specialities and for some of the most complex illnesses, with benefits for patients everywhere.

Since 2012, the National Institute of Health Research (NIHR) has published outcomes against public benchmarks, including a target of 70 days from the time a provider receives a valid research application to the time they recruit the first patient for that study. This metric provides assurance that we are giving patients the opportunity to participate in research in a timely way.

We did not achieve our target of 90 per cent of clinical trials recruiting their first patient within 70 days of a valid research application however we are improving due to focused work and action, and are also now above the national average. Performance has declined nationally following process/data changes introduced by the Department of Health in 2016/17. A new consultation by NHS England is currently proposing to establish a single set of national metrics which are more robust and which are resistant to different interpretations by trusts. The Trust joint research office team continue to develop proportionate contractual and financial review procedures whilst at the same time protecting the Trust and its patients from unnecessary risk or liability.

Caring

We want to ensure that our staff involve and treat people with compassion, kindness, dignity and respect as we know this has a positive effect on recovery and clinical outcomes. To improve their experience in our hospitals, we ensure that we listen to our patients, their families and carers, and respond to their feedback.

In this section we describe our progress with the targets under the caring domain during 2017/18 as well as with our key priority improvement work streams.

Accessible information standard

We have continued to implement the accessible information standard (see glossary on page xx for definition) by providing information in a range of formats and languages, undertaking promotional work to raise awareness about the need to ask patients if they have any specific communication needs and adding hearing loops in rooms where public meetings are held. We have also introduced an assessment process through our electronic patient record which enables automatic flagging of specific communication requirements patients may have.

Schwartz rounds

These meetings provide an opportunity for staff from all disciplines to reflect on the emotional aspects of their work. Their purpose is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care. The underlying premise is that the compassion shown by staff can make all the difference to a patient's experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work. Research shows the positive impact that they have on individuals, teams, patient outcomes and organisational culture. We have continued to run Schwartz rounds throughout 2017/18 with positive feedback from those who attended.

Wayfinding strategy

In response to patients reporting issues with finding their way around our sites and services we have implemented a wayfinding project to make navigation easier for both our patients and staff. This has included improvements to signage and physical and digital wayfinding systems.

Experience labs

This one year learning and development programme has focussed on using patient experience data to inform changes and improvements in nine of our outpatient departments. Focused on improving patient and staff experience the programme brought multidisciplinary teams together and equipped them with a mix of customer service skills alongside quality improvement (QI) methodology. Teams used patient feedback to drive and generate measurable improvement and within short weekly 'huddles' agreed changes to test every week. Five full day collaborative workshops and 'observe and learn' sessions brought the teams back together to share their work and learn from one another. The teams involved achieved success shown through the sustained and consistent 10 per cent increase in their local survey patient experience scores.

Other successes include improved communication around waiting times; teams planned, tested and implemented different ways to keep patients updated; from verbal, to regular white board notifications and electronic messages on screens. Teams also worked to improve how they use patients time while they're waiting, resulting in improved patient information, patient journey visuals to explain the pathway, agenda-setting sheets to help patients plan what they would like to ask in their appointment and other distractions including music, magazines, volunteers and refreshments.

Improving how we use patient experience data

We routinely collect a large amount of patient feedback data. This year we have focused on improving our understanding of what this is telling us and how we can better use it to improve. We now provide patient feedback reports to every ward and department, as well as reviewing data alongside key safety metrics at a local level to identify quality improvement projects.

A new project funded by the Health Foundation was launched in September 2017. This is a joint collaboration with the PSTRC, to apply novel analytics to free text in the FFT feedback to transform how quickly we can learn from patient feedback and use it to make improvements.

The table below sets out our performance in 2017/18 as a trust. Where applicable, it presents national targets and averages and information about our performance in 2016/17.

Goal/Target	National Target / National Average	Performance in 16/17	Target for 17/18	Outcome in 17/18	Target achieved?
To maintain the percentage of inpatients who would recommend our trust to friends and family to 94 per cent	95.86% (April 17 – Feb 18)	97%	94%	97%	Yes
To maintain the percentage of A&E patients who would recommend our trust to friends and family to 94 per cent	86.43% (April 17 – Feb 18)	95%	94%	94%	Yes
To increase the percentage of Outpatients who would recommend our trust to friends and family to 94 per cent	93.8% (April 17 – Feb 18)	91%	94%	91%	No
We will achieve and maintain a FFT response rate of 30 per cent in inpatient departments	25.14% (April 17 – Feb 18)	30%	30%	33%	Yes
We will achieve and maintain a FFT response rate of 20 per cent in A&E	12.69% (April 17 – Feb 18)	15%	20%	14%	No
We will achieve and maintain a FFT response rate of 6 per cent in Outpatients	Not reported	9.5%	6%	11%	Yes
We will improve our national cancer survey scores year-on-year	N/A	8.6/10) (annual result from 2015 survey)	Above 8.6	8.5/10 (annual result from 2016 survey)	No
We will improve our score in the national inpatient survey relating to responsiveness to patients' needs	N/A	6.74 (annual result from 2015 survey)	Above 6.74	6.72 (annual result from 2016 survey)	No
We will maintain our responsiveness to complaints – 95 per cent of complaints responded to within the timeframe agreed with the patient	N/A	100%	95%	99.5%	Yes

Caring quality highlights & challenges

We have exceeded our target for the percentage of our inpatients who would recommend us to friends and family: The Friends and Family Test (FFT) is a key indicator of patient satisfaction. We collect feedback through a range of different methods including text messaging; paper surveys; Trust website and our real time patient experience trackers. The FFT asks patients whether they would be happy to recommend our Trust to friends and family if they needed similar treatment. This system also means we can accurately track key protected characteristics (gender, age, ethnic group and disability) of those who respond, enabling us to compare experiences across these characteristics. We have continued to work to implement improvements based on any concerns that impact on one group more than another.

For patients reporting a positive experience, interaction with staff continues to be the most significant factor. We are continuing to build upon this relationship by actively encouraging staff to understand and act upon patient feedback.

In addition to ensuring that we are compliant with the accessible information standard and improving how we use patient data experience, we have:

- Introduced a 'super user' award for our staff, to recognise those who access the patient feedback system the most. This system enables staff to see what our patients are saying at ward or department level. We have seen excellent examples of staff using this information to drive patient experience.
- Commenced our new patient support volunteer programme (kindly sponsored by Imperial Charity) with the initial pilot phase being conducted at St Mary's Hospital. The intention is for these to be implemented across all sites by summer 2019. The volunteers offer a befriending service and are able to identify, resolve or refer any Patient Advice and Liaison Service (PALS) issues as they occur. During 2018/19, the volunteers will be supporting us to understand more about what matters to our patients and we will be conducting focussed conversations during this time, looking at areas such as 'noise at night' and quality of food where have seen an increase in negative feedback.
- Continued to build upon our work for patients with learning disabilities. The Trust has been involved in a Health Education England initiative to train staff across West London in how to care for people with learning disabilities, autism and challenging behaviour. More than 400 staff members have completed the training.
- Worked with NHS Improvement on the new national learning disability improvement standards for NHS trusts. As part of this we were a pilot site for the national quality checking pilot undertaken by Changing our Lives. The audit highlighted the positive impact of the 'purple pathway' (our learning disability pathway as part of our Learning Disability and Autism policy).
- Developed bespoke communication resource folders that are now in use in all areas. To support our staff to communicate with people who have communication problems.
- Continued work to improve care for our patients with dementia. We were the first London trust to sign up for John's Campaign (a national campaign to give carers of patients right to stay with their loved ones). The Trust is now a John's Campaign ambassador.

In 2017, the carer's passport was re-launched with the support of Imperial Charity. Each ward and department has the new Carer's Charter displayed as well as the new carers' passport and information book available. In addition to this, we have purchased a number of carers' beds that are located on each site. The beds have enabled carers to stay by the bedside, providing invaluable support to vulnerable people.

When patients report a negative experience, the cause is usually due to ineffective systems and processes. We continue to take steps to improve and ensure that waiting and delays are kept to a minimum and, where they are unavoidable, patients are kept informed and the environment and staff are as welcoming and supportive as possible.

Patient transport continues to be a key issue for those who are not able to travel to appointments independently. Our FFT results for patient transport continue to be below target. Contract performance has seen an improvement in general this year, but does drop with increased Trust activity because of limited resource availability across the sector. Our current non-emergency patient transport contract will come to an end in November 2018 and is currently being re-tendered in conjunction with the CCG and with the help of patient representatives and service users, to deliver quality improvements for our patients.

We met our target for the percentage of our A&E patients who would recommend us and were significantly above national average: Despite not achieving the waiting time standard for A&E we are pleased that 94 per cent of our patients would still recommend our A&E services.

We have maintained, but not improved, the percentage of outpatients who would recommend our Trust since last year: Although we are disappointed that our outpatient FFT rate has not improved, we are confident that the changes we are making as part of our outpatient improvement programme (see page xx for more details) will significantly improve outpatient experience in the long run.

We did not improve on our national cancer patient experience survey results: Unfortunately we did not improve on our survey results from last year (8.5/10 compared to 8.6/10 last year). Although our overall score dropped only slightly, the number of questions which scored in the lowest range increased from 12 last year to 23 this year. We also scored above or within the expected range for 29 out of 50 questions, compared to 38 last year. The questions where the Trust scored above the expected ranges related to whether taking part in cancer research was discussed with the patient, and if the patient was given the name of the CNS who would support them through their treatment.

Since the survey was published in 2017, we have been focussing on:

- The on-going work around the role of the CNS and strengthening links with primary care
- The clinical haematology teams participation in the experience lab project, focusing on making real improvements to patient experience in this area. As this programme started in April 2017, the impact of this work should be evident in 2018 (see page xx for more information on the experience lab project).

One of the main challenges is how we monitor progress throughout the year as the national cancer patient experience survey (NPES) is an annual survey and the report is not published until over 12 months after the survey has been undertaken. The Royal Marsden (RM) Partners have commissioned a Vanguard Patient Feedback System into which the Trust will report. The system is based on key questions taken from the NPES and will enable the Trust to track patient feedback each month. It is hoped that this will inform our on-going improvement work, supporting staff to measure the impact of change in an increasingly timely manner.

We have exceeded our target to respond to 95 per cent of complaints within the timeframe agreed with the patient: The process for complaints handling is fully embedded and effective. With a strong commitment to resolving concerns as promptly and effectively as possible and with better access to complaints investigators, we have also seen a reduction in the numbers of complainants taking their complaint onto the Parliamentary & Health Service Ombudsman (PHSO). Overall, the volume of formal complaints continues to fall year-on-year which suggests that people's concerns are being dealt with nearer the point at which they occur. Clinical care and issues with appointments continue to be the most frequent categories of complaints received. In the latest inspection reports for the Trust, the CQC concluded that overall the management of complaints was "good".

The complaints team have strengthened links with the clinical divisions and attend quality and safety meetings to share complaints outcomes and themes. They have also been able to

improve the volume and quality of reporting to divisions and directorates so that they are better equipped to introduce changes where necessary. How we learn from complaints and change practice was a key focus in 2017/18 and the Complaints and Service Improvement Manager ran a project to improve the quality of discharge for patients who may not have suitable clothes to go home in. This involved reviewing the discharge process and policy and setting up a clothing bank on each of our three main sites. The need for this work would not have been identified without the ability to systematically review and monitoring of the complaints received.

In 2018/19 the complaints team will continue to provide a responsive service for complainants and to identify further areas for improvement. We will introduce an online version of the complaints survey so that we can monitor the level of satisfaction with the services provided

Responsive

Having responsive services that are organised to meet people's needs is a key factor in improving experience and preventing delays to treatment, which can cause harm to our patients. Our goal is to consistently meet the national targets.

In this section we describe our progress with the targets under the responsive domain during 2017/18 as well as with our key priority improvement work streams.

Specialty review programme

The Trust specialty review programme (SRP) is our clinically led process to develop a five-year clinical strategy, which is built upwards from specialty level strategic plans. Each specialty participates in three workshops, to support them to develop their clinical strategies, workforce transformation plans and specialty level roadmaps to improve financial, operational and clinical sustainability. The programme launched in April 2017 and will complete in July 2018.

Following the completion of the three workshops the outputs from each are consolidated into a draft specialty specific strategy which then follows an agreed approvals process. A series of 'wash-up' sessions are in progress to further develop the specialty plans where there are inter-dependencies between specialties and also physical co-adjacencies across our sites. As a result the specialty specific plans will need to be iterated to ensure that they are aligned with the refreshed clinical strategy. This will form part of the continuing programme of specialty review into 2018/19 as part of the wider sustainability and transformation programme.

Next year we will also ensure opportunities for improvement are mapped and support is prioritised for those areas where capacity/capability is required. We will also continue to iterate the approach to support directorates to make improvements to meet the Trusts objectives and vision as well as further developing our approach measurement of the impact and outcomes.

Outpatient improvement programme

Around a million people come to the Trust's hospitals as outpatients every year and we have been running a major programme to improve the quality of their experience. Some of the highlights of this work are described in more detail below. Improvements have been more challenging in other areas including appointments being rescheduled at short notice and long waits in clinics. Both areas have been the subject of detailed analysis and addressing the root causes of these challenges will be a key focus for the programme in the 2018/19.

<u>Patient Environment</u>

Imperial Health Charity supported this programme with £3 million of investment which was used to redesign and refurbish our clinics at Charing Cross and Hammersmith hospitals. This work is close to completion. Waiting areas are now more open and comfortable with new zones and updated signage which will make it easier for patients to navigate the departments and check in at the right place for their appointments.

<u>Using technology to improve our services</u>

The way we communicate with our patients has improved to keep pace with mobile lifestyles. This includes options for email notification of appointments as well as voicemail and text reminders. This work will continue into 2018/19 using learning from other trusts.

Other improvements include the development of an electronic vetting system to enable clinicians to view referrals easily and quickly in order to decide the best course of action for a patient. One third of our clinical interactions are now paper free and this will be rolled out across the remaining clinics in 2018/19.

Redevelopment of Patient Services Centre (PSC)

The PSC was created in 2016/17 with funding from Imperial Health Charity (£3.5m). This allowed us to commence centralisation of the administration of appointments and admissions and this work has progressed throughout 2017/18. A number of services were integrated this year. Approximately two thirds of first outpatient appointments and one third of admissions and day case activity are currently managed via the PSC.

In 2017/18 we began preparations for the NHS e-Referral 'Paper Switch Off' project. This is a national requirement that all GP referrals should be made electronically by October 2018. Mapping our directory of services is key to delivery of this project and 5 per cent of services have been completed to date. Good progress has been made on a further 73 per cent of services. The Trust will focus on completing this mapping, ensuring the required IT interfaces are in place and that training is completed ahead of the go-live date.

Thinking differently about outpatients - models of care

To help improve services offered by ICHT's outpatient teams four workshops were held in March 2018. These workshops included learning from vanguard trusts as well as learning from initiatives already happening across services at the Trust. Key stakeholders from across the North West London healthcare landscape played a crucial role in shaping the recommendations which will be taken forward in 2018/19.

In parallel we have been working collaboratively with our STP partners on the NWL outpatient transformation programme to review and transform pathways in several specialities including Dermatology, Trauma and Orthopaedics, Cardiology, Gynaecology, and Gastroenterology. Good progress has been made including development of NWL referral guidelines to support consistent high standards of care as well as an interactive visualisation tool to help identify referral variation in primary care.

Flow Coaching Academy (Imperial)

One of our key approaches to reducing unwarranted variation within a clinical pathway is the use of 'flow coaching'. This year we have participated in an innovative coaching programme, run by Sheffield Teaching Hospitals Foundation Trust and The Health Foundation which aims to improve how patients flow through a specific care pathway with positive impacts on patient experience, safety and efficiency. Three prototype "big rooms", each supported by a pair of trained improvement coaches, have been running for the Sepsis, Diabetic Foot and Children's Asthma and Wheeze clinical pathways.

At the heart of the approach is a one-year programme with two components:

- Coaching pairs – leading on the improvement of a defined clinical pathway. Made up of a clinician working within the pathway plus another individual from outside of the pathway. The pairs have 18 days of face-to-face training across 11 sessions.
- Big rooms – a weekly, face-to-face session bringing together a range of staff and patients involved in the pathway to discuss, plan and review improvements. The pairs put their learning into practice by coaching the big room, focusing on making it as easy as possible for patients to 'flow' through the pathway and reducing unwarranted variation.

Learning from the work this year has demonstrated the value of using the big room as a means of bringing the multidisciplinary team together to design, test and implement improvements. Across all three big rooms benefits were seen across the key themes of improvement culture, improvement skills & capability and demonstrable improvements in patient care. The table below describes some of the specific improvements realised:

Sepsis	Diabetic Foot	Asthma and Wheeze in Children
• Improvement in the identification and management of sepsis. • Progress towards using real-time data • Staff reporting improved engagement with their job. • Junior staff empowered to lead improvement and change and increased motivation in their roles • New multidisciplinary work.	• Decrease in length of stay for MDT foot patients. • Increase awareness of diabetes foot checks and subsequent increase in referrals to podiatry team. • Development of key Cerner EPR products to reduce variation and improve data quality. • Improvements in the way data is used.	• New collaboration across ED, paediatrics & specialist allergy resulting in improved engagement. • Establishment of a base from which all children with asthma/wheeze will have an asthma management plan, check of inhaler technique & education. • Design & build of coding folders, work lists (to form a patient registry) & asthma M-page all on Cerner.

Following the success of the pilot, the Trust is one of the first three partners selected from across the UK to be a 'flow coaching academy'. Flow Coaching Academy (Imperial) launched in March 2018 with 9 pathways.

Waiting list improvement programme

We have continued the work of our waiting list improvement programme to ensure that delays in treatment are minimised and we are now transitioning from a period of data clean-up to business as usual.

The work will continue in 2018/19 to ensure that we continue to improve the service we provide to our patients. We will focus on:

- Acting on the recommendation from an external review completed in 2017/18;
- Training, supporting and coaching our staff to enter data correctly into our Cerner system to reduce data quality issues;
- Continuing the roll out of our electronic validation system to increase efficiency in our process and better support for our administrative teams;
- Reducing the number of patients who wait over 52 weeks for treatment;
- Continuing to ensure our patients do not come to harm when they do wait for treatment.

In September 2017 the Trust conducted a review of endoscopy waiting list management and reporting to identify root causes of on-going under performance against the six week maximum waiting standard for diagnostic tests. A number of recommendations were taken forward in response to the review overseen by an executive led endoscopy steering group. Actions included a number of changes to the system and processes as well as additional training for endoscopy scheduling staff, Improvements have been seen in diagnostic waiting times performance, from 4.32 per cent in October 2017 to meeting the target by the end of this year.

As part of the Trust's waiting list improvement programme, a number of clinical review processes have also been established. The purpose of these are to monitor the impact waiting for treatment is having on our patients and to ensure that avoidable harm has not/is not occurring as a result of delays in treatment on the RTT pathway. A senior nurse coordinates and oversees

the process to review all patients waiting over 52 weeks for treatment and ensures that if appropriate the patient's medical records are reviewed by a senior clinician. The clinical harm and individual treatment plan reviews are discussed within speciality team meetings, which allows each patient to be tracked and for service to expedite admission and investigation dates when required. If any cases of clinical harm are found resulting from an extended wait for treatment, the patient details are recorded on the Trust's incident reporting system and investigated.

The table below sets out our performance in 2017/18 as a trust. Where applicable, it presents national targets and averages, and information about our performance in 2016/17. Site level data is described where available and appropriate.

Target	National Target / National Average	Performance in 16/17	Target for 17/18	Outcome in 17/18	Target achieved ?
To consistently meet all relevant national access standards	N/A	4 out of 12 met in all 4 quarters	All targets met in all 4 quarters	4 out of 12 met in all 4 quarters	No
We will reduce the unplanned readmission rates for patients aged 0-15 and be below the national average	9.1% (Oct 16 –Sept 17)	4.95%	Below national average	4.92% (Oct 16 – Sept 17)	Yes
We will reduce the unplanned readmission rates for patients aged over 16 and be below the national average	8.2% (Oct 16 – Sept 17)	6.76%	Below national average	6.92% (Oct 16 – Sept 17)	Yes
We will have no inpatients waiting over 52 weeks for elective surgery, reduce the number of patients waiting over 40 weeks, and implement our agreed clinical validation process	N/A	52 week waits: 1,578 (16/17 total)	0	52 week waits: 1,896 (17/18 total) Clinical validation process described on page xx	No
We will reduce the proportion of outpatient clinics cancelled by the trust with less than 6 weeks' notice to 7.5 per cent or lower	N/A	8%	7.5%	8.5%	No
We will reduce the proportion of patients who do not attend outpatient appointments to 10 per cent	N/A	11.8%	10%	11.8%	No
We will ensure 95 per cent of outpatient appointments are made within 5 working days of receipt of referral	N/A	77%	95%	83.7%	No
We will improve our PLACE scores year-on-year; aiming to maintain our score above national average for cleanliness; meet the national average for food; be above the bottom 20% for condition, appearance and maintenance and for privacy and dignity; and	Cleanliness: 98.38% Food: 89.68% Privacy, Dignity & Wellbeing: 83.68% Condition, Appearance & Maintenance: 94.20% Dementia: 76.71% Disability: 82.56%	Cleanliness: 98.73% (above average) Food: 87.1% (below average) Privacy: 71.77% (bottom 20%)	Score above national average for cleanliness; meet the national average for food; be above the bottom 20% for condition,	Cleanliness: 99.53% (above average) Food: 89.41% (below average) Privacy, Dignity & Wellbeing:	No

improve our scores compare to last year for dementia and disability.		Condition:91.02 % (below average) Dementia: 62.62% (bottom 20%) Disability: 64.82% (bottom 20%)	appearance and maintenance and for privacy and dignity; and improve our scores compare to last year for dementia and disability	74.74% (below average) Condition: 95.72% (above average) Dementia: 80.61% (above average) Disability: 76.29% (below average)	
We will discharge at least 35 per cent of our patients on relevant pathways before noon	33%	17.5%	35%	11.7%*	No
We will ensure 98 per cent of admissions to an intensive care bed occur within 2 hours of the decision to admit/completion of surgery	N/A	New target not previously measured	98% within 2 hours	78.2%	No

** reporting commenced in November 2017*

The table below shows our performance against the national access standards throughout 2017/18. The Trust consistently met four out of the twelve standards however performance was challenged in the others. We know that we still have much work to do to tackle long-standing pressures around demand, capacity and patient flow (see glossary on page xx for definition) to enable us to meet these targets.

National Targets and Minimum Standards	Measure	Threshold	Q1	Q2	Q3	Q4	Target achieved in all quarters
Access to treatment	18 weeks referral to treatment - incomplete pathway	92.00%	84.48 %	83.15%	82.77 %	82.98%	No
Access to Cancer Services	2 week wait from referral to date first seen all urgent referrals	93.00%	89.47 %	93.70%	94.78 %	93.55%	No
	2 week wait from referral to date first seen breast cancer	93.00%	67.71 %	95.90%	95.09 %	93.25%	No
	31 days standard from diagnosis to first treatment	96.00%	96.97 %	98.20%	97.59 %	98.00%	Yes
	31 days standard to subsequent Cancer Treatment - Drug	98.00%	99.67 %	100.00 %	99.72 %	100.00 %	Yes
	31 days standard to subsequent Cancer Treatment - Radiotherapy	94.00%	98.70 %	98.80%	99.02 %	96.16%	Yes
	31 days standard to subsequent Cancer Treatment - Surgery	94.00%	97.09 %	97.50%	98.61 %	96.65%	Yes

	62 day wait for first treatment from urgent GP referral	85.00%	83.47 %	86.30%	87.91 %	86.80%	No
	62 day wait for first treatment from NHS Screening Services referral	90.00%	90.07 %	93.70%	94.48 %	74.20%	No
A&E Performanc e	A&E maximum waiting times 4 hours	95.00%	90.03 %	88.82%	86.13 %	83.64%	No
Cancelled Operations	Cancelled operations for non-clinical reasons	0.80%	0.79%	1.00%	0.96%	1.3%	No
	Rebooking non-clinical cancellations within 28 days	<5%	11.1%	9.1%	11.5%	19.5%	No

Responsive quality highlights & challenges

We have not met the national four hour A&E standard: A&E performance is measured by the percentage of patients that are seen, treated and discharged from an urgent or emergency care setting within four hours. Our overall performance is derived from attends across all our emergency areas. These include:

- The main Emergency Departments (Type 1)
- Western Eye Hospital (Type 2)
- The Urgent Care Centres at our three main sites (Type 3).

An 'improving patient flow programme' was launched in early 2017 to improve operational performance across the whole urgent care patient pathway at the Trust and to enable us to meet the trajectory for performance against the four hour A&E wait standard. Significant work was completed against the programme milestones and improvements have been realised in a number of key areas, however performance against the four hour wait standard is lower than expected. We achieved an average of 87.1 per cent across 2017/18.

Key challenges for the Trust included:

- Increased demand and acuity within type 1 departments;
- An increase in arrivals via ambulance and major trauma presentations at St Marys Hospital;
- High levels of bed occupancy;
- The number of days with black capacity alerts.

The Trust was compliant against seven of the eight national cancer standards in last three quarters of 2017/18: Although we did not consistently meet all eight cancer standards across the year, improvements have been seen. These improvements have been the result of a number of actions across each of the targets, including increasing MRI capacity to deliver same day scanning and reporting for prostate cancer referrals and increasing CTC scanning and reporting capacity to support the colorectal straight to test pathway. In September the Trust signed a memorandum of understanding with RMP Vanguard to deliver the £943k investment over the next two years to fully establish the prostate RAPID diagnostic pathway.

We have not met the national performance targets for referral to treatment (RTT) and we continue to have significant numbers of patients waiting 52 weeks and over for treatment on a RTT pathway: In 2016 and 2017, the Trust identified issues with how we were managing our waiting lists as well as underlying capacity problems in a number of areas. We have not met the

standard of 92 per cent of patients treated within 18 weeks of referral this year, reporting an average of 83 per cent across the year. Improvement trajectories have been agreed with our commissioners and NHSI and a waiting list improvement programme is in place (for more details see page xx).

The Trust reported 1,896 patients waiting over 52 weeks in 2017/18, which is an increase on the 1,578 patients reported last year. The clinical review process is detailed on page xx. Three cases of clinical harm have been confirmed for patients waiting over 52 weeks since the process began in August 2016.

In 2017/18 we also included an 'on admission' clinical harm review for patients waiting 52 weeks and over for treatment within specialities that are included within the 'high risk' category. To date there have been no incidences of clinical harm.

A dedicated email address was set up for GP colleagues to alert us to patients who were potentially at risk of harm due to their wait. No cases of harm have been identified by this route.

We improved our PLACE (patient led assessment of the care environment) scores in all categories: PLACE (see glossary on page xx for definition) was introduced in 2013 as an annual patient led initiative that monitors and scores the environment under the following headings:

- Cleanliness;
- Privacy, Dignity & Wellbeing;
- Food & Hydration;
- Condition, Appearance & Maintenance;
- Dementia (introduced in 2015);
- Disability (introduced in 2016).

All patients should be cared for with compassion and dignity in a clean, safe environment. PLACE assessments provide a clear message, from patients, about how the environment or services might be enhanced.

This year's results showed an improved position in all six areas, with five of the six areas also meeting the targets that we set ourselves for this year:

- Cleanliness – scores above national average.
- Food and hydration – although our results remain slightly below average, they have improved since last year.
- Privacy, Dignity & Wellbeing – although our results remain below average, they have improved since last year and we are no longer in the bottom 20 per cent.
- Condition, appearance and maintenance – scores have improved and are above national average
- Dementia – results show the most significant improvement. We have now moved from the bottom 20 per cent to above the national average.
- Disability – scores remain below average, but are no longer in the bottom 20 per cent.

These improvements were the result of a detailed action plan led by the PLACE steering group, as well as progress with our wayfinding, clinical and estate strategies. A number of areas have benefitted from major refurbishment programs including works to enable the introduction of new equipment, services being moved to larger spaces, and replacement of flooring and refurbishment of side room and bathroom facilities across the different hospital sites. In addition regular unannounced cleaning inspections have been introduced in clinical areas and a new seasonal menu has been developed with support from patient representatives to improve the standards of food.

A detailed analysis of the 2017 assessment findings has taken place to assess any recurring themes and a detailed action plan will again be implemented to improve scores again next year.

We have not achieved our target to discharge at least 35 per cent of our patients on relevant pathways before noon: Untimely discharge has been identified as one of the most common reasons why A&E departments fill and patients have long waits to be seen and admitted or discharged. Planning discharges before the peak in admissions is an effective way to smooth the total demand for beds and run safer, more effective services.

By discharging patients earlier where clinically appropriate, we are in a better position to place all patients appropriately in the right ward, in the right bed and at the right time. Due to the indicator needing to be reviewed and validated in depth, reliable reporting did not commence against this target until November 2017. The Trust is supporting wards to implement the SAFER flow bundle which combines five elements of best practice to improve patient flow and prevent unnecessary waiting for patients. This includes early discharge to make beds available on the wards to admit new patients from A&E. This year 11.7% per cent of our patients were discharged before noon compared to 17.5 per cent last year.

Well-led

Evidence shows that staff who are engaged and happy in their jobs, respected and given opportunities to learn, provide better care for their patients. We have implemented a number of improvements to increase staff engagement throughout the organisation.

In this section we describe our progress with the targets under the well-led domain during 2017/18 as well as with our key priority improvement work streams.

Leadership development programme
Last year we committed to further developing training programmes as well as piloting management and leadership apprenticeship programmes. The Trust runs a suite of leadership and management development programmes for staff across the organisation. Linked to the Trust's talent and succession plan, these programmes equip our leaders with the skills to be highly effective in their roles. Our 'Horizons' and 'Aspire' leadership programmes bring together our senior leaders and develop their ability to lead across teams and systems in an authentic and engaging way. Our 'Headstart' and 'Foundations' programmes are highly practical and participative management development programmes for those who are new to management or looking to broaden their existing skill set.

Our offer is continually evolving with two new programmes added in 2017; 'Springboard' for band 5-6 nurses in support of our retention strategy and 'Engage' to further improve our employee's experience of working here. In August 2017, following our progress in the 2016 NHS Staff Survey and the development of our local 'Engage' workshop and toolkit for managers we were featured as a best practice case study published by NHS Employers.

We also organised, in partnership with the Patient Safety Translational Research Centre (PSTRC), a two-day leadership course aimed at senior leaders in the Trust and College to enhance collaborative learning on leadership for safer care.

Retention strategy
During 2017/2018 we fully launched our recruitment and retention plan for our nursing and midwifery staff (bands 2-6). A number of initiatives were introduced including:

- Creating a new brand for recruitment;
- Launching career clinics;
- Automatic offers for students;
- Extending the Preceptorship to one-year;
- Introducing a new leavers survey;
- Implementing a new leadership programme for band 5/6 nurses;
- Creating a retention toolkit.

Our action plan was showcased by NHSI as part of their master class series in November 2017.

Occupational Health service review
In July 2017 we commissioned an external strategic review of our occupational health service to ensure that it was set up in the most appropriate way to deliver an effective and high quality service for our staff. The review assessed the service provided both to the Trust and to external clients. A number of improvements were made to the service in response to the recommendations of this review, including:

- An upgrade to the software sytem to enable more efficient scheduling, processing and delivery of work;

- More streamlined working with the recruitment team to enable speedier health clearance of newly-recruited employees;
- Revision of pricing.

We have also submitted a Safe Effective Quality Occupational Health Services (SEQOHS – see glossary on page xx for definition) re-accreditation case. As part of the accreditation process, the assessors are scheduled to conduct their on-site visit, which is the final part of the assessment process, in October 2018.

Improving the offer to our staff from our occupational health service including timeliness and efficiency is important to support health and well being. An action plan is in place to deliver this improvement and will be key to delivering this during 2018/19.

Staff engagement programme
We made a commitment last year to develop plans to improve based on what our staff tell us. The results of our annual internal staff survey are included below. In response, directorates were asked to prepare engagement action plans which showed enormous breadth of action and activity to promote engagement. Some activity centred on effective implementation of pre-existing processes including PDRs and Make a Difference Awards, whilst others focused on innovative actions to address very local concerns such as improving rest areas for staff and the introduction of new newsletters.

We also ran the 'In our Shoes' focus groups again this year, which are an opportunity for staff to share with each other what makes a good day and what makes a bad day at work, and identify what the Trust can do to improve staff experience. Over 800 employees across the organisation participated.

Ward accreditation programme
Our internal annual ward accreditation programme (WAP) was launched in 2014 and continues to support ward, unit and department managers to understand how they are delivering care, identifying what works well and where further improvements are needed. Areas are assessed against a number of criteria, and given a rating, from gold (achieving highest standards with evidence in data) to white (not achieving minimum standards and no evidence of active improvement work).

In 2017 overall, out of 90 areas reviewed, 38 had improved since last year. 34 per cent of clinical areas were rated as gold, 32 per cent were rated as silver, and four per cent were rated as white.

To support continued improvement in leadership, which was highlighted as an area for improvement in the first year of the WAP, the Trust has launched a bespoke Band 5 and 6 nursing and midwifery leadership programme. The impact of this will be measured during the 2018 programme, which will also be expanded to include more clinical areas and to support the new Trust quality strategy.

Patient and public involvement strategy
In 2016, we developed a Trust-wide approach to increasing and improving patient and public involvement in every aspect of our work. Progress with the strategy in 2017/18 has included:

- A new digital patient reference group - providing input and feedback on the development of apps, the use of digital patient records and other online opportunities to help ensure our digital strategy meets the needs and preferences of our patients and communities
- The establishment of an additional 22 lay partner roles – enabling patients and local people to play a full part in the Trust's key projects and programmes, bringing the total

to 44 and influencing major developments such as waiting list improvements, estates redevelopment and a new patient transport tender
- The creation of a new volunteer role to support improvement projects – focusing on gathering feedback directly from patients, carers, family and friends in clinical environments
- Publishing our first involvement toolkit for staff – offering advice and practical support to involve patients and the public in services and improvement work.

We also include patient stories at each of our bi-monthly public board meetings to learn from the experiences of our patients.

Flu campaign

Flu vaccination rates at the Trust have been reducing over preceding years and with only 20.6% of 'frontline healthcare workers' vaccinated in 2016/17 we were a national outlier (Source: CQC Insight Report, December 2017).

In August 2017, it was agreed that a new approach was needed. The Improvement Team were asked to design and implement a comprehensive vaccination plan in preparation for the 2017/18 flu season. The vaccination programme was active between 25 September 2017 and 31 January 2018 and by March 60.5% of our frontline healthcare workers had been vaccinated against flu.

Whilst the Trust did not meet NHS England's target of ensuring that at least 70 per cent of frontline healthcare workers were vaccinated, the results represent a significant improvement in protecting more of our staff than ever before. We finished the flu campaign as the most improved Acute Trust in England; achieving an improvement of very nearly 40 per cent from last year's performance.

Digital

The digital big room (see page xx for more information on 'big rooms') has identified seven priority areas for 2018/2019. These act as really important enablers across 'improvement priorities' for trust wide digital transformation. The digital priority areas overlap with GDE priorities and comprise:

i) Optimal use of existing digital features;
ii) Going paperless;
iii) Introducing voice recognition;
iv) Device and system integration; to develop systems that connect and share information safely and securely;
v) Developing a mobile App interface;
vi) Care Information Exchange (CIE);
vii) Analytics; to ensure provision of access to data to develop real time feedback mechanisms to collect and act upon data.

The table below sets out our performance in 2017/18. Where applicable, it presents national targets and averages, and information about our performance in 2016/17. Site level data is described where available and appropriate.

Goal/Target	National Target / National Average	Performance in 16/17	Target for 17/18	Outcome in 17/18 (data to end Feb 2018)	Target achieved?
To increase the percentage of staff who would recommend this trust to friends and family as a place to work	N/A	65% (internal staff survey published Sept 2016) 62% (national staff survey published March 2017)	67% (internal staff survey) 64% (national staff survey)	72% (internal staff survey published August 2017) 66% (national staff survey published March	Yes

				2018)	
To increase the percentage of staff who would recommend this trust to friends and family as a place for treatment	N/A	83% (internal staff survey published Sept 2016) 70% (national staff survey published March 2017)	85% (internal staff survey) 72% (national staff survey)	86% (internal staff survey published August 2017) 73% (national staff survey published March 2018)	Yes
We will achieve a voluntary turnover rate of 10 per cent	N/A	10.22%	10%	9.1%	Yes
We will maintain our sickness absence rate at below 3.10 per cent	N/A	3.00%	3.10%	2.9%	Yes
We will achieve a performance development review rate of 95 per cent	N/A	86.24%	95%	88.5%	No
We will achieve a non-training grade doctor appraisal rate of 95 per cent	90.1%	91.13%	95%	84.5%	No
We will achieve compliance of 90 per cent with statutory and mandatory training	95%	85.60%	90%	87.4%	No
We will further develop our ward accreditation programme to ensure it links with other quality initiatives and has quality improvement at its heart	N/A	Programme re-run	Programme re-run	Programme re-run	Yes
We will reduce the number of programmes with red flags in the GMC's national trainee survey by 5 per cent	N/A	25 red flags (50% reduction on previous year)	5% reduction	11 programmes with red flags (24 red flags in total)	No
We will increase the overall number of green flags in the GMC's national trainee survey by 5 per cent	N/A	54	57 or more	53	No
We will obtain a minimum score of 0.5 for placement satisfaction for all student placements as measured by SOLE	N/A	76% (academic year 2016/17)	100% of placements with 0.5 or more	79%	No
We will have a departmental safety coordinator in 60% of clinical wards, clinical departments and corporate departments	N/A	91.87% (departments with trained coordinators)	60%	49%	No
We will ensure at least 10 per cent of our staff are trained as fire wardens	N/A	New target not previously measured	10%	9%	N/A
We will ensure we respond to all exception reports from junior doctors within 14 days of an application being made and that we deliver improvements as a result	N/A	New target not previously measured	Within 14 days	45%	N/A

Well-led quality highlights & challenges

We have achieved our goal and increased the percentage of staff who would recommend our Trust as a place to work and as a place for treatment: We monitor staff engagement through the national staff survey and through our annual internal survey 'Our Voice' which was run between

May and June 2017. 2,802 of our people responded, which represents 33 per cent of the total workforce.

The survey included questions about whether staff would recommend the Trust to friends and family as a place for treatment or a place to work. We were very pleased to see that our scores for both of these increased again this year; they are our best results for these two questions since the staff survey was introduced in November 2013.

In addition to these, the top 5 performing questions across our survey were:

- I understand how my work makes a difference to other people (96 per cent)
- I am clear about the values and behaviours expected of me at work (94 per cent)
- I am clear about my own objectives and responsibilities (94 per cent)
- I am trusted to prioritise my workload myself (93 per cent)
- The people in my team work together to provide a great service (90 per cent)

Our staff were less positive about the following questions:

- Senior leaders are genuinely interested in staff opinions and ideas (57 per cent)
- Senior leaders communicate well with the rest of the organisation (57 per cent)
- Senior leaders are visible and approachable (56 per cent)
- I generally have enough time to complete all my work (54 per cent)
- Poor behavior and performance is addressed effectively in this organisation (48 per cent)

Information on what we did in response to this feedback is included on page xx

The national staff survey results were published in March 2018, which also showed an improvement in the percentage of our staff who recommend the Trust to friends and family as a place to work and as a place for treatment. Our overall engagement score was 3.84 which is above (better than) average when compared with trusts of a similar type.

We achieved some very positive scores in the national staff survey, above the national average, including in the following four areas:

- Quality of non-mandatory training, learning or development (4.17 out of 5, against a national average of 4.05);
- Percentage of staff agreeing that their role makes a difference to patient/service users (91 per cent, against a national average of 90 per cent);
- Quality of appraisals (3.20 out of 5, against a national average of 3.11);
- Staff satisfaction with the quality of work and care they are able to deliver (3.99 out of 5, against a national average of 3.91).

Nevertheless, the survey results also make it clear that we still have much more to do. We have below average scores when compared to other trusts in relation to the numbers of our staff reporting experiences of harassment, bullying or abuse in the workplace as well as discrimination, and witnessing potentially harmful errors, near misses or incidents. The results in these areas, as follows:

- 35 per cent of our staff experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- 29 per cent experienced harassment, bullying or abuse from staff in the last 12 months.
- 37 per cent witnessed potentially harmful errors, near misses or incidents in the last 12 months.
- 19 per cent experienced discrimination at work in the last 12 months.

Nevertheless, the survey results also make it clear that we still have much more to do. We have below average scores when compared to other trusts in relation to the numbers of our staff reporting experiences of harassment, bullying or abuse in the workplace as well as discrimination, and witnessing potentially harmful errors, near misses or incidents. The results in these areas, as follows:

- 35 per cent of our staff experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.
- 29 per cent experienced harassment, bullying or abuse from staff in the last 12 months.
- 37 per cent witnessed potentially harmful errors, near misses or incidents in the last 12 months.
- 19 per cent experienced discrimination at work in the last 12 months.

Good progress continues to be made on improving the level of support and information available to our staff in relation to violence and aggression in the workplace. This includes training during induction and the provision of a 'tool box' of information with a particular emphasis on conflict resolution. Work is also underway to improve security arrangements in hot spot areas including CCTV and access control changes and upgrades. Whilst this section relates to staff well-being, if our staff are at risk then our patients are also at risk.

The results for the 2017 National Staff Survey are currently being analysed to inform local and strategic engagement plans.

We have met our voluntary turnover rate target: We are pleased to have seen a decrease in staff voluntarily leaving the Trust this year and have met our voluntary turnover rate target. A key aspect of reducing the voluntary turnover rate is to ensure staff have the opportunity for career progression, feel their job is worthwhile and fulfilling, and they are supported to develop. Some of the ways we are working to ensure this include:

- The implementation of the Nurse Recruitment & Retention Strategy;
- Careers clinics (band 2 – 6 nurses and midwives);
- Development of Springboard (band 5/6 Nurse Development Programme);
- Exploration of flexible benefits for staff;
- Further development of flexible recruitment and retention premium (RRP);
- Becoming an 'employer of choice' for student nurses and midwives;
- "Great place to work week", Pulse magazine and "Your working life" intranet pages.

Our sickness absence rate remains low: Low sickness absence is an indicator of effective leadership and good people management. We are continuing our focus on supporting the health and wellbeing of our staff along with supportive management interventions for those who are absent due to sickness. There are a range of activities and services available within the Trust including occupation health, staff counselling, stress management, yoga and meditation classes, and smoking cessation clinics. In September 2017 we also ran our third 'Living Week' which is a campaign of events designed to get staff fit, active and having fun.

We have maintained our performance overall in the General Medical Council's National Training Survey of junior doctors and our performance for placement satisfaction as measured by SOLE (student online evaluation): We aim to provide the best learning environment for our doctors. Two important elements we use to monitor the satisfaction of our trainee doctors and medical students are:

- **Student Online Evaluation (SOLE)**: The feedback we receive from our medical students through the local SOLE system has previously been mixed. Our aim is to focus on improving their experience in a consistent manner, with the target of obtaining a minimum score of 0.5 (which corresponds to a 'mostly agree' score) for satisfaction for all

student placements. In 2016/17, we achieved this target for 79 per cent of our programmes this year, compared to 76 per cent last year.

General Medical Council's national training survey (GMC NTS): This annual survey can highlight not only problems with teaching in organisations, but also patient safety issues and problems with bullying and undermining. The results of the GMC NTS were published in July 2017. Whilst the 2016 survey demonstrated significant improvement on previous results, the 2017 results indicate that we have maintained our performance overall. Ongoing supportive improvement plans are in place for specialties of concern through education specialty reviews.

Two specialties (ophthalmology and neurosurgery) have been removed from enhanced monitoring by the GMC due to their sustained improved performance. Critical care at Charing Cross Hospital remain under enhanced monitoring with a formal action plan in place with monthly review meetings with the medical director. Actions being taken include:

- Increasing registrar level posts to decrease rota intensity;
- Increasing consultant supervision by increasing consultant level posts;
- Providing suitable rest facilities for our junior doctors.

Since the results of the 2017 survey, we have been focusing on driving further change by:

- Strengthened governance with education specialty reviews chaired by the medical director and continued support for local faculty groups embedded as business as usual.;
- Sharing good practice from the specialties with green flags;
- Embedding time for education in job plans and making it sustainable;
- Supporting the development of the multi-professional workforce through the implementation of the integrated education strategy;
- Enhanced our faculty development programme for consultant supervisors to include refresher modules and provision of educational appraisals.

Although we have not met our percentage target for the number of doctors who have had an appraisal, we had positive feedback from our Higher Level Responsible Officer Quality Review Visit: It is a national requirement that non-training grade doctors have an annual medical appraisal as part of the General Medical Council's Revalidation process (see glossary on page xx for definitions), during which doctors have a formal structured opportunity to reflect on their work and to consider how their effectiveness might be improved, with the focus on enhancing quality and improvements in patient care. A number of actions are being taken to increase compliance including monthly professional development drop-in sessions across all Trust sites and reviewing the PREP system to ensure it is user friendly and easy to navigate by doctors. There is also ongoing contact with doctors who are overdue with application of the Trust policy where appropriate.

In February 2017 the Trust was visited by the London Revalidation Team to assess against the Core Standards Framework for the supervision, support and management of medical staff by the organisation and the Responsible Office (see glossary on page xx for definition). The visit highlighted a number of areas of good practice including appraisers having refresher training that was well evaluated by participants, the production of electronic revalidation monthly newsletters, and good working relationships between the medical staff team and the revalidation team. An action plan has been developed for areas highlighted for improvement.

We have not met our target for the percentage of staff who have had a performance development review (PDR): Our appraisal scheme 'Performance Development and Review (PDR)' for staff, excluding doctors, is aimed at driving a new performance culture across the Trust. Although we are below target we have improved on last year's result.
The National Staff Survey results for 2017 indicate that out of those who completed the survey, 89% had been appraised within the last 12 months which is above the national average. In addition respondents stated that the quality of appraisals was above the national average and was in our top five highest performing results. We continue to run a one day essential training course for all managers undertaking PDRs. We have also introduced an additional half day training to support managers in preparing for specific PDR conversations, maintaining a real focus on making sure that staff have meaningful and positive PDR meetings.

We have not achieved our target of 90 per cent of staff being compliant with core skills training: Our core skills training programme ensures the safety and well-being of all our staff and patients; this includes modules which have a direct impact on patient safety. The percentage of staff who have completed all the core skills modules has slightly decreased this year; we continue to target areas where compliance is particularly low. We have an ongoing work programme to maximise compliance rates which includes introduction of pre-assessment modules, a review of target groups, better communication and improving access to training.

We have not achieved our target to have 10 per cent of staff trained as fire wardens and departmental safety coordinators in 60 per cent of clinical wards, clinical departments and corporate departments: Targets for the departmental safety co-ordinators (DSCs – see glossary on page xx for definition) and fire wardens are included to drive improvements in health and safety. Targeted work has been underway to increase the numbers of trained staff, however high demand on our clinical areas has restricted the availability of our staff to attend the training sessions. In response, a more concise training package for fire wardens has been developed this year and a new e-learning course is being considered for DSC training. We are also reviewing the way that we measure DSC compliance to ensure accurate reporting next year.

A task and finish group approach has been commenced to achieve compliance with DSC numbers. All departments have been invited to join the group and a targeted approach will be employed to ensure we achieve improved coverage across all areas during the coming year.

The Acute Quality Schedule 2017/18

Each year, we agree a number of quality metrics with our commissioners which we are required to deliver as part of our contract. These include nationally mandated metrics, as well as locally agreed ones. Our commissioners (local and NHS England) monitor our performance with these indicators throughout the year through the Clinical Quality Group. They include most of the quality strategy priority goals and targets described above. We have achieved the majority of the quality schedule metrics throughout the year and have agreed plans with our commissioners to help us improve in areas where we have not performed consistently.

Maternity performance indicators

The quality schedule includes 14 key targets to drive improvement in maternity care. In all quarters this year, we have achieved the following eight targets:

- 90 per cent breastfeeding initiation rate within 48 hours of the baby's birth. We have also made significant progress towards achieving UNICEF Baby Friendly Accreditation.
- 95 per cent of women receiving one-to-one midwife care in established labour. We are delighted that this key metric is consistently met and this aligns with the findings of the national maternity survey.
- 100 per cent of women with a named midwife or named team. We are using this as a building block for the 'Better Births' early adopter work to improve continuity of care for women.
- 14 per cent of women giving birth in a midwifery led unit. We are very proud of our two highly rated Birth Centres.
- Less than five per cent of women smoking at the time of delivery. We continue to work with Public Health Partners to support women to give up smoking.
- Less than three per cent of women experiencing third or fourth degree tears. We monitor this closely and ensure that women are receiving the latest evidenced based care in this important area.
- 98 hours per week consultant presence on the labour ward at St Mary's Hospital
- 1:30 midwife to birth ratio. We continue to be funded to this ratio and have many mechanisms in place to ensure safe midwifery staffing across our service.

Areas of challenge

Maternity booking assessments in 12 weeks and 6 days.
We achieved this performance target for three out of four quarters this year. We did not meet this target for the last quarter following a change in structure of the Patient Services Centre in addition to a shortage of staff. This is a focused area of attention with plans in place to improve this metric.

Home births
The number of women giving birth at home remains below the threshold of 1 per cent. Maternal choice is one of the main factors driving this. In addition, 40 per cent of women that give birth at the Trust are from outside of our catchment area although they are included in the denominator. We continue to strive to increase home birth choices where clinically appropriate.

Percentage of women having a non-elective caesarean section and percentage of women having an elective caesarean
Performance against these targets fluctuated, although we met non-elective caesarean section targets in three out of four quarters. We just missed the target (16.1%) in Q2. We have a process in place to review non-elective caesarean sections. We met the elective caesarean

section targets in two out of four quarters. Counselling occurs for women requesting an elective caesarean section.

Postpartum haemorrhage
Our performance against this target has improved since last year. In 2016/17 our performance was 3.1 per cent against a target of 2.8 per cent. Following the introduction of a focussed action plan we have now met the target in all quarters, except in Q2 where we reported 2.84 per cent.

Hours of consultant labour ward cover
The Trust met the RCOG threshold for the number of hours of consultant presence on the labour ward at St Mary's hospital (60 hours per week for units under 4000 maternities per year), but not at Queen Charlotte's and Chelsea Hospital (168 hours per week). Neither hospital met the London Maternity Quality Standards and CCG target of 168 hours per week. These targets are not evidenced based and recent evidence shows that 168 hour consultant labour ward presence does not lead to an improvement in patient outcomes. Following this emerging evidence, the RCOG wrote to all Clinical Directors of Maternity retracting from its commitment to the 168 hour standard for consultant presence on labour ward in maternity units with over 5000 maternities. The London Maternity Clinical Leadership Group have revised London Quality Standards and are due to imminently publish the updated standards which will not include a requirement to have 168 hour consultant presence on labour ward. There is currently a significant shortage of junior doctors at Queen Charlotte's and Chelsea Hospital and with Trust board support we have now reduced consultant labour ward presence from 113 to 98 hours and redeployed resident on-call consultants to perform daytime duties. This will maintain safety during the day and night as consultants remain on-call overnight and can be called in to the hospital if required. This will be reviewed when the staffing situation improves. This has been in place now for several months and no significant risks have emerged from the slight reduction in hours.

Safeguarding training

We are committed to the protection and safeguarding (see glossary on page xx for definition) of all patients, including children and young people. As part of this, we provide staff with different levels of safeguarding training, depending on their role. Throughout 2017/18, compliance with training has remained below our target of 90 per cent for most levels although we have seen gradual improvement for Level 2 adult safeguarding training and are now just below target at 87 per cent. Training compliance remains a important but challenging priority for us and we have included compliance with level 3 children's safeguarding training as one of our quality account targets for 2018/19. Level 3 child safeguarding is delivered as a four hour face-to-face session.

Level 1 & 2 training for both adult and child training is delivered via e-learning modules. We have communication plans in place to improve compliance, including regular reminders to staff and reviews of monthly compliance reports with managers. In addition, all staff are required to confirm that they are up to date with their core mandatory training as part of their annual personal development review.

We have not reported any serious incidents related to adult safeguarding in 2017/18, but two serious incidents were generated by children safeguarding concerns. In order to ensure learning from any incidents, summary care records are disseminated out to staff in the Trust during training and supervision sessions and we have introduced 'learning flyers'. In addition, learning themes from any incidents recorded on our reporting system, Datix, are shared with staff.

The NHS Outcomes framework indicators 2017/18

The NHS Outcomes Framework 2017/18 sets out high level national outcomes which the NHS should be aiming to improve. The framework provides indicators which have been chosen to measure these outcomes. An overview of the indicators and our performance is outlined in the table below. Some of this data is repeated because we chose to include these indicators as our quality strategy targets for 2017/18. It is important to note that whilst these indicators must be included in the quality accounts, the most recent national data available for the reporting period is not always data for the most recent financial year. Where this is the case, the time period used is noted underneath. This data is included in line with reporting arrangements issued by NHS England. Further information about what we are doing to improve our performance can be found in the individual target pages.

Indicator	ICHT 2017/18	National Average (Median Reporting Rates)	Where Applicable - Best performer	Where Applicable - Worst Performer	Trust Statement	2016/17	2015/16	2014/15
SHMI value and banding	74.29 (Q2 2016/17 – Q1 17/18) Second lowest SHMI ratio of all non-specialist providers in England	100 (Q2 2016/17 – Q1 17/18)	72.61 (Q2 2016/17 – Q1 17/18)	122.77 (Q2 2016/17 – Q1 17/18)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • It is drawn from nationally reported data • We have reported a lower than expected SHMI rate for the last three years. • ICHT has the second lowest SHMI ratio of all non-specialist providers in England We intend to take the following actions to improve this rate, and so the quality of our services, by: • Continuing to work to eliminate avoidable harm and improve outcomes. • Reviewing every death which occurs in our Trust and implementing learning as a result. See page xx for more information on our implementation of the new Learning from Deaths framework.	75.54 Second lowest SHMI ratio of all non-specialist providers in England	73.8 Third lowest SHMI ratio of all non-specialist providers in England	73.17 Third lowest SHMI ratio of all non-specialist providers in England
Percentage of admitted deaths with palliative care coded	52.6% (January to December 2017)	29.6% (January to December 2017)	Not applicable	Not applicable	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • It is drawn from nationally reported data. • It shows we have the second highest rate of palliative care coding as measured by this indicator of all acute non-specialist providers. • We are confident that we have a robust process in place to ensure that we are coding patients correctly. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Continuing to work to improve the accuracy of our clinical coding.	54.9%	53.5%	24.6%
Patient reported	Not available	EQ-5D: 0.089 EQ-VAS: -	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons:	* (Low	* (Low	* (Low

outcome scores (PROMs) for groin hernia surgery		0.132 (April – Sept 17)			• Data was not available on the NHS Digital PROMS database. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Groin hernia surgery PROMs collection has been ceased at a national level. See page xx for further information.	sample size)	sample size)	sample size)
PROMs for varicose vein surgery	EQ-5D: 0.077 EQ-VAS: 1.324 Aberdeen varicose vein score: -1.899 (April – Sept 17)	EQ-5D: 0.096 EQ-VAS: -0.418 Aberdeen varicose vein score: Not available (April – Sept 17)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • It is drawn from the independently administered NHS Digital PROMS database. • It shows that we had health gain below national average for varicose veins. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Whilst varicose veins surgery PROMs collection has been ceased at a national level, ICHT are developing measures to allow on-going monitoring of the outcomes for patients. See page xx for further information.	EQ-5D: 0.083 EQ-VAS: 0.3 Aberdeen varicose vein score: -0.1	EQ-5D: 0.038 EQ VAS: -2.966 Aberdeen varicose vein score: -2.724	EQ-5D: 0.047 EQ VAS:-1.093 Aberdeen varicose vein score: -2.224
PROMs for hip replacement surgery	Not available	Not available	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • Data was not available on the NHS Digital PROMS database. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • implementing our action plan. See page xx for further information.	* (Low sample size)	EQ-5D: 0.475 EQ VAS: 14.259 Oxford Hip Score: 24.229	EQ-5D: 0.453 EQ VAS: 12.756 Oxford Hip Score: 22.537
PROMs for knee replacement surgery	Not available	Not available	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • Data was not available on the NHS Digital PROMS database. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • implementing our action plan. See page xx for further information.	* (Low sample size)	EQ-5D: 0.292 EQ VAS: * low sample size Oxford Knee Score: 13.420	EQ-5D: 0.326 EQ VAS: 10.411 Oxford Knee Score: 14.940

28 day readmission rate for patients aged 0-15	4.92% (Dr Foster data – Oct 16 – Sept 2017)	9.1% (Dr Foster data – Oct 16 – Sept 2017)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • It is drawn from the nationally reported data obtained from Dr Foster • We have maintained our low unplanned readmission rate for both paediatric patients and adult patients with both rates remaining below national average throughout the year. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Continuing to ensure we treat and discharge patients appropriately so that they do not require unplanned readmission. • Working to tackle long-standing pressures around demand, capacity and patient flow.	5.15% (Oct 2015-Sep 2016)	4.81% (Jan-Dec 2015)	6.31%
28 day readmission rate for patients aged 16 or over	6.92% (Dr Foster data – Oct 16 – Sept 2017)	8.2% (Dr Foster data – Oct 16 – Sept 2017)	Not available	Not available	See above.	6.64 % (Oct 2015-Sep 2016)	7.39% (Jan-Dec 2015)	8.84%
Percentage of staff who would recommend the provider to friends or family needing care	73% [national staff survey – published March 2018]	71% [national staff survey – published March 2018]	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • It is drawn from the nationally reported data from the National Staff Survey which was published in March 2018. • The results show an improvement in our national staff FFT score compared to last year, which is also above average for acute trusts. • Results from our local engagement survey also show an improvement, with 86% of staff recommending the Trust. We intend to take the following actions to improve this percentage, and so the quality of our services, by: •See page xx for information on our improvement plans.	70%	68%	71%
Percentage of admitted patients risk-assessed for VTE	93.87% (2017/18 full year data) Q1: 92.71% Q2: 91.63% Q3: 95.53% Q4: 95.64%	95.36% (Q3 17/18)	100% (Q3 17/18)	76.08% (Q3 17/18)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • It is drawn from the nationally reported data published quarterly by NHS England. • Last year, an internal audit identified some issues with our data for this indicator. In response, the Trust moved to assessment for VTE at drug prescription on admission rather than at discharge at the end of March 2017. • We have monitored VTE risk assessments on a monthly basis throughout the year. After an initial drop in performance across the Trust which we had anticipated, a Trust-wide action plan that included sharing performance data locally was implemented.	95.33%	95.87%	96.56%

					• We met our target in Q3 and Q4. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Using CRAB outcome data in 2018/19 which should be more specific			
Rate of C-Diff per 100,000 bed days	17.64 Total cases: 63	13.2 (2016/17 data)	0.0 (2016/17 data)	82.7 (2016/17 data)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • It is drawn from nationally reported data • We monitor performance regularly through our Trust Infection Control Committee and weekly taskforce meeting. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • To reduce the risk of infections occurring in the hospital we will continue to work on reducing the use of anti-infectives (antibiotics) and improving hand hygiene.	18.03 (63)	20.9 (73)	22.6 (79)
Responsiveness to inpatients personal needs: National Inpatient survey score	No new data has been published since the 2016/17 scores that were published in May 2017.	Not available	9.2 [national inpatient survey overall score – published May 2017]	7.4 [national inpatient survey overall score – published May 2017]	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data from the National Inpatient Survey which was published in May 2017. We intend to take the following actions to improve this percentage, and so the quality of our services, by: •See pages x-x for information on our improvement plans.	8.2 [overall score] 6.72 [responsiveness score]	7.9 [overall score] 6.74 [responsiveness score]	75.8 [overall score] 6.82 [responsiveness score]
Rate of reported patient safety incidents per 1,000 bed days	47.96 (NRLS data April – Sept 17)	41.68 (NRLS data April – Sept 17)	76.2 (NRLS data April – Sept 17)	23.47 (NRLS data April – Sept 17)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • The NRLS data is nationally reported and verified. • The data shows all incidents reported by ICHT for the period April – September 17: our incident reporting rate for this period was 47.96 against a median peer reporting rate of 41.68 • Our individual incident reporting data is made available by the NRLS every six months We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Improving how we report, manage and learn from incidents as part of our ongoing safety culture work. See page xx for further information.	April – Sept 16: 42.3 Oct 16 – March 17; 46.82 (rate per 1,000 bed days)	April – Sept 15: 41.38 Oct 15 – March 16: 43.18 (rate per 1,000 bed days)	April – Sept 14: 42.98 Oct 14 – March 15: 40.69 (rate per 1,000 bed days)
Percentage of	0.1% severe/major	0.28% (severe harm)			Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons:	April – Sept 16: 0.1%	April-Sept 15: 0.1% -	April-Sept 14: 0.1%

patient safety incidents reported that resulted in severe/major harm or extreme harm/death	harm (6 incidents) 0.1% extreme harm/death (6 incidents) (NRLS data April – Sept 17) Full year internal data: 27	0.11% (extreme harm/death) (NRLS data April – Sept 17)			• It is drawn from the nationally reported data from the NRLS •We reported 0.1% severe/major harm incidents (6 incidents) compared to a national average of 0.3%, and 0.1% extreme/death incidents (6 incidents) compared to a national average of 0.12%. • Based on our full year internal data, we have also achieved a small reduction in the total number of incidents causing extreme harm/death or severe/major harm in 2017/18, reporting 27 compared to 28 in 2016/17. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • see pages xx-xx for an update on our improvement plans.	severe/major harm (7 incidents) 0.0% extreme harm/death (2 incidents) Oct 16 – Mar 17: 0.1% severe/major harm (6 incidents) 0.1% extreme harm/death (10 incidents)	severe/major harm (8 incidents) 0.1% - extreme harm/death (5 incidents) Oct 15 – March 16: 0.1% severe/major harm (10 incidents) 0.1% extreme harm/death (8 incidents)	severe/major harm (6 incidents) 0.3% extreme harm/death (19 incidents) Oct 14 – March 15: 0.1% severe/major harm (9 incidents) 0.1% extreme harm/death (8 incidents)
Inpatient Friends & Family Test	97%	96%	100%	64%	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data • we have actively monitored our performance throughout the year. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • see pages xx-xx for an update on our improvement plans.	97% (2016/17)	96% (2015/16)	95% (2014/15)
A&E Friends & Family Test	94%	86%	100%	46%	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data • we have actively monitored our performance throughout the year. We have taken the following actions to improve this percentage, and so the quality of our services, by: • see pages xx-xx for an update on our improvement plans.	95% (2016/17)	92% (2015/16)	88% (2014/15)

Statements from stakeholders

(to be inserted once received)

Independent Auditor's Assurance Report

(to be inserted once received)

Appendix A: National Clinical Audit

As described on page xx, the reports of twenty four national clinical audits and confidential enquires were fully reviewed by the provider in 2017/18. The majority of these have provided a satisfactory level of assurance, however the exceptions are listed below with the actions required to improve the quality of healthcare provided.

National Audit of Dementia
St Mary's was ranked first place for aspects of care relating to nutrition, which is reflective of the considerable work put in by the dementia care team (NOSH project and other initiatives). There was a significant improvement in the standard of documentation relating to discharge since the 2012/13 audit. The Trust also scored higher than the national average on initial screening, clinical assessment and the summary of symptoms for discharge summary. Recording the functional assessment of the patient was below the national average, and we have updated the delirium pathway as an action to improve this.

The audit highlighted areas for improvement where we are already aware of the challenges, such as creating a dementia friendly environment and adequate social space in the very old estate at St Mary's. The audit also identified inappropriate bed moves for patients with dementia, and this is another area for focus in over the coming year.as an issue that requires improvement.

National Neonatal Audit Programme (NNAP)
This audit monitors whether the care provided to babies and their families matches up to professionally agreed standards, and compares the results against all levels of neonatal units in England, Scotland and Wales. This audit provided substantial assurance against six of the audit findings, with reasonable assurance for two.

Over the next year we need to improve the number of babies who have their temperature taken within one hour of admission to the neonatal unit. We have utilised posters to raise awareness and have taken additional actions to ensure transport incubators are warmed up in advance to prevent deterioration in body temperature.

MBRRACE–UK Perinatal Confidential Enquiry
This confidential enquiry focusses on intrapartum-related deaths, specifically those born at term, excluding major abnormality (but including those anomalies where the cause of death was felt to be related to the intrapartum period rather than the anomaly). The enquiry explored preventable failures along the whole care pathway, but with a particular focus on care during labour, delivery and any resuscitation which may have contributed to the death.

Over the next year we are going to continue to train consultants to use Structured Judgement Review (SJR) forms, and plan for all healthcare professionals who are routinely present at births should undertake regular Newborn Life Support training.

Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme
This audit identified areas for improvement nationally with the transfusion process. We already have a checklist in place beside the patient to record the final administration check before transfusion is commenced. Over the next year we intend to develop a system to formally assess the risk of transfusion associated circulatory overload, as this is the major cause of death and morbidity.

RCP/BTS Adult Asthma
This audit assessed adult patients with acute asthma exacerbation who were admitted as in-patients, and looked at patient demographics, assessment, management, discharge bundle, follow up arrangements and re-admission rates. This showed that the local patient cohort appears to have more severe or complex disease than the national average. Documentation of PEF post bronchodilation was poor at 84%. Although patients were seen by an asthma nurse on

discharge, there was no specific discharge bundle in place. Follow up arrangements were not always conducted in a timely way which led to a slight increase in readmission rates.

Since this audit, and over the next year, we have appointed an asthma lead clinician and implemented the discharge care bundle. We are continuing to recruit to nurse specialist roles and are integrating teams across both acute sites. We are improving training and education of nursing staff and junior doctors to improve standards of care, and are developing improved online training regarding inhaler and PEF technique. We have held a 'Asthma Big Room' quality improvement session since the audit, and these were some of the improvement ideas that were generated at this session.

Elective Surgery National PROMs Programme
Previous audits had shown that the Trust was a negative outlier for knee surgery, and this was not evident in the latest audit report. Our actions for the coming year include improving our response rates for post-operative questionnaires, tendering a new data collection service and using the information we receive from PROMs to shape improvements in care. The first project using this approach will be a review of post-operative analgesia regimes.

Critical Care Case Mix Programme (ICNARC)
The Critical Care Units are compliant with quarterly data submission, which is then used to inform the annual report. This year's report showed some extremely positive progress, such as low rates of unit acquired blood stream infections, particularly those related to catheter use, and no non-clinical transfers.

The areas for improvement over the next year are delayed discharges, particularly at the St Mary's site. There is currently work being undertaken to reconfigure Level Two areas and open additional beds on the St Mary's site. There are also actions in place to improve readmissions at Charing Cross, high risk sepsis referrals the Hammersmith, and outcomes for patients at low risk of death at St Mary's.

Appendix B: Local Clinical Audit

Trustwide Priority Audits

Over the year the trust has identified a number of areas for targeted audit work across the organisation. These have been selected as areas where improvement is needed, areas of risk or in order to support a strategic aim. Audits conducted in these areas have been coordinated centrally and reported to the trust Quality and Safety Group for oversight and monitoring of actions and to provide assurance. Many of these audits are ongoing or form part of a wider improvement project and they will be taken forward with specific actions or a requirement for further or wider audit and QI involvement. These audits include:

- Patient Falls
- Medications and Medicines
- Safer surgery and the WHO surgery checklist safety stream
- Patient Consent
- Duty of Candour
- Nasogastric tubes and feeding: Adults; critical care patients
- Pain: Assessment, recording and management
- The deteriorating patient: (NEWS and MEWS scoring)
- Hand hygiene
- Completion of action plans following Serious Incidents

Some of the actions taken following the completion of these audits include:

- Changes to Trust policy following Duty of Candour audit. This will be re-audited in 2018/19.
- A safety stream with a Quality Improvement focus has been set up following the safer surgery audit. Regular audits run throughout the year, and there will be a repeat Trust-wide WHO check list audit in Q2 2018/19.
- NEWS and MEWS audit led to improvements in the calculation of early warning scores in the electronic patient record. There was also a focused piece of work within maternity services to improve the standards of documentation of observations.
- Improvements were made to documentation and handover of NG tube placements in Critical Care following the audit. Naso-gastric tube placement will be audited across the Trust during 2108/19.

Local Clinical Audits

Over 2017/18 there were 365 local audits registered in the Trust. The findings and action plans from these audits are presented at Directorate or Divisional level with local oversight of the action plans. Some of these audits have wider implications for the organisation and are then presented at Quality and Safety sub-group meetings where learning is shared and directed towards improvement.

A selection of these audits where specific learning or improvement has been identified includes:

The colorectal surgery team audited practice within their team undertaking procedures in the out-patient department. From this, they were able to quantify the number of procedures being completed and the grade of doctor performing them. As a result, the team were able to implement improvements in coding to ensure accurate records were kept and that the correct tariff was being applied.

Hammersmith General ICU reviewed the common practice of fasting patients prior to invasive procedures and were able to make improvements to safely reduce the length of time that ICU patients are kept nil by mouth.

The diabetes team looked at the causes of the delays in discharge experienced by some of the patients on a diabetic foot pathway. This has led to redesign of some clinical pathways around larvae therapy, vacuum assisted closure of wounds and time to theatre.

The trauma and orthopaedic team audited the time to first review and subsequent treatment for patients sustaining hand and wrist fractures. They identified unacceptable delays and have been able to reduce these by modifying patient pathways, improving communication and developing a new virtual fracture clinic. This has been successfully funded in the pilot stage by an NIHR-CLAHRC grant application.

The neurology team have audited the presentation and management of patients with papilloedema in the trust via a number of complex pathways. This is a complex referral system form a regional catchment area including emergency departments, GPs, ophthalmology units and opticians. They have been able to identify potential delays in the pathway and ways to streamline this. These are under discussion with stakeholders to agree a more efficient regional process.

The neurosurgery team reviewed their practice and performance in the provison of driving advice to patients treated for non-traumatic sub arachnoid haemorrhage. They identified a number of areas for improvement and have undertaken a programme of education for their junior medical staff.

The paediatric ophthalmology service audited their practice and performance to identify any serious complications of strabismus surgery. The audit identified no areas of concern.
The maternity team audited the prevalence and outcomes of recorded major obstetric haemorrhage and the use of the trust protocol. Outcomes were generally good however they were able to identify areas for improvement in identification of risk factors, reporting, use of tranexamic acid and cell salvage. This is now a ‘rolling audit’ and will be revisited to confirm ongoing improvement.

The trauma and orthopaedic surgery department conducted an audit of the use of aspirin for VTE prophylaxis in hip and knee arthoplasty. This identified that aspirin is safe and effective in selected patients. The department is reviewing the trust guidelines and agreement for future standards with the trust thrombosis committee.

The anaesthetic team conducted an audit of the preoperative fasting of patients before elective surgery and advice given to patients. They found considerable variation in advice and practice and have revisited the guidance and initiated an education programme for staff. This is now an area of joint working between the anaesthetic team and the trust quality improvement team.

Appendix C: Quarterly Learning From Deaths Dashboards

Imperial College Healthcare NHS Trust : Learning from Deaths Dashboard - January 2017-18

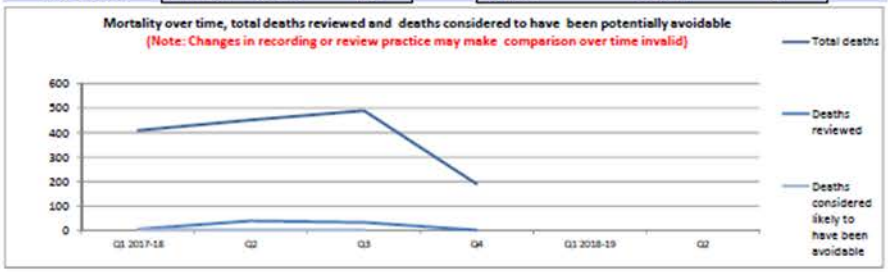
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
190	162	2	6	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
190	490	2	33	0	3
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1541	0	80	0	7	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

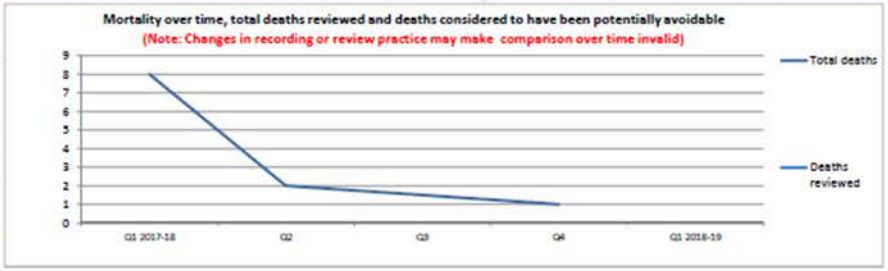
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	2	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	100.0%
This Year (YTD)	1	1.3%	This Year (YTD)	3	3.8%	This Year (YTD)	3	3.8%	This Year (YTD)	7	8.8%	This Year (YTD)	14	17.5%	This Year (YTD)	52	65.0%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
11	0	2	0	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



Glossary

Academic Health Science Centre (AHSC) – a partnership between one or more universities and healthcare providers focusing on research, clinical services, education and training. AHSCs are intended to ensure that medical research breakthroughs lead to direct clinical benefits for patients.

Accessible Information Standard (AIS) – launched in August 2016, the standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services.

Anti-infectives – drugs that are capable of acting against infection. They include antibacterials, antifungals and antivirals. These agents are often referred to collectively as antibiotics.

Avoidable infections – within the Trust we define 'avoidable infections' as: a case of MRSA BSI occurring 48 hours after admission; and a case of *Clostridium difficile* that is both PCR and toxin (EIA) positive occurring 72 hours after hospital admission when there is non-compliance with the antibiotic policy or the patient crossed pathways with a known case of the same ribotype (a method used to compare the genetic relatedness of different *C. difficile* strains).

Big Room - A big room is a regular standardised meeting which provides time and space for a range of staff and patients to come together to discuss improvements to the quality of patient care.

Carbapenem-resistant Enterobacteriaceae (CRE) - gram-negative bacteria that are resistant to the carbapenem class of antibiotics. They are resistant because they produce an enzyme called a carbapenemase that disables the drug molecule

Cardiac Arrest – also known as cardiopulmonary arrest or circulatory arrest, a cardiac arrest is a sudden stop in blood circulation due to the failure of the heart to contract effectively or at all.

Cardiotocography - a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. The machine used to perform the monitoring is called a cardiotocograph, more commonly known as an electronic fetal monitor (EFM).

Care Quality Commission (CQC) – the independent regulator of health and social care in England. It makes sure health and social care services provide people with safe, effective, caring, well-led and responsive care, and encourages care services to improve.

Cerner - supplier of health information technology (HIT) solutions, services, devices and hardware

Clinical Coding – the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised. The use of codes ensures the information derived from them is standardised and comparable.

Clinical Guidelines – these are recommendations of how healthcare professionals should care for people with specific conditions. They can cover any aspect of a condition and may include recommendations about providing information and advice, prevention, diagnosis, treatment and longer-term management. They aim to help health professionals and patients make the best decisions about treatment or care for a particular condition or situation.

Clinical Nurse Specialist (CNS) – provide expert advice related to specific conditions or treatment pathways. They focus on improving patient care and developing services.

Clostridium difficile – an anaerobic bacterium that can live in the gut of healthy people where it does not cause any problems, as it is kept in check by the normal bacterial population of the intestine. However, some antibiotics used to treat other illnesses can interfere with the balance of bacteria in the gut which may allow *C. difficile* to multiply and produce toxins that damage the gut. Symptoms of *C. difficile* infection range from mild to severe diarrhoea and more unusually, severe inflammation of the bowel.

Core Skills Training – nationally defined and mandated training programmes which all Trust staff must complete in accordance with the requirements of their roles.

CQUIN - Commissioning for Quality and Innovation (CQUIN) is a payment framework that allows commissioners to agree payments based on agreed quality improvement and innovation work.

Datix – patient safety and risk management software for healthcare incident reporting and adverse events. This is the system the Trust uses to report incidents, manage risk registers and as of 1st April 2016, to record mortality reviews.

Departmental Safety Coordinator (DSC) – appointed by departmental managers to assist them in meeting their health, safety and wellbeing responsibilities.

DNA ('did not attend') – when a patient misses a hospital appointment.

Driver Diagrams – a visual model used in quality improvement (QI) methodology that identifies all the things that must in place to achieve an aim by breaking it down into small steps that can be directly influenced with change ideas and can be measured.

Dr Foster – provider of healthcare variation analysis and clinical benchmarking.

Duty of Candour – Secondary care providers registered with CQC in England are subject to a statutory duty of candour, introduced in November 2014. It is a statutory requirement to ensure that patients and their families are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and are supported throughout.

Emergency readmissions – unplanned readmissions that occur within 28 days after discharge from hospital. They may not be linked to the original reason for admission.

Five moments - The My 5 Moments for Hand Hygiene approach defines the key moments when health-care workers should perform hand hygiene.

Flow – the progressive movement of people, equipment and information through a sequence of processes. In healthcare, the term generally denotes the flow of patients between staff, departments and organisations along a pathway of care.

Flow coaching - providing training to build team coaching skills and improvement science at care pathway level

Friends and Family Test (FFT) – The NHS FFT was launched in 2013 to help service providers and commissioners understand whether their patients are happy with the service provided. It is a quick and anonymous way for patients to give their views after receiving care or treatment.

General Medical Council (GMC) – The GMC regulates doctors in the United Kingdom. They set standards, hold a register, quality assure education and investigate complaints.

Getting it Right First Time (GIRFT) – is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.

Hospital Episode Statistics (HES) - HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.
This data is collected during a patient's time at hospital and is submitted to allow hospitals to be paid for the care they deliver.

Hospital Standardised Mortality Ratio (HSMR) – an overall quality indicator that compares a hospital's mortality rate with the average national experience, accounting for the types of patients cared for.

Information Governance – ensures necessary safeguards for, and appropriate use of, patient and personal information.

Integrated Care – NHS England has recently changed the name of accountable care systems to integrated care systems. Integrated care happens when NHS organisations work together to meet the needs of their local population.

IR(ME)R – the Ionising Radiation (Medical Exposure) Regulations 2000 is legislation which provides a framework intended to protect patients from the hazards associated with ionising radiation.

Local Faculty Group – a group in each department which meets regularly to take responsibility for the learning environment, and undergraduate and postgraduate training in that service.

Luer lock - an industry standard tapered termination utilized by most syringe manufacturers including medical Hypodermic syringes. Luer Lock needles are common because their design is controlled by a series of universal standards which guarantees compatibility between manufacturers.

Medical Appraisal - all doctors must undertake and record an annual medical appraisal in order to demonstrate that they comply with Good Medical Practice as required by the GMC.

Medical Devices – any instrument, apparatus, material, software or healthcare product, excluding drugs, used for a patient or client for:

- diagnosis, prevention, monitoring, treatment or alleviation of disease;
- diagnosis, monitoring, treatment or alleviation, or compensation for, an injury or handicap;
- investigation, replacement or modification of the anatomy or a physiological process;
- control of conception

Methicillin-resistant *Staphylococcus aureus* (MRSA) – a type of bacteria that's resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections. Staphylococcus aureu is a common type of bacteria. It's often carried on the skin and inside the nostrils and throat. If the bacteria get into a break in the skin, they can cause life-threatening infections, such as blood poisoning or endocarditis.

Model for improvement - a method for structuring an improvement project, guiding the development of an idea and testing it out using a simple framework. The model consists of two parts: 1) Three questions help us define what we want to achieve (aim), what ideas we think might make a difference (change ideas), and how we'll know if a change is an improvement (measures). 2) PDSA (Plan Do Study Act) cycles to implement and test change ideas. Multiple PDSA cycles allows the change to be refined and improved through repeated cycles of testing and learning as a vehicle for continuous improvement.

National Reporting and Learning System (NRLS) – the NRLS enables patient safety incident reports to be submitted to a national database on a voluntary basis and is designed to promote learning. Participation enables us to compare our incident reporting rates with our peers.

Never events – serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

NEWS – national early warning score is a score allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital

Outpatient parenteral antimicrobial therapy (OPAT) - OPAT is the administration of intravenous antimicrobial therapy to patients in an outpatient setting or in their own home.

Palliative Care – a multidisciplinary approach to specialised medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, physical stress, and mental stress of a serious illness, whatever the diagnosis. Palliative care is normally offered to terminally ill patients, regardless of their overall disease management style, if it seems likely to help manage symptoms such as pain and improve quality of life.

Patient advice & liaison service (PALS) – PALS offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Patient led assessments of the care environment (PLACE) – A national system for annually assessing the quality of the patient environment in hospitals, hospices and day treatment centres providing NHS funded care. The assessments see local people go into hospitals as part of teams to assess how the environment supports privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. Results are reported publicly to help drive improvements.

Patient reported outcome measures (PROMs) – tools we use to measure the quality of the service we provide for specific surgical procedures. Patients complete two questionnaires at different time points, to see if the procedure has made a difference to their health.

Patient safety incident – any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. Patient safety incidents are categorised by harm level, defined as follows by the NRLS:

- Near miss –incident that had the potential to cause harm but was prevented, resulting in no harm.
- No harm – incident that ran to completion but no harm occurred.
- Low harm: incident that required extra observation or minor treatment and caused minimal harm.
- Moderate harm: incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm.
- Severe harm: incident that appears to have resulted in permanent harm.
- Extreme harm/death: incident that directly resulted in the death of one or more persons.

Patient safety translational research centre (PSTRC) - The NIHR Imperial Patient Safety Translational Research Centre (PSTRC) is part of National Institute for Health Research (NIHR). It is a partnership between Imperial College Healthcare NHS Trust and Imperial College London, with researchers from a specialised set of research groups working together to improve patient safety and the quality of healthcare services.

Performance Development Review (PDR) – our annual performance review process for all staff, excluding doctors, which is aimed at driving a new performance culture across the Trust.

Patient-Led Assessments of the Care Environment (PLACE) - system for assessing the quality of the patient environment. The assessments primarily apply to hospitals and hospices providing NHS-funded care in both the NHS and private/independent sectors but others are also encouraged and helped to participate in the programme.

Pressure ulcer – a type of injury that affect areas of the skin and underlying tissue. They are caused when the affected area of skin is placed under too much pressure. They can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle.

Quality Improvement (QI) – is a formal approach to the analysis of performance and systematic efforts to improve it. It is a method for developing, testing and implementing changes so that improvements can be made quickly.

Referral to Treatment (RTT) – consultant-led Referral To Treatment (RTT) waiting times, which monitor the length of time from referral through to elective treatment.

Responsible Officer - individuals within designated bodies who have overall responsibility for helping doctors with revalidation.

Revalidation – the process by which all licensed doctors and nurses are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field.

Radio-frequency identification (RFID) – technology which uses radio waves to identify, authenticate, track and trace objects or devices. RFID has two main components: a tag and a reader

Root Cause Analysis (RCA) – a systematic investigation that looks beyond the people concerned to try and understand the underlying causes and environmental context in which the incident happened. Serious incidents and never events undergo RCA as part of the investigation.

Safe Effective Quality Occupational Health Services (SEQOHS) - set of standards and a voluntary accreditation scheme for occupational health services in the UK and beyond. SEQOHS accreditation is the formal recognition that an occupational health service provider has demonstrated that it has the competence to deliver against the measures in the SEQOHS standards.

Safeguarding – protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care.

SBAR – an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication.

Schwartz Rounds – meetings which provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work. Research shows the positive impact that they have on individuals, teams, patient outcomes and organisational culture.

Secondary Users Service (SUS) – the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

Serious Incident (SI) – events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

Standardised hospital mortality indicator (**SHMI)** – a national way of measuring mortality. It includes deaths related to all admitted patients that occur in all settings – including those in hospitals and those that happen 30 days after discharge.

Stakeholder – a person, group, organisation, member or system who affects or can be affected by an organisation's actions.

Structured judgement review (SJR) - based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

Student Online Evaluation (SOLE) – online module evaluation which gives medical students the opportunity to feedback on their experience in a simple, secure and confidential way.

Venous thromboembolism (VTE) – a blood clot within a blood vessel that blocks a vein or an artery, obstructing or stopping the flow of blood.

Ward accreditation programme (WAP) – Reviews of patient areas during which patient care is observed, documentation reviewed, the environment assessed and discussion with patients, carers and staff members takes place.

WHO checklist – The World Health Organization Surgical Safety Checklist ensures that surgical teams have completed the necessary listed tasks to ensure patient safety before, during and after surgery.

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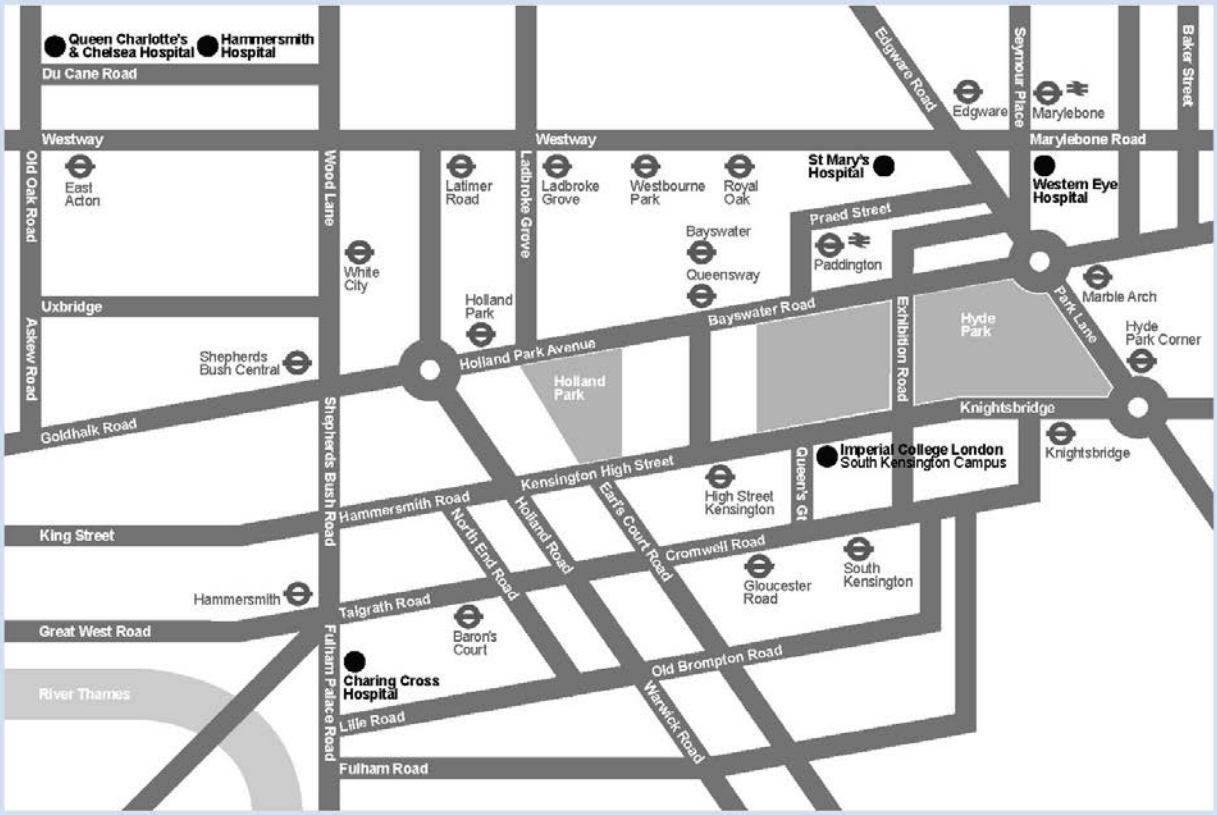

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Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	23 May 2018

NHS Improvement self-certification declarations

Executive summary:

Introduced in April 2017, NHS Improvement require that NHS trusts, as foundation trusts (FT) have always been required to do, self-certify compliance against a number of specific declarations.

The self-certification declarations in this paper are, in essence, FT Licence requirements. However, the introduction of NHS Improvement's (NHSI) Single Oversight Framework in 2016/17 bases its oversight along similar lines, and NHS trusts are required to comply with conditions equivalent to the licence that NHS Improvement has deemed appropriate.

The Trust company secretary would contend that sufficient assurance has been provided to the Trust board during 2017/18 (and continues to be provided) to enable the Trust board to confirm that the declarations made in Appendix Two (for G6 and FT4) are considered to be an accurate reflection of the Trust's position.

Following review and discussion, the Trust board is asked to support the proposed declaration as follows:

- Condition G6(3)
  Not later than two months from the end of the Financial Year (by 31 May 2018), the Trust board ('the Licensee') is required to self-certificate to the effect that it "Confirms" or "Does not confirm" that it has taken all precautions necessary to comply with the licence, NHS acts and the NHS Constitution.

  It is recommended that the Trust board formally sign-off the Self-Certification for Condition G6 as "Confirmed".

- Condition FT4 (8)
  By 30 June 2018, the Trust board is required to self-certificate "Confirmed" or "Not confirmed" to compliance with required governance standards and objectives.
  It is recommended that the Trust board formally sign-off the Self-certification for Condition FT4 as "Not confirmed for (a) and confirmed for (b-h)".

All Self-Certifications will be made public on the Trust's website within one month of the highlighted self-certification deadlines.

Quality impact:

The self-assessment statements and the board assurance framework that enables these to be confirmed, are a key element of the Trust corporate governance arrangements, and link clearly with NHS Improvement/CQC Well-led assessments.

Financial impact:

The paper as outlined has no direct financial impact.

Risk impact:

The introduction of these Board self-assessment statements forms part of NHS Improvement's assurance and oversight mechanism, strengthening the Single Oversight Framework, and as part of the revised NHS Improvement/CQC Well-led assessments.

The Trust has clear risk management arrangements and a comprehensive board assurance framework that enables potential risks within these areas of activity to be identified, managed and mitigated.

Recommendations to the Trust board:

The Trust board is asked to:

- review the board self-certification statements and definitions of the requirements of those statements;
- consider whether the evidence outlined constitutes sufficient assurance for the Trust board to be in a position to complete the self-certification statements;
- confirm that the statements made in Appendix Two (for G6 and FT4) are considered to be an accurate reflection of the Trust's position (recognising that the annual governance statement will have been submitted by the end of May 2018)
- approve statements FT4 and G6 (in Appendix Two) being published on the Trust's publication scheme on the website
- note that NHS Improvement may audit that self-certification has been completed
- note the fuller review of compliance with the Provider Licence provided in Appendix Three.

Trust strategic objectives supported by this paper:

To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Author	Responsible executive director	Date submitted
Jan Aps for Peter Jenkinson, Trust company secretary	Prof Julian Redhead, Interim chief executive	14 May 2018

Imperial College Healthcare NHS Trust

NHS Improvement self-certification declarations

Introduction

The Provider Licence is part of the legislative framework of foundation trusts, rather than NHS trusts. However, directions from the Secretary of State require the Trust Development Agency (now operating as NHS Improvement) to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate, including giving directions to an NHS trust where necessary to ensure compliance. NHS Improvement, in the way it is now requiring NHS trusts to report against licence conditions, is making it clear that it intends to use the requirements of the Licence directly (rather than create an aligned framework) as part of its oversight arrangements.

Introduced in April 2017, NHS Improvement require that NHS trusts, as foundation trusts (FT) have always been required to do, self-certify compliance against a number of specific statements. However, the introduction of NHS Improvement's (NHSI) Single Oversight Framework bases its oversight along similar lines.

During development of the new board assurance framework in 2016/17, it was agreed to introduce similar statements from the executive team to the Trust board to provide a further layer of assurance. Executive directors were asked to confirm the status against these statements in September 2017, and again in preparation for the board approval of the NHS Improvement self-certification statements outlined in the paper – these are attached as Appendix One.

The specific requirements of the two conditions, FT4 and G6 are detailed below, with simulated template submission forms attached as Appendix Two. The Trust is not, as yet, required to submit the forms enclosed, merely to assure itself as to the Trust's position against the conditions within the statements.

A list of the evidence of assurance that has been provided to the Trust board and its committees in the last year is provided below.

Requirements of the specified conditions

Condition FT4

Condition FT4 requires that:

- the [Licencee] Trust shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS (such systems and processes are detailed on the self-certification form)
- the [Licencee] Trust shall submit to [Monitor] NHS Improvement within three months of the end of each financial year:
  - a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial and any actions it proposed to take to manage such risks.

Condition G6

Condition G6(2) requires NHS trusts to have processes and systems that:

- identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring.

Providers must annually review whether these processes and systems are effective. Providers must publish their G6 self-certification within one month following the deadline for sign-off.

Evidence of assurance in relation to the NHS Improvement self-certification statements:

The Trust board and its committees receive assurance in relation to the requirements of the specified conditions in a number of ways through the year. These include:

- Executive self-assessment statements (Appendix One)
- Board assurance statement (reviewed and approved by the Trust board in November 2017, and an agenda item on this Trust board agenda)
- Annual governance statement (draft reviewed by Audit, risk & governance committee (ARG) in April 2018, final to be approved for submission by ARG on 23 May 2018)
- Quality account (draft reviewed by ARG in April 2018, final to be approved for submission by ARG on 23 May 2018)
- Corporate risk register (provided to ARG on a quarterly basis, and the Trust board on a six-monthly basis), and comprehensive risk registers in place below this
- Annual internal audit review of the risk management arrangements (provided to ARG – *reasonable assurance* rating received) and board assurance framework (provided to ARG – *substantial assurance* rating received)
- Chief executive's report to Trust board (provided to the Trust bi-monthly)
- Board committee reports (provided to Trust board – public, following each committee)
- Board committee minutes (provided to Trust board – private, once confirmed as accurate; audit minutes provided to Trust board – public)
- CQC report to Trust board – public, bi-monthly
- Board seminar presentations from divisions and areas of interest (eg education; research; integrated care), bi-monthly.

Audit of self-certification

NHS Improvement will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified. This can either be through providing the templates if they have used them, or by providing relevant Trust board minutes and papers recording sign-off.

Provider Licence conditions

Appendix Three outlines each of the conditions and the definitions of the Provider Licence, and also describes the Trust's position in relation to each of them.

Appendix One

Executive governance statements for Trust board – May 2018

SAFE	Executive lead
Q1. *The Trust board can be satisfied that, to the best of the Executive's knowledge, the Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.* *(This takes account of NHSI's oversight model, CQC information and its own data on serious incidence and patterns of complaints)* **Director response:** Yes **Explanation, where response is No:**	Prof Tim Orchard / Dr Bill Oldfield, Medical directors Prof Tim Orchard, Dr Katie Urch, Prof TG Teoh Divisional directors
Q2. *The Trust board can be satisfied that plans in place are sufficient to ensure on-going compliance with the Care Quality Commission's registration requirements.* **Director response:** Yes **Explanation, where response is No:**	Janice Sigsworth, Director of nursing Prof Tim Orchard, Dr Katie Urch, Prof TG Teoh Divisional directors
Q3. *The Trust board can be satisfied that processes and procedures are in place to ensure all clinical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.* **Director response:** Yes **Explanation, where response is No:**	Prof Tim Orchard / Dr Bill Oldfield, Medical directors Prof Janice Sigsworth, Director of nursing
EFFECTIVE	**Executive lead**
Q4. *The trust board can be satisfied that appropriate clinical audit arrangements are in place to ensure effective care and treatment is received in line with legislation, standards, evidence based guidance and service change.* **Director response:** Yes **Explanation, where response is No:**	Prof Tim Orchard / Dr Bill Oldfield, Medical directors
CARING	**Executive lead**
Q5. *The trust board can be satisfied that the trust takes appropriate measures to engage patient and public involvement in the development of services and in shaping patient care.* **Director response:** Yes **Explanation, where response is No:**	Michelle Dixon, Director of Communications
Q6. *The trust board can be satisfied that patients are treated with kindness, dignity, respect and compassion.* **Director response:** Yes **Explanation, where response is No:**	Prof Janice Sigsworth, Director of nursing
RESPONSIVE	**Executive lead**
Q7. *The Trust board can be satisfied that plans in place are sufficient to ensure on-going compliance with all existing operational targets and a commitment to comply with all known targets going forward.* **ICHT Response:** No **Explanation, where the response is No:** <u>Emergency department:</u> The Trust is not currently achieving the national standard to see, treat and discharge 95 per cent of patients that present to an urgent or emergency care setting within four hours. The key drivers of this underperformance are rising demand, increasing acuity and high levels of inpatient bed occupancy. There are a number of initiatives underway across the Trust that aim to improve our ability to move patients through our urgent and emergency pathways as effectively as possible. The plan is supported by a trajectory for improvement, agreed with our commissioners and approved by NHS Improvement, which will bring performance to 95 per cent by the end of March 2019. The Trust's 'four-hour A&E access' improvement programme is led by the division of medicine and integrated care and progress is reported to the Executive Operational Performance Committee. There are six work streams, each led jointly by a clinician and manager. These are: • Improving emergency department processes • Improving specialist decisions and pathways	Prof Tim Orchard, Dr Katie Urch, Prof TG Teoh Divisional directors

• Developing real-time bed management • Improving ward processes • Working with external partners to improve pathways into and out of hospital • Improving our infrastructure. Each scheme includes a plan of delivery with clear measurement of the impact of the change and its effect on the minimising breaches of the four-4 hour standard. The biggest risk to delivery of the trajectory remains rising demand. Winter 2017/18 has seen unprecedented demand and any further increase above that planned would stretch current resources well beyond capacity. <u>Referral to treatment for elective care:</u> The Trust is not currently achieving the national standard with respect to referral to treatment (RTT) within 18 weeks, and more than 200 patients have had to wait in excess of 52 weeks. The key drivers for this underperformance include: increasing demand on limited elective capacity (surgical, diagnostic and outpatient – especially impacted by the emergency pressures seen in Winter 2018), limited training for staff to interact correctly with IT systems and consequently poor data quality. These key drivers are being addressed via seven work streams: 1) Waiting list recovery – focus on supporting long waiting patients through the system, using IST metrics to develop demand and capacity and trajectory mapping 2) Elective care operating framework – focus on developing high quality user validation dashboards, supporting training and recruitment programs, link to correct input and performance. Use QI methodology and engagement to ensure adherence to SOP, GIRFT and rapid improvement cycles. 3) Digital optimisation – on-going work to improve the data extraction and BI reporting suite 4) Clinical harm reviews – patient safety and review 5) Oversight and governance – reporting to CEO; CCG, NHSI/ NHSE, POM 6) Audit framework – DQI / external audit / external assurance check 7) Data clean up – focus on validation and cleansing of current PTL (Inpatient and outpatient waiting list complete) Each workstream has a lead and reports through the internal to external reporting framework. The agreed trajectories suggest a focused reduction in over 52 week waiting to zero long waiters by July 2018 (with acknowledgement that pop-ons and in month tip overs will occur for some time). However the Trust is not expected to meet the 92 per cent RTT performance target until late in 2019.	
WELL-LED:	
Q8. *The Trust board can be satisfied that plans in place are sufficient to ensure on-going compliance with all existing financial targets and a commitment to comply with all known targets going forward.* **ICHT Response:** Yes **Explanation:** At the end of the year 2017/18, the Trust delivered its control total, and received £25.5m of STF. CIP savings of £43.1m were delivered, against a target of £54.0m, with a major factor in the under delivery this year being an extended period of significant winter pressures affecting elective activity, alongside capacity constraints and an ailing estate. The undelivered target will be carried over in to 2018/19. The Trust's control over its cash position and capital programme were significantly strengthened during the year resulting in the delivery of both our cash and capital targets. The improved cash control and the receipt of the STF meant that none of the approved working capital facility was required. The 2018/19 plan has been approved by the Board and submitted, to meet the control total of £20m deficit before STF, representing an improvement of over £10m in the underlying deficit but requiring another challenging CIP of £48.0m. The issue of going concern has been discussed at audit, risk and governance committee with the active engagement of external audit. The Trust still has access to the working capital facility provided by the Department of Health if required. If appropriate repayment conditions can be agreed then this short term facility may be converted into a more appropriate funding model during 2018/19. The condition of the majority of the Trust's estate is a cause of continuing concern reported elsewhere, however the financial drain of this on both capital and revenue resources, and significant estate deterioration could also call into account the going concern status of the Trust. The Trust has applied for additional capital support to make repairs and has also submitted a document outlining the vision for St Mary's redevelopment which sets out the need for major capital funding. The Trust board exercises much of its financial governance via the finance and investment committee and the audit, risk and governance committee; both of these committees are engaged in the oversight of the issues and actions outlined above.	Richard Alexander, Chief financial officer Prof Tim Orchard, Dr Katie Urch & Prof TG Teoh Divisional directors

Q9. *The Board can be satisfied that they will be proactively, reliably & independently advised as to the going concern status of the Trust and the issues impacting that status, as defined by the most up to date accounting standards in force from time to time and financial best practice.* **ICHT Response:** Yes **Explanation, where response is No:**	Richard Alexander, Chief financial officer
Q10. *An Annual Governance Statement is in place, and the Trust board can be satisfied that the Trust is compliant with the risk management and assurance framework requirements that support the Statement and that significant issues are included within the board assurance framework.* **ICHT Response:** Yes **Explanation, where the response is No:**	Peter Jenkinson Trust company secretary Prof Janice Sigsworth, Director of nursing
Q11. *The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.* **ICHT Response:** Yes **Explanation, where the response is No:**	Kevin Jarrold Chief information officer
Q12. *The Trust board will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; that all board positions are filled appropriately, and that plans exist to fill any vacancies as required.* **ICHT Response:** Yes **Explanation, where response is No:**	David Wells Director of people and organisational development Peter Jenkinson Trust company secretary
Q13. *Fit and proper persons: The Board can be satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.* **ICHT Response:** Yes **Explanation, where the response is No:**	David Wells Director of people and organisational development Peter Jenkinson Trust company secretary
Q14. *The Board can be satisfied that: the management team has the capacity, capability and experience necessary to deliver the Trust objectives; and the management structure in place is adequate to deliver the annual operating plan.* **ICHT Response:** Yes **Explanation, where the response is no:**	David Wells Director of people and organisational development
Q15. *The Trust board can be satisfied that the Trust seeks to remain at all times compliant with the NHSI Single Oversight Framework and shows regard to the NHS Constitution at all times. All current key risks to compliance have been identified and addressed – or there are appropriate action plans.* **ICHT Response:** Yes **Explanation, where the response is No:**	Prof Julian Redhead, Interim chief executive officer

Appendix 2

FT4 declaration for Imperial College healthcare NHS Trust

Corporate governance statement (FTs and NHS Trusts)		
The Trust board is required to respond 'confirmed' or 'not confirmed' to the following statements, settings out any risks and mitigating actions for each one where it is 'not confirmed'		
Corporate governance statement	**Response**	**Risks and mitigating actions**
1 The Trust board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of heat care services to the NHS	Confirmed	
2 The Trust board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	
3 The Trust board is satisfied that the Licensee has established and implements: (a) effective board and committee structures (b) clear responsibilities for its Trust board, for committees report to the Trust board and for staff reporting to the Trust board and those committees and (c) clear reporting lines and accountabilities throughout its organisation	Confirmed	
4 The Trust board is satisfied that the Licensee has established and effectively implements systems and/ or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively (b) For timely and effective scrutiny and oversight by the Trust board of the Licensee's operations (c) To ensure compliance with healthcare standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of healthcare professions (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/ or processes to ensure the Licensee's ability to continue as a going concern) (e) To obtain and disseminate accurate, comprehensive, timely and up-to-date information for the Trust board and committee decision-making (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence (g) To ensure compliance with all legal requirements	**Not confirmed**	Not confirmed for (a). The Trust is not currently achieving the national standard to see, treat and discharge 95 per cent of patients that present to an urgent or emergency care setting within four hours, or the national standard with respect to referral to treatment (RTT) within 18 weeks. The Trust achieved its control total for 2017/18 and, with allocated STF funding, achieved a year-end surplus of £3m. However the Trust continues to have an underlying deficit. The Trust Board approved the financial plan for 2018/19, to achieve the control total of £20m deficit, but recognises the risks in achieving the plan, including a CIP target of £48m.
5 The Trust board is satisfied that the systems and/or processes referred to in paragraph 4 should include but not be restricted to systems and/ or processes to ensure: (a) That there is sufficient capability at Trust board level to provide effective organisational leadership on the quality of care provided	Confirmed	

(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		
6 The Trust board us satisfied that there are systems to ensure that the Licensee has in place personnel on the Trust board, reporting to the Trust board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence	Confirmed	
Signed on behalf of the Trust board Signature . . . . . Signature . . . . . Name . . . . . Name		

Appendix 2 (cont)

G6 declaration for Imperial College Healthcare NHS Trust

Declaration required by General condition 6 of the NHS provider licence
The Trust board are required to respond 'Confirmed or Not confirmed to the following statements
1&2 General condition 6 – Systems for compliance with license conditions (FTs and NHS Trusts)
1 Following a review for the purpose of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution. **Confirmed** Signed on behalf of the Trust board of directors Signed . . . . . Signed . . . . . . Name . . . . . Name . . . . . . Capacity . . . . . Capacity . . . . . . Date . . . . . Date . . . . .

Appendix Three

PROVIDER LICENCE CONDITIONS AND COMPLIANCE				
Licence Condition and description		**Level of Compliance**	**Evidence/Board Assurance**	**Comment where non-compliant or at risk of non-compliance and required action**
SECTION 1: GENERAL				
G1	This condition requires 'licensees' to provide NHSI with any information they may require for licencing functions.	**Compliant**	The Trust has robust data collection and validation processes and has a good track record of producing and submitting large amounts of accurate, complete and timely information to regulators and other third parties to meet specific requirements. Weaknesses identified in the RTT arrangements have been comprehensively addressed, and Data Quality Steering Group introduced to oversee continued improvement and monitoring.	N/A
G2	This condition contains an obligation for all 'licensees' to publish such information as NHSI may require, in a manner that is made accessible to the public.	**Compliant**	The Trust is committed to operating in an open and transparent manner and has robust governance arrangements to ensure that required information is made accessible to the public. The Trust board meets in public and will continue to undertake the majority of Trust business in public meetings; agendas, minutes and associated papers are published on our website, and include a summary of business conducted in private. Our website contains a variety of information and referral point details providing advice to the public and referrers who may require further information about services. Copies of the Trust's Annual Report and Accounts and Quality Account are published on the website and the Trust operates a publication scheme for Freedom of Information requests.	N/A
G3	Payment of fees to NHSI The Health & Social Care Act 2012 ("The Act") gives NHSI the ability to charge fees and this condition obliges licence holders to pay fees to NHSI if requested.	N/A	No decision has yet been made by NHSI to charge fees. The Trust pays fees to other parties such as the Care Quality Commission and NHS Resolution (was NHSLA).	N/A

PROVIDER LICENCE CONDITIONS AND COMPLIANCE

Licence Condition and description		Level of Compliance	Evidence/Board Assurance	Comment where non-compliant or at risk of non-compliance and required action
G4	Fit and proper persons as Directors (also applicable to those performing equivalent or similar functions)	**Compliant**	All employment contracts contain a clause concerning possible termination in the event of gross misconduct. The Trust disciplinary policy defines misconduct. The Trust operates a rolling programme of Disclosure & Barring Service (DBS) checks for front line staff and for staff with access to sensitive information. The Trust board are subject to DBS checks on appointment. The Standing Orders contains relevant clauses for directors about eligibility, disqualification and removal.	N/A
G5	Having regard to Monitor/NHSI Guidance. This condition requires licensees to have regard to any guidance that NHSI issues.	**Compliant**	The Trust has had regard to NHSI guidance through submission of required annual and quarterly declarations, self-certifications and exception reporting as set out in the Single Oversight Framework and previous Compliance Frameworks.	N/A
G6	Systems for compliance with licence conditions and related obligations. This requires providers to take all reasonable precautions against the risk of failure to comply with the licence and other important requirements.	**Compliant**	The Trust has an approved risk management policy and a clear approach to identifying, managing, escalating and mitigating risk. The executive committee monitors risks across the organisation, and assurance provided to, and oversight given by, relevant board committees. The Trust has a robust board assurance framework which is reviewed on a six-monthly basis by the audit, risk and governance committee and Trust board. Internal and external audit reports on regulatory compliance are reviewed at the executive and audit, risk and governance committees.	N/A
G7	Registration with the Care Quality Commission. This licence condition requires providers to be registered with the Care Quality Commission and to notify NHSI if registration is cancelled.	**Compliant**	The Trust has full registration of all services with the CQC.	N/A

PROVIDER LICENCE CONDITIONS AND COMPLIANCE				
Licence Condition and description		**Level of Compliance**	**Evidence/Board Assurance**	**Comment where non-compliant or at risk of non-compliance and required action**
G8	Patient eligibility and selection criteria. This condition requires licence holders to set transparent eligibility and selection criteria for patients and to apply these in a transparent manner.	**Compliant**	The Trust publishes descriptions of the services it provides and who the services are for on the Trust website. Eligibility is defined through commissioners' contracts. Assurance is gained through the assessment stages to ensure that the appropriate services are provided.	N/A
G9	Application of Section 5 (Continuity of Services). This condition applies to all 'licensees'. 'Licensees' are required to - notify NHSI at least 28 days prior to the expiry of a contractual obligation if no renewal or extension has been agreed. - continue to provide the service on expiry of the contract until NHSI issues a direction to continue service provision for a specified period or is advised otherwise. Services shall cease to be CRS if: - commissioners agree in writing that there is no longer a service need and the regulator has issued a determination in writing that the service is no longer a CRS; or - the contract to provide a service has expired and the direction notice issued by NHSI specifying a further period of	**Compliant**	The Trust has strong working relationships with its commissioning partners within the local health economy. The Trust board has a director responsible for leading on contract negotiations. The Trust has a strong track record of delivering service transformation, efficiency, productivity and quality improvement to meet the needs of the local population.	N/A

PROVIDER LICENCE CONDITIONS AND COMPLIANCE				
Licence Condition and description		**Level of Compliance**	**Evidence/Board Assurance**	**Comment where non-compliant or at risk of non-compliance and required action**
	provision has expired. 'Licencees' are required under this Condition, to notify NHSI of any changes in the description and quantity of services which they are under contractual or legal obligation to provide.			
SECTION 2 - PRICING				
P1	Recording of information. Under this condition, NHSI may oblige licensees to record information, particularly information about their costs, in line with guidance to be published by Monitor/NHSI.	**Compliant**	The Trust records all of its information about costs in line with current guidance and will comply fully with any new guidance.	N/A
P2	Provision of information. Having recorded the information in line with Pricing condition 1 above, licensees can then be required to submit this information to NHSI.	**Compliant**	The Trust will comply fully with any new requirements to submit information to NHSI.	N/A
P3	Assurance report on submissions to NHSI When collecting information for price setting, it will be important that the submitted information is accurate. This condition allows NHSI to oblige licensees to submit an assurance report confirming that the information that they have provided is accurate.	**Compliant**	The audit risk and governance committee receives and monitors all internal audit reports including specific reports on pricing.	N/A
P4	Compliance with the National Tariff . The Health and Social	**Compliant**	The Trust will follow national guidance which is consistent with the NHS payment system, with a value based commissioning contract	N/A

PROVIDER LICENCE CONDITIONS AND COMPLIANCE				
Licence Condition and description		**Level of Compliance**	**Evidence/Board Assurance**	**Comment where non-compliant or at risk of non-compliance and required action**
	Care Act 2012 requires commissioners to pay providers a price which complies with, or is determined in accordance with, the National Tariff for NHS health care services. This licence condition imposes a similar obligation on licensees, i.e. the obligation to charge for NHS health care services in line with the National Tariff.		where variable payments are related to outcomes or activities.	
P5	Constructive engagement concerning local tariff modifications	**Compliant**	The Act allows for local modifications to prices. This licence condition requires licence holders to engage constructively with commissioners, and to try to reach agreement locally, before applying to NHSI for a modification. The Trust will follow national guidance which is consistent with the NHS payment system, with a value based commissioning contract where variable payments are related to outcomes or activities.	N/A
CHOICE & COMPETITION				
CI	The Right of patients to make choices. This condition protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider. This condition applies wherever patients have a choice under the NHS Constitution, or where a choice has been conferred locally by commissioners.	**Compliant**	The Trust complies fully with all guidance in relation to patient choice.	N/A

PROVIDER LICENCE CONDITIONS AND COMPLIANCE				
Licence Condition and description		**Level of Compliance**	**Evidence/Board Assurance**	**Comment where non-compliant or at risk of non-compliance and required action**
C2	Competition oversight. This condition prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users. It also prohibits licensees from engaging in other conduct that has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	**Compliant**	All licensed provider organisations will be treated as 'undertakings' under the terms of the Competition Act 1998. This means that all licensed providers will be deemed to be organisations engaging in an 'economic activity' for which the provisions of the Competition Act will apply. The Trust will ensure compliance with the Competition Act. The Trust board and executive committee have access to expert advice to ensure compliance with this condition.	N/A
INTEGRATED CARE				
IC1	Provision of integrated care. The licensee shall not do anything that could reasonably be regarded as detrimental to enabling integrated care	**Compliant**	The Trust is an active participant and leader in the local health and social care economy across the STP and is a formal member, working in partnership with commissioners of the Hammersmith and Fulham integrated care partnership. The Trust has a strong track record of working on integrated care pathways with other health and social care providers.	N/A
CONTINUITY OF SERVICES				
CoS1	Continuing provision of Commissioner Requested Services. This condition prevents licensees from ceasing to provide Commissioner Requested Services, or from changing the way in which they provides Commissioner Requested	**Compliant**	The Trust has strong working relationships with its commissioning partners within the local health economy. The Board has a director responsible for leading on contract negotiations. The Trust has a strong track record of delivering service transformation, efficiency, productivity and quality improvement to meet	N/A

PROVIDER LICENCE CONDITIONS AND COMPLIANCE				
Licence Condition and description		**Level of Compliance**	**Evidence/Board Assurance**	**Comment where non-compliant or at risk of non-compliance and required action**
	Services, without the agreement of relevant commissioners.		the needs of the local population.	
CoS2	Restriction on the disposal of assets. This licence condition ensures that licensees keep an up to date register of relevant assets used in the provision of Commissioner Requested Services. It also creates a requirement for licensees to obtain NHSI's consent before disposing of these assets when NHSI is concerned about the ability of the licensee to carry on as a going concern.	**Compliant**	The Finance Department maintains a capital asset register for all depreciable assets valued at over £5,000 on purchase, or group assets valued individually over £1,000, and when grouped together functionally, valued at more than £5,000. The Estates Department maintains a property and property leases register. The Procurement Department a register of contracts (including non-estates leases).	N/A
CoS3	Standards of Corporate Governance and Financial Management. This condition requires licensees to have due regard to adequate standards of corporate governance and financial management. The single Oversight Framework will be utilised by NHSI to determine compliance The Trust has a corporate Governance manual containing a suite of governance documents including: - An overarching corporate governance framework; - Standing Financial Instructions; and - Reservation and Delegation of Powers to the Board.	**Compliant**	Governance and financial reports to the Trust board meetings and board committees confirming details of the Trust's governance and financial management and information which supports the Governance and Continuity of Services declarations, including: - standing orders Scheme of reserved and delegated powers Standing financial instructions and delegated financial authorities - Board assurance framework	N/A

PROVIDER LICENCE CONDITIONS AND COMPLIANCE				
Licence Condition and description		**Level of Compliance**	**Evidence/Board Assurance**	**Comment where non-compliant or at risk of non-compliance and required action**
CoS4	Undertaking from the ultimate controller. This condition requires licensees to put in place a legally enforceable agreement with their 'ultimate controller' to stop ultimate controllers from taking any action that would cause licensees to breach the license conditions. This is best described as a 'parent/subsidiary company' arrangement.	N/A	This licence condition would not apply as the Trust is not an authorised NHS Foundation Trust.	N/A
CoS5	Risk Pool Levy. This licence condition obliges licensees to contribute, if required, towards the funding of the 'risk pool' – this is like an assurance mechanism to pay for vital services if a provider fails.	N/A	The regulatory Risk Pool Levy has not come into effect to date. The Trust currently contributes to the NHS Resolution(NHSLA) risk pool for clinical negligence, property expenses and public liability schemes.	N/A
CoS6	Cooperation in the event of financial stress. This licence condition applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with NHSI and any of its appointed persons in these circumstances in order to protect services for patients.	**Compliant**	As part of the single oversight framework the Trust has a score for Finance and use of resources based on 5 key metrics. The Trust has remained rated as a 3 throughout the year. The Trust has a track record of co-operating with external bodies and regulators.	N/A
CoS7	Availability of Resources. This licence condition requires licensees to act in a way that secures access to the resources needed to operate Commissioner Requested	**Compliant**	The Trust has forward plans and agreements in place with commissioners that meet this condition.	N/A

PROVIDER LICENCE CONDITIONS AND COMPLIANCE				
Licence Condition and description		**Level of Compliance**	**Evidence/Board Assurance**	**Comment where non-compliant or at risk of non-compliance and required action**
	Services.			
NHS FOUNDATION TRUST CONDITIONS				
FT1	Information to update the register of NHS Foundation Trusts.	N/A	This licence condition would not apply as the Trust is not an authorised NHS Foundation Trust.	N/A
FT2	Payment to NHSI in respect of registration and related costs.	N/A	If NHSI moves to funding by collecting fees, the Trust may need to comply with this licence condition. Monitor/NHSI would consult stakeholders before introducing such a fee.	N/A
FT3	Provision of information to advisory panel.	N/A	This licence condition would not apply as the Trust is not an authorised NHS Foundation Trust.	N/A
FT4	NHS Foundation Trust Governance arrangements. This condition will enable NHSI to continue oversight of governance of NHS Foundation Trusts and NHS Trusts. In summary, licensees are required to: (a) operate efficiently, economically and effectively; (b) have systems and processes and standards of good corporate governance; (c) have regard for the guidance published by NHSI; (d) have effective Board Committee Structures (e) have clear accountabilities and reporting lines throughout the organisation and maintain appropriate capacity and capability of the Board; (f) comply with healthcare	**Not compliant for (a)** **Compliant for (b) to (h)**	The Trust board undertakes regular review of: • board and committee effectiveness; • strategic objectives and risks to delivery through the board assurance framework, corporate risk register and annual plan • review of committee terms of reference; • standing financial instructions and reservation of powers to the board and delegation of powers. Other forms of assurance include: • Executive self-assessment statements • Managerial and professional lines of accountability and clinical leadership; • Audit, risk and governance committee scrutiny; • Corporate risk register, and annual internal audit of risk management arrangements; • Internal controls framework; • Internal and external audit reports; • Monthly integrated performance reports; • Annual appraisals and development plans; • Annual report and quality account; • Reports to the Trust board from committee chairs; • Divisional quality scorecards & dashboards;	Not confirmed for (a) (As per self-certification statement May 2018)

PROVIDER LICENCE CONDITIONS AND COMPLIANCE				
Licence Condition and description		**Level of Compliance**	**Evidence/Board Assurance**	**Comment where non-compliant or at risk of non-compliance and required action**
	standards; (g) have effective financial management, control and decision making; and (h) maintain accurate information		• Specialty or subject 'deep dives' at committees; • Strategies and policies kept under regular review; • Internal Well-led framework review.	

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	**23 May 2018**

Infection Prevention and Control (IPC), and Antimicrobial Stewardship Quarterly Report: Q4 2017/18

Executive summary:

- Two cases of Trust-attributed MRSA BSI were identified at the Trust during Q4. There have been three Trust-attributed MRSA BSI in FY 17/18, which is the same as in FY 16/17.
- There have been 63 cases of Trust-attributed *C. difficile* for the FY, which is the same as in FY 16/17. This means that ICHT had the third lowest rate of Trust-attributed *C. difficile* in the Shelford Group of hospitals.
- The bi-annual antibiotic point prevalence survey has found that all indicators of antibiotic prescribing quality are in excess of the target level of 90%.
- The first round of revised hand hygiene auditing will be performed throughout the Back to the Floor Thursdays in May. This programme aims to provide accurate hand hygiene compliance information for all inpatient areas to inform improvement initiatives.

Quality impact:

IPC and careful management of antimicrobials are critical to the quality of care received by patients at ICHT, crossing all CQC domains.

Financial impact:

No direct financial impact.

Risk impact:

The report highlights key risks related to IPC from the risk register, and how they are being managed.

Recommendation(s) to the Board:

To note.

Trust strategic objectives supported by this paper:

- To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
- To educate and engage skilled and diverse people committed to continual learning and improvements.
- As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care.
- To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Author	Responsible executive director	Date submitted
Eimear Brannigan, Interim Deputy DIPC. Jon Otter, Interim Head of Operations, IPC. Jan Hitchcock, IPC Interim General Manager.	Dr William Oldfield, Medical Director	3 May 2018

1 Healthcare-associated infection (HCAI)

1.1 *HCAI mandatory reporting summary*

Table 1 provides a summary of Public Health England's HCAI mandatory reporting, showing the number of cases by month.

	Apr-17		May-17		Jun-17		Jul-17		Aug-17		Sep-17		Oct-17		Nov-17		Dec-17		Jan-18		Feb-18		Mar-18		YTD	
	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	No. cases	Ceiling	**No. cases**	YTD (ceiling)
Trust MRSA BSI	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	**3**	**0**
Trust *C.difficile*	5	7	3	6	7	5	2	5	4	5	4	5	8	5	8	6	6	6	2	6	4	6	10	7	**63**	**69**
Trust *E.coli* BSI	6	-	8	-	6	-	5	-	5	-	5	-	10	-	10	-	5	-	3	-	6	-	4	-	**73**	**-**
Trust MSSA BSI	3	-	3	-	2	-	2	-	4	-	4	-	7	-	1	-	3	-	4	-	3	-	0	-	**36**	**-**

'Trust' refers to cases defined epidemiologically as having most likely been acquired in hospital. For MRSA, MSSA, and E. coli BSI Trust cases are those that are identified after two days of hospitalisation; for C. difficile, Trust cases are those that are identified after three days of hospitalisation.

Table 1: HCAI mandatory reporting summary.

1.2 *C. difficile*

There have been 63 Trust-attributed cases this financial year (FY), against an annual ceiling of 69 cases; Trust-attributed *C. difficile* was detected in 0.9% of 1766 stool specimens tested during Q4 (Figure 1). The Trust has a comprehensive set of measures in place to minimise antibiotic usage, especially antibiotics that are associated with *C. difficile* infection, and to reduce its transmission, including multidisciplinary clinical review of all cases, rapid feedback of lapses in care to prompt ward-level learning, and use of the Trust's serious incident framework to investigate lapses in care. To reduce the risk of transmission of multiple pathogens and to maximise the efficient use of resources, a business case for introducing an on-site hydrogen peroxide vapour (HPV) / ultraviolet (UV) room decontamination service has been approved and a tender process will begin in FY 18-19.

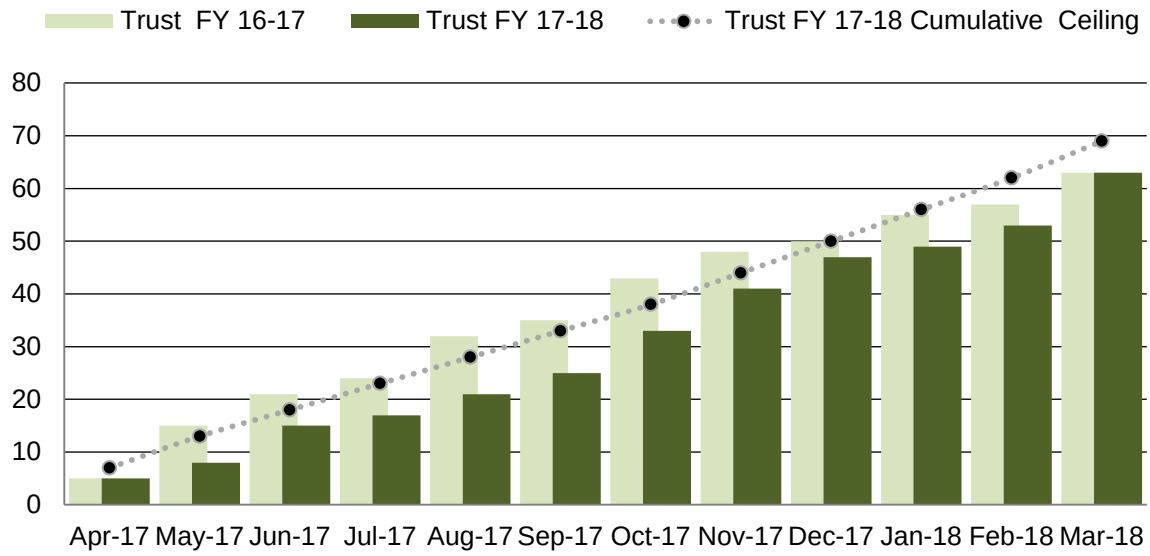

Figure 1: Cumulative monthly Trust-attributed C. difficile (PCR+/EIA+) in FY 17-18 (dark green bars) compared with FY 16-17 (light green bars).

1.2.1 *C. difficile*: lapses in care

There have been 16 cases of Trust-attributable *C. difficile* during Q4; three of these cases had lapses in care identified (Table 2). The three cases occurred on wards in the MIC division with one incidence of transmission and two related to antibiotic choices. This has prompted a ward-level investigation of potential transmission routes and feedback to the prescribers, wards, and Divisional management structures involved.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Total number of toxin positive cases 17/18	5	3	7	2	4	4	8	8	6	2	4	10
Specimens sent for *C.difficile* testing	547	615	558	553	551	589	682	597	582	601	569	596
Antibiotics												
No exposure	0	0	1	1	0	0	1	0	0	0	1	0
Prescribed as per policy	5	3	6	1	4	4	6	8	3	1	3	8
Outside of policy and action taken	0	0	0	0	0	0	1	0	3	1	0	2
Transmission												
No contact with other patients with *C. difficile*	3	2	6	1	2	4	5	5	4	2	3	6
Had contact with other patients with *C. difficile*	2	1	1	1	2	0	3	3	2	0	1	4
Lapse in care*	0	0	0	0	1	0	1	1	1	0	0	3

*The definition of a lapse in care associated with toxin positive *C. difficile* disease is non-compliance with the ICHT antibiotic policy, or potential transmission. Potential transmission is identified if, following a review of the patient's journey prior to the positive test, there is a point at which the patient shared a ward with a patient who was symptomatic with *C. difficile* positive diarrhoea of the same ribotype. Where there is patient contact but no lapses in care, this is because the patients had different *C. difficile* ribotypes.

Table 2: Summary of lapses in care related to C. difficile.

1.2.2 *C. difficile*: time to isolation

The Trust has a policy in place to isolate patients who develop diarrhoea within two hours of the start of their symptoms. 66% of patients were isolated within two hours of the start of their symptoms during Q4 (Figure 2). Failing to isolate promptly patients who are symptomatic with *C. difficile* infection introduces transmission risk and may have contributed to the increase in Trust-attributed *C. difficile* in Q4. However, the fact that only one case in Q4 was found to be a lapse in care due to cross transmission suggests that other factors also contributed to the increase in *C. difficile* in Q4.

Lack of policy awareness and poor documentation increased marginally in Q4, but lack of isolation rooms is the most common reason (16%) for not isolating patients within two hours of the start of their symptoms. On each occasion when a *C. difficile* case is not isolated within two hours, the IPCNs provide real-time feedback and education to the clinical team. This seeks to address the specific reason for non-compliance and is reinforced by a one-page training sheet, which is disseminated to the ward team. The importance of improving rapid isolation of patients with diarrhoea has been discussed with Divisions on the weekly HCAI Taskforce call, which has prompted Divisional action to improve compliance with this

policy. From Q1 18/19, a summary of time to isolation by Division will be included in the monthly IPC Scorecard.

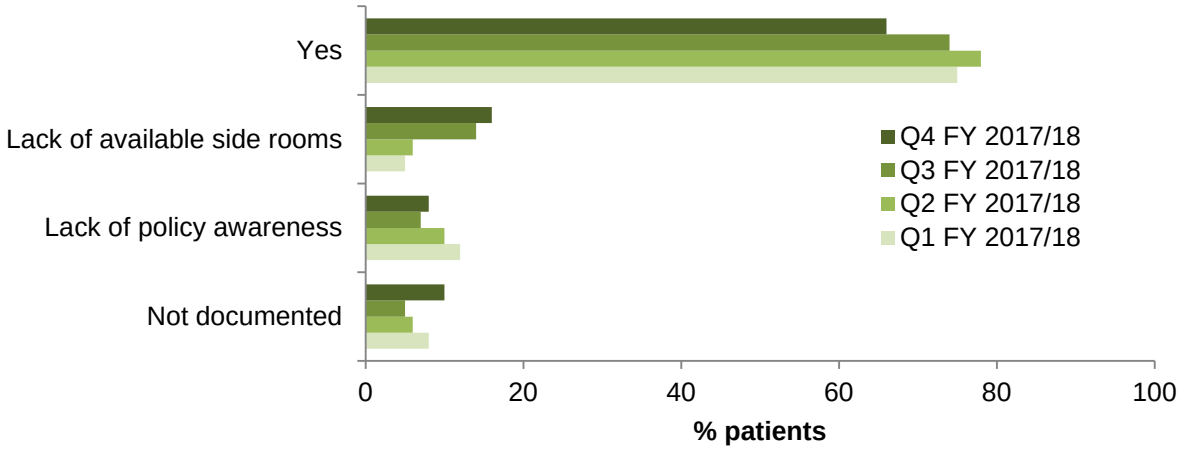

Figure 2: Compliance with isolation and reasons for non-compliance with the policy to isolate cases of diarrhoea within two hours of symptom onset for patients with C. difficile diarrhoea.

1.2.3 *C. difficile:* comparison with the Shelford group

Imperial has the 3rd lowest Trust-attributed *C. difficile* rate in the Shelford group of hospitals, based on 53 cases for the period Apr-18 to Feb-18 (using the latest available data from PHE) (Figure 3); this has improved from the last FY, where Imperial ranked 4th highest. The rate of specimens tested for *C. difficile* in the other Trusts is unknown, but remains broadly constant at ICHT (see Table 2).

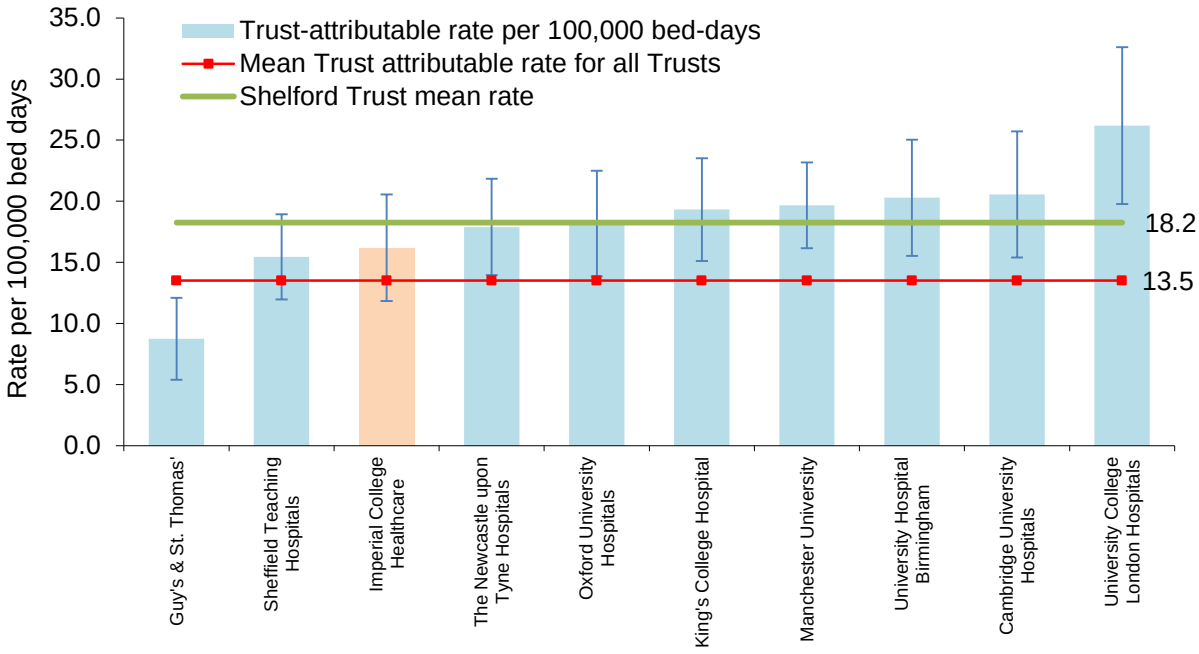

Figure 3: C. difficile Shelford Group comparison, FY 17/18. Error bars denote the 95% confidence interval around the rate for each hospital.

1.3 MRSA BSI

8754 blood cultures were tested during Q4. There were two cases of Trust-attributed MRSA BSI identified at the Trust during Q4. One case (in January 2018) was originally assigned as

a non-Trust case but was reallocated as a Trust case following an arbitration panel. This was in a renal patient who had a central line in place for an extended period, which may have contributed to the BSI. One case (in March 2018) was a surgical patient known to be MRSA colonised, who subsequently had a MRSA positive blood culture; the source of infection was considered to be either the skin or a surgical site infection. All Trust-attributed MRSA BSIs undergo a detailed investigation by IPC in conjunction with the clinical team involved to identify any learning points and implement any improvements in practice, which is reported to PHE.

Overall, there have been three Trust-attributed MRSA BSI in the FY. MRSA admission screening continues to be monitored monthly via the IPC Scorecard; compliance for Q4 was 88% (8680 of 9837 patients were screened). Patient-level validation exercises of MRSA admission screening data are in progress in several clinical areas to understand the reasons why some patients are not being screened. Findings will be included in the FY 18/19 report.

1.4 MSSA BSI

There have been seven cases of Trust-attributed MSSA BSI in Q4, and 36 cases this FY, compared with 30 in last FY. There is no national threshold for MSSA BSI at present. Four of the seven cases in Q4 were associated with a vascular access device (one associated with peripheral cannulae, two associated with an acute dialysis catheter, and one with an arterial catheter). Investigations have been conducted with the clinical team, with local action plans addressing the issues identified.

1.5 *E. coli* BSI

There have been 13 cases of Trust-attributed *E. coli* BSI in Q4, compared with 21 cases in Q4 FY 16/17 (Figure 4). Of these 13 cases, 9 had urinary sources (3 associated with urinary catheters), 2 with abdominal sources (both biliary), 1 with a vascular line source, and 1 was related to neutropenic sepsis. In each case, clinical management was advised by a microbiologist at the time of the result becoming available. There is no national threshold for *E. coli* BSI at present. Cases of *E. coli* BSI are reviewed monthly to identify any potential trends. Addressing the various sources of *E. coli* BSI, especially urinary sources, is a focus of multidisciplinary group working around reducing Gram-negative BSI (see section 1.5.2).

The total number of cases of *E. coli* BSI in FY 17/18 (73) is considerably lower than in FY 16/17 (102). This reduction has been noted in a letter from NHSI.

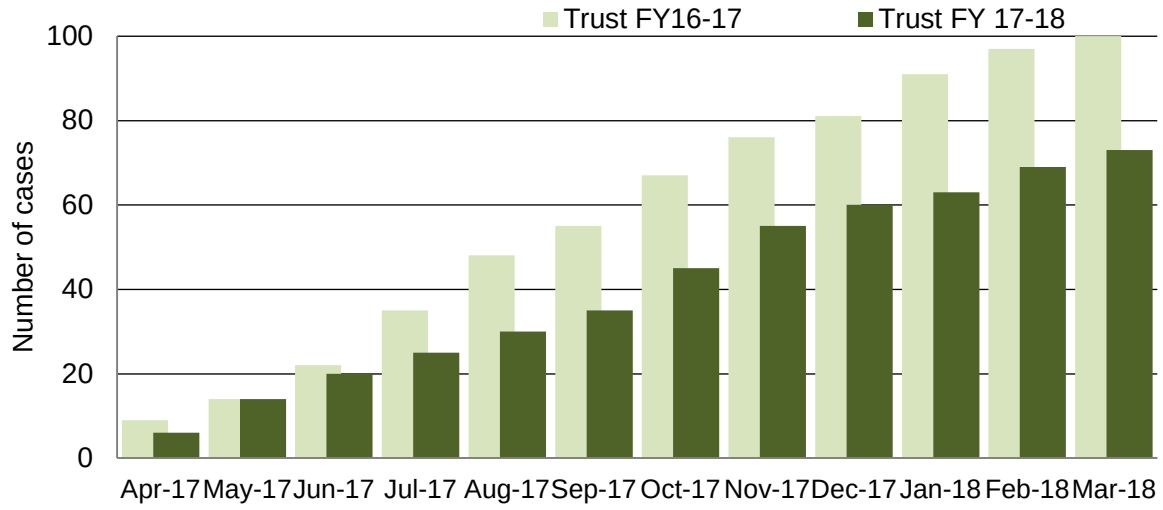

Figure 4: Cumulative monthly FY 17-18 Trust-attributed E. coli BSI (dark green bars) compared to FY 16-17 (light green bars).

1.5.1 *E.coli* BSI: comparison with the Shelford group

Imperial has the 5th highest rate in the Shelford group of hospitals for the combined rate of healthcare and community-associated *E. coli,* based on 338 cases for the period Apr-17 to Feb-18 (Figure 5); this is one rank lower than in Q3.

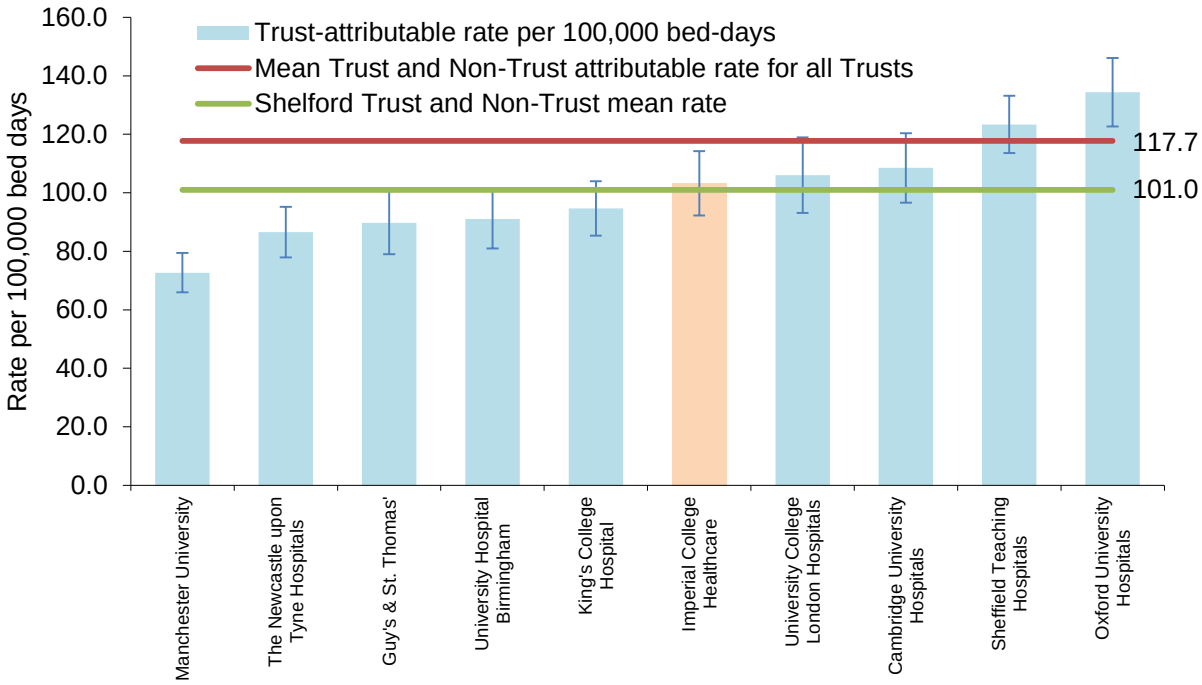

Figure 5: E.coli BSI Shelford Group comparisons, FY 17/18. Error bars denote the 95% confidence interval around the rate for each hospital.

1.5.2 Gram-negative BSI reduction target

Klebsiella pneumoniae and *Pseudomonas aeruginosa* BSIs are included in PHE's mandatory reporting scheme from April 2018. ICHT are already submitting these cases to PHE, and will begin including a quarterly summary in Q1 FY 18/19.

The government has announced an ambition to halve healthcare-associated Gram-negative BSI by 50% by 2021. No specific targets have been provided for acute care providers. The details of the Trust's approach to reducing Gram-negative BSIs were detailed in the Q2 report, encompassing enhanced case review and reporting to PHE including regular review of local antibiotic susceptibility and guidelines, supporting the CCG in investigating non-Trust attributed Gram-negative BSIs, close working with the sepsis identification and management plans in the Trust that may impact Gram-negative BSIs, improving the appropriate use of urinary catheters and hydration management with the nursing directorate, and planning new prevention initiatives in partnership with high-risk clinical areas (for example haematology, renal, NICU, and post-surgical wards).

NHSI have invited ICHT to an Executive Masterclass in May 2018 on addressing urinary-catheter associated BSIs. A representative of the Nursing Director's office and IPC will attend.

1.6 Surgical site infection

The Trust reports SSI rates following selected orthopaedic procedures in line with national mandatory reporting, and selected cardiothoracic procedures participating in a national voluntary reporting scheme.

1.6.1 Orthopaedics

The latest quarter (Jan – Mar 18) has seen:

- 1 SSI in 73 knee procedures so far recorded.
- 0 SSI in 43 hip procedures so far recorded.

The 12-month average for knee procedures is 0.3% (1 SSI in 344 operations) (national average 0.6%). The 12-month average for hip procedures is 0.5% (one SSI in 185 operations) (national average 0.6%).

1.6.2 Cardiothoracic

The latest quarter (Jan – Mar 18) has seen:

- 3 SSI of 58 CABG operations so far recorded.
- 0 SSI of 34 non-CABG operations so far recorded.

The 12-month average for CABG procedures is 4.0% (11 SSI in 291 operations) (national average 3.7%). The 12-month average for non-CABG procedures is 1.1% (2 SSI in 194 operations) (national average 1.2%).

1.6.3 Vascular SSIs

A serious incident is in progress to investigate the potentially high rate of SSI in Vascular (STEIS 2017/19226), in conjunction with ward-based transmission of CPE on ZCO and Albert wards. The resulting action plan is being finalised and will be presented monthly to the Surgical Infection Group.

1.7 *Carbapenemase-producing Enterobacteriaceae (CPE)*

1.7.1 Detection of CPE

Figure 6 provides a breakdown of CPE detected at the Trust by bacterial species and mechanism of resistance. The majority of cases are from screens, without evidence of clinical infection (Figure 7). The number of screens taken each month and number of new CPE cases detected have stabilised over Q3 and Q4.

1.7.2 CPE admission screening compliance

CPE admission screening compliance is summarised in Figure 8. CPE admission screening compliance is included by ward in the monthly Harm Free Care report, providing a mechanism to prompt ward-level action to address areas of low compliance. A target of 90% compliance with CPE admission screening has been agreed. Compliance has risen in Private Patients, probably in response to investigations and reminders in December 2017. However, admission screening compliance in Vascular has not improved. Vascular continue to review patient level data to understand why some patients are not screened, and will work with IPC to develop plans to improve local compliance.

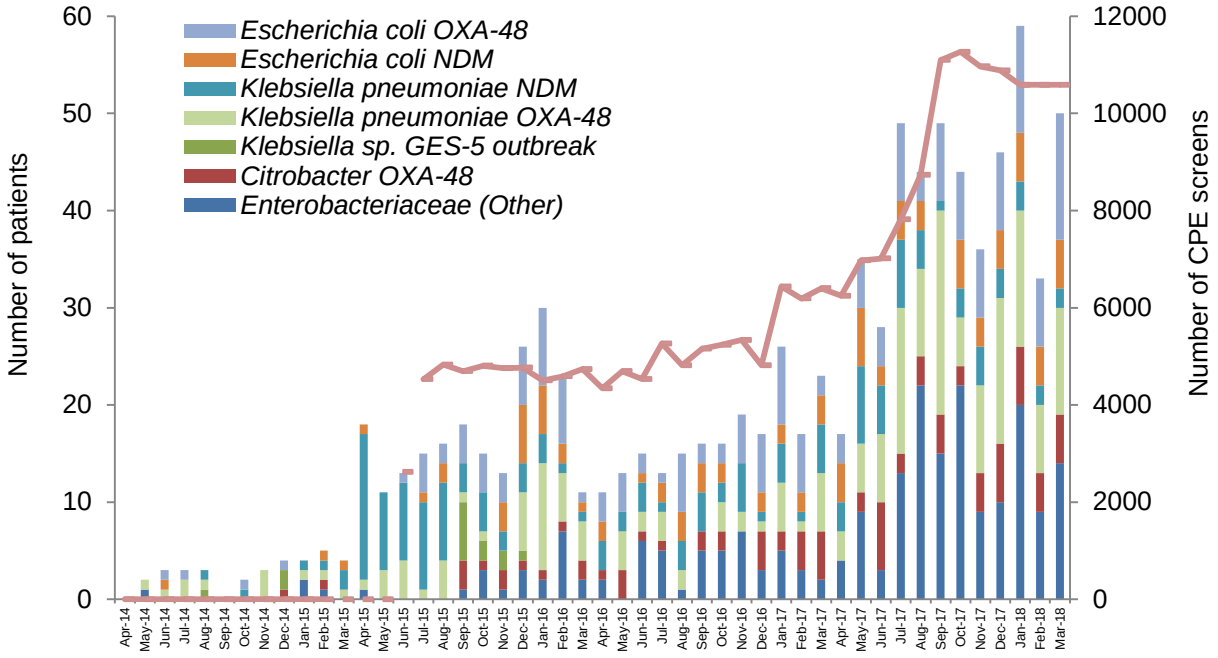

Figure 6: CPE detected at the Trust, by bacterial species and mechanisms, deduplicated by patient.

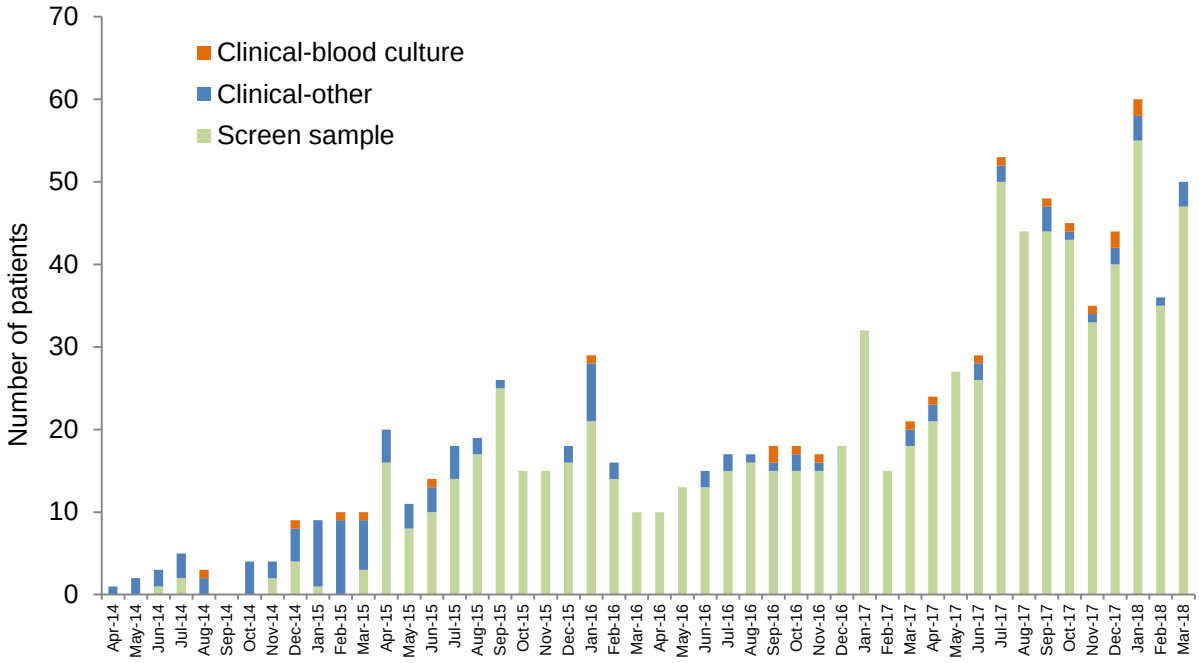

Figure 7: CPE detected at the Trust by culture type.

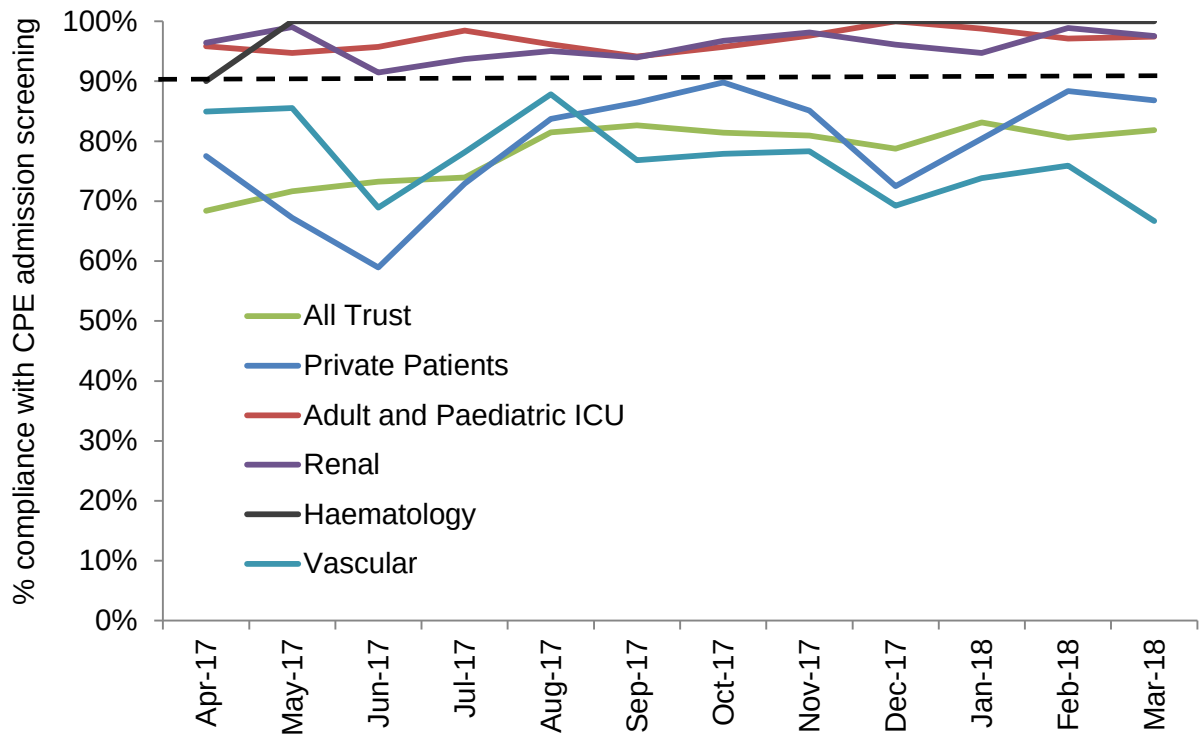

Figure 8: CPE admission screening compliance. Adult and paediatric ICU, renal, haematology, and vascular are performing universal admission screening; private patients and the rest of the Trust are performing risk-factor based admission screening. The dotted line represents the target of 90% compliance.

1.7.3 Increased incidence of CPE detection across the organisation

There has been an increased incidence in detection of CPE across the Trust in Q4. Several different epidemiologically-linked clusters have been identified, where isolates from routine screening samples were found to be indistinguishable on typing and cross transmission is suspected:

- In January, two patients on an intensive care unit had *Citrobacter freundii* OXA-48 (a type of CPE) identified from screening samples. These were found to be indistinguishable on typing and cross transmission is suspected.
- In February, seven patients in haematology at HH had *Citrobacter freundii* OXA-48 identified from screening samples; four of these have been found to be indistinguishable by typing and cross transmission is suspected. One of these patients had the organism grown from a blood culture; this patient has responded to antibiotic treatment.
- In February, four patients in paediatrics at SMH had *Citrobacter freundii* NDM (a type of CPE) identified from screening samples; three of these have been found to be indistinguishable by typing and cross transmission is suspected.

No new clusters of CPE were identified in March. In all cases above, enhanced IPC measures were put in place in the affected areas as per the CPE Policy and no further cases were detected in the ICU or in paediatrics. However, further cases have been identified in haematology; this will be updated in Q1 2018/9.

1.7.4 CPE Action Plan

In response to the Trust-wide increase in the detection of CPE, the CPE Action Plan has been revised. This is to provide additional focus on reducing acquisition, improving screening, laboratory, epidemiology, and surveillance (including a focus on increasing compliance with CPE admission screening), improving ward-level IPC practice (including the development specific criteria for ward re-opening in the event of a CPE outbreak, reviewing toilet ratios usage and access, and reviewing cleaning standards), and optimising antimicrobial strategies for CPE management and treatment (including the implementation of a new report from Cerner relating to patients on carbapenem antibiotics). A report will be submitted to the Quality and Safety Sub-Group to measure the performance of this plan in May 2018.

2 Antibiotic stewardship

Antibiotic Stewardship (AS) encompasses all activities intended to improve patient outcomes from infection related to the use of antibiotics while minimising negative consequences such as HCAI and limiting development of bacterial resistance. AS is a key aspect of patient safety.

2.1 *Assurance regarding quality of antibiotic prescribing*

2.1.1.1 Point Prevalence Results – Prescribing & Safety Indicators

The biannual antibiotic point prevalence study (PPS) (based on a review of inpatients) examines a suite of key antibiotic prescribing and safety indicators as advised by the Department of Health's "Start Smart then Focus" antibiotic programme and acts as a mechanism to identify areas for improvement. The 2nd PPS of 17/18 was conducted in February 2018.

1369 patients were reviewed; approximately 40% of inpatients were scheduled to receive an antibiotic. 1015 antibiotics were prescribed (55% intravenous). Of these, 92% were prescribed according to policy or on the advice of infection teams with 98% having a documented indication on the drug chart or medical notes. 90% of antibiotic prescriptions had a documented review within 72 hours of initial prescribing and 95% had a duration in line with policy or approved by microbiology / ID. The Trust has a suggested compliance of 90% for these indicators (Table 3). The results from Private Patients for indicators A and C will be discussed at the next Private Patients Quality and Safety Committee, and IPC will be working closely with Private Patients to understand the reasons for the results and develop improvement plans.

Division	**Number of patients on anti-infective(s)/total patients seen (%)**		**Number of anti-infectives prescribed**		**INDICATOR A % anti-infectives in line with policy or approved by Microbiology/ ID**		**INDICATOR B % indication documented on drug chart or in notes**		**INDICATOR C % review within 72 hours of initial prescribing**		**INDICATOR D % duration in line with policy or approved by Microbiology /ID**	
	Aug 2017	**Feb 2018**	***Aug 2017***	**Feb 2018**	***Aug 2017***	**Feb 2018**	***Aug 2017***	**Feb 2018**	***Aug 2017***	**Feb 2018**	***Aug 2017***	**Feb 2018**

Trust Results	*513/127*	**589/13**	*908*	**1015**	*91%*	92%	*98%*	98%	*89%*	90%	*93%*	95
Medicine	*210/561*	**274/65**	*337*	**436**	*92%*	92%	*97%*	99%	*90%*	92%	*95%*	96
Surgery,	*220/415*	**216/42**	*422*	**404**	*92%*	90%	*97%*	97%	*86%*	87%	*91%*	94
Women's and Children's	*75/238 (32%)*	**84/239 (35%)**	*135*	**148**	*88%*	97%	*100 %*	99%	*96%*	96%	*96%*	96 %
Private	*8/57*	**15/60 (25%)**	*14*	**27**	*75%*	74%	*100*	100 %	*60%*	56%	*86%*	85
Trust Target					90%		90%		90%		90%	

Table 3: PPS results summary from February 2018 survey.

These results have been shared with the Divisions, and will be included in the IPC Scorecard sent to the Divisions monthly to increase awareness; also antimicrobial stewardship is an agenda item on the IPC Taskforce call once a month.

2.1.1.2 Point Prevalence Results - Safety Indicators

As part of the bi-annual antibiotic point prevalence study there were 9019 antibiotic doses prescribed at the time of data collection with 280 doses (3.1%) documented as not given. Of these 280 doses, 125 were intravenous doses of antibiotics. In addition, 99% of patients who received an antibiotic had their allergy status completed. Divisions have been given a breakdown of missed doses by speciality to review and discuss at their local quality and safety committee meetings.

2.2 Overall antibiotic consumption

Work started in July 2017 on analysing the Trust antimicrobial consumption data looking specifically into the classes of antibiotics used within specialities and reasons for variation. This data is used along with antibiotic resistance data and local point prevalence studies to help target stewardship interventions and work with Divisions to drive improvement.

The Trust continues to take part in the Reducing the Impact of Serious Infections CQUIN supported by the fixed term infection pharmacist position. The capacity to control antibiotic consumption and shortages has been enhanced by this position.

We continue to report our antimicrobial usage to Public Health England (PHE) and participate in their national programme, facilitating benchmarking and helping to drive improvement. Q4 antibiotic consumption data has been submitted to PHE in April 2018.

Unlike in previous years where antimicrobial consumption decreased in Q4, the Trust had an increase in its overall consumption of antimicrobials compared with Q3 in 2017/18 (Figure 9). Antibiotic consumption is currently at the highest point observed since Q4 2015/16. This may reflect resource constraints due to vacancies within the infection teams or a large volume of respiratory cases due to an increased influenza season who may have been prescribed antimicrobials prior to influenza diagnosis or due to a secondary bacterial infection.

Prior to Q4 2017/18, the Trust was on course to meet the 2% target reduction of total antimicrobial DDDs/1000 admissions set by the national CQUIN. Due to the continued increase in antimicrobial consumption in Q4 of 17/18 the Trust has delivered a 1% reduction in overall CQUIN reported antimicrobial DDDs/1000 admissions from 2016 to 2017/18.

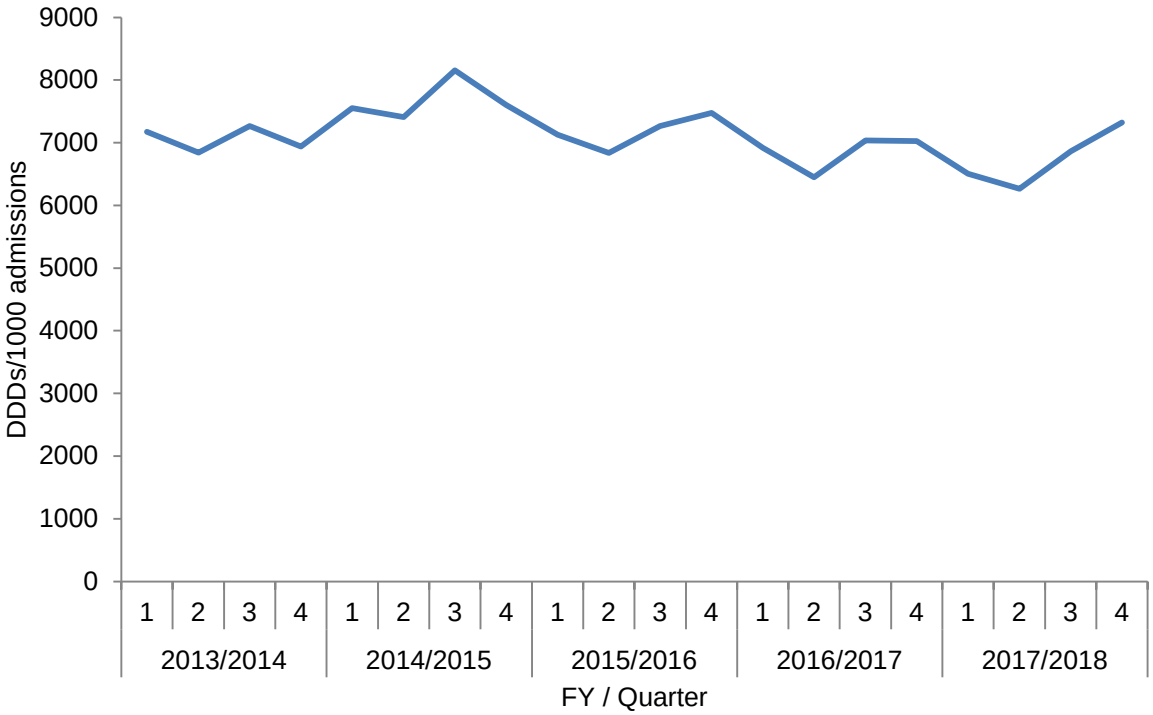

Figure 9: Trust wide antimicrobial DDD / 1000 admissions 2013 – present.

The greatest increase in antimicrobial consumption during Q4 was for oral (PO) antibiotics (Figure 10) which occurred in both inpatient and outpatient use; intravenous (IV) usage remains steady.

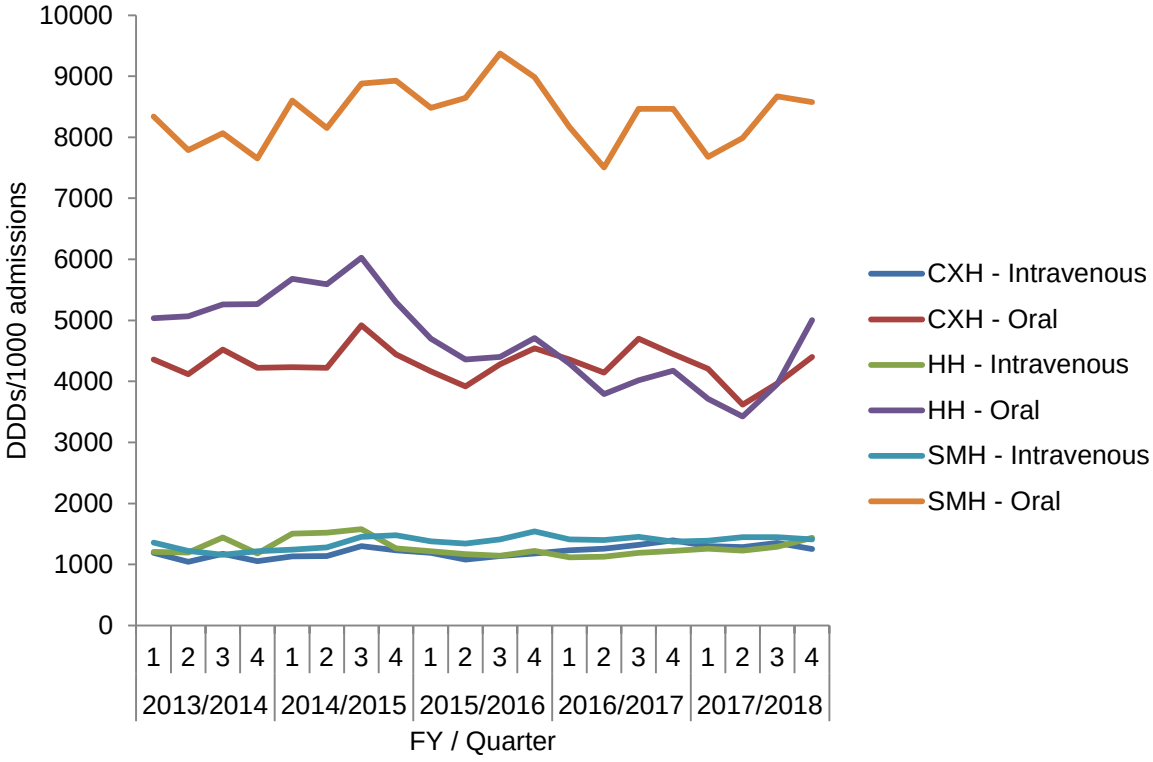

Figure 10: Trust wide antimicrobial DDD / 1000 admissions 2013 – present by route of administration and site.

There was a 1% reduction in antimicrobial consumption at SMH between Q3 and Q4 but increases in antimicrobial consumption at both the CXH and HH sites (6% and 23% respectively). Relatively large increases in antibiotic consumption have been identified in some specialties between Q3 and Q4 (summarised below). Whilst the reasons for this are not clear, it is most likely related to more cases of respiratory infection (including influenza) than usual. This is supported by the fact that the increase is across sites and specialties. These increases will be reviewed by the relevant specialities together with infection leads to understand where improvements could be made.

- At CXH there were a number of areas which had large increases in antimicrobial consumption between Q3 and Q4 2017/18. These include ambulatory and emergency care, critical care, emergency medicine, endocrine and diabetes, imperial private healthcare, specialist surgery (urology / ENT / breast / riverside), stroke and neurosciences and orthopaedics and plastics. The oral agents which had an increase in consumption of >20% at CXH between Q3 and Q4 were antituberculosis drugs, phenoxymethylpenicillin, clindamycin, macrolides, rifaximin and tetracyclines. The increase macrolides and tetracyclines is likely due to a large proportion of respiratory patients admitted to hospital due to high levels of circulating influenza in the community.

- At HH there were large increases in antimicrobial consumption between Q3 and Q4 in cardiac (including cardiothoracics), critical care, dermatology, endocrine and diabetes, gastroenterology, gynaecology and reproductive medicine and neonatology. The oral agents which had an increase in consumption of >20% at HH between Q3 and Q4 were antituberculosis drugs, phenoxymethylpenicillin, broad spectrum penicillins, fluroquinolones, flucloxacillin, linezolid, macrolides, co-trimoxazole, tetracyclines and nitrofurantoin.

- At SMH there were large increases in antimicrobial consumption between Q3 and Q4 in ambulatory and emergency care, dermatology, elderly medicine, endocrine & diabetes, gastroenterology, gynaecology and reproductive medicine, infectious diseases, imperial private healthcare, neonatology, respiratory and trauma. The only oral agents which had an increase in consumption of >20% at SMH between Q3 and Q4 were antituberculosis drugs.

2.2.1 Piperacillin/ Tazobactam (Tazocin®) / Carbapenem consumption

A 2% reduction in consumption of Piperacillin/Tazobactam (Tazocin®) and carbapenems has been requested as part of the CQUIN. Piperacillin/Tazobactam, reduced by 96% in Q1, primarily due to a global shortage of this agent.

In August 2017, limited supplies of Piperacillin/Tazobactam started to be received and the Trust reintroduced it into empirical guidelines for the treatment of neutropenic sepsis in haematology and oncology patients. For all other indications, piperacillin/tazobactam must be authorised by the infection team. As a result, use of piperacillin/tazobactam has increased steadily from Q2 – Q4 (Figure 11).

The controlled rise in Piperacillin/Tazobactam use has reduced carbapenem consumption in Q4 (Figure 11). Overall, there was an 18% increase in carbapenem consumption from 2016/17 to 2017/18. This was in part due to antimicrobial shortages and lack of alternative agents in Q1 17/18 combined with the challenge of treating multidrug resistant Gram-negative infections within our healthcare setting across 2017/18. In order to address the

overall increasing trend of carbapenem usage in recent years, it is expected that the Trust will have electronic Cerner antimicrobial patient specific reports in Q1 2018/19. This will highlight patients prescribed carbapenems for review to aid efforts to reduce carbapenem consumption.

Further analysis of carbapenem consumption has highlighted areas of high use, in particular acute medicine, neurosciences, and renal medicine. These areas have been discussed within the Medicine IPC group and work is planned to examine the data and develop plans for improvement.

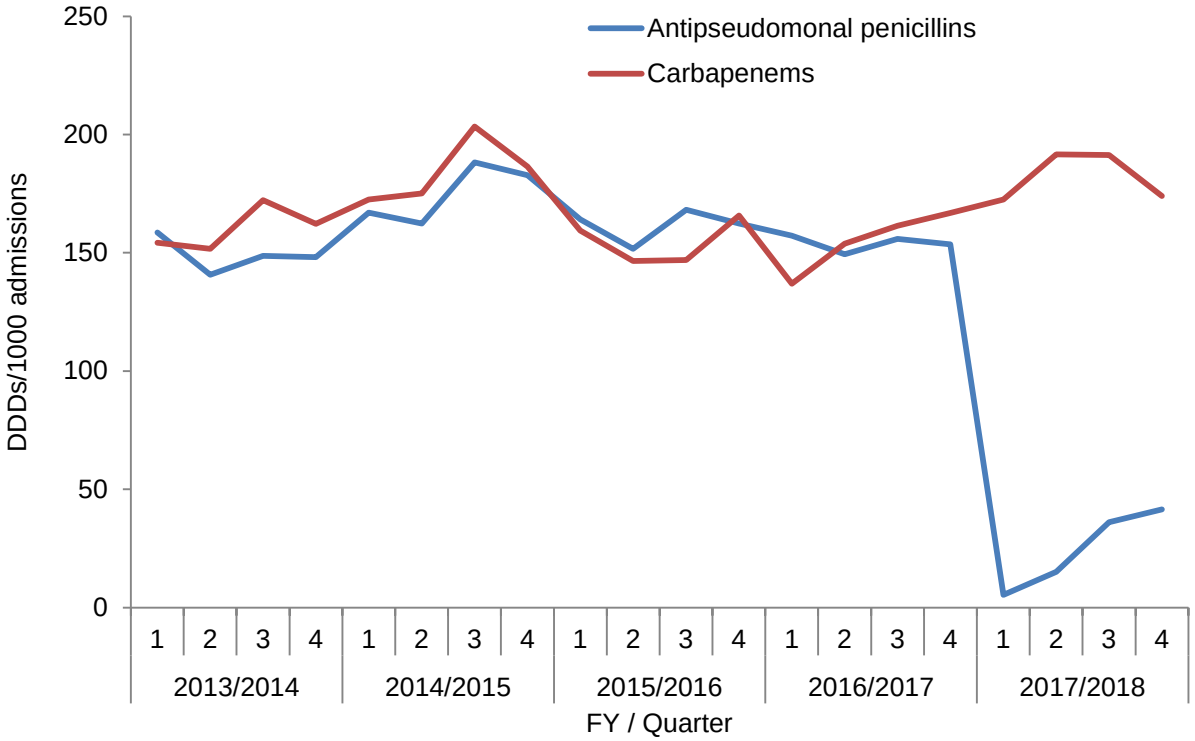

Figure 11: Trust-wide Piperacillin/Tazobactam) and carbapenem consumption (DDDs / 1000 admissions), 2013 – present.

2.3 Antibiotic shortages and expenditure

The Trust continues to experience critical antimicrobial shortages as described earlier. The Infection Pharmacy team are managing these shortages together with microbiology colleagues and releasing stock where appropriate on a patient by patient basis. The agents include piperacillin/tazobactam, ceftriaxone, amikacin, meropenem, gentamicin, cefuroxime, ceftazidime and vancomycin.

Trust-wide there was an average spend of £883k per quarter on antibacterials and £652k on antifungals in 2017/18 YTD, compared to £761k per quarter on antibacterials and £756k per quarter for antifungals in 2016/17 (Figure 12). The increase in antibacterial costs is due to the antibacterial drug shortages, because of the need to procure a number of agents off-contract to maintain Trust antibiotic guidelines and patient safety.

There was a potential for a much greater increase in expenditure on antimicrobials in 2017/18. Consumption of piperacillin/tazobactam at the 16/17 rate within 2017/18 would have resulted in a cost pressure to the Trust of £1.6 million. The controlled restriction and reintroduction of piperacillin/tazobactam usage through the work of the infection pharmacy

team facilitated by the CQUIN pharmacist post is predicted to have resulted in a £1.3 million averted cost for the Trust during FY 2017/18.

Further, there is a pan-London contract for echinocandins where cost is calculated on a volume based matrix of drug usage. From 1st September 2017, the cost of anidulafungin and micafungin decreased. There was a corresponding decrease in antifungal expenditure in Q3 which then increased again in Q4. It should be noted that high cost antifungals are funded by NHS England with the exception of patients within 90 days of renal transplant or bone marrow transplant.

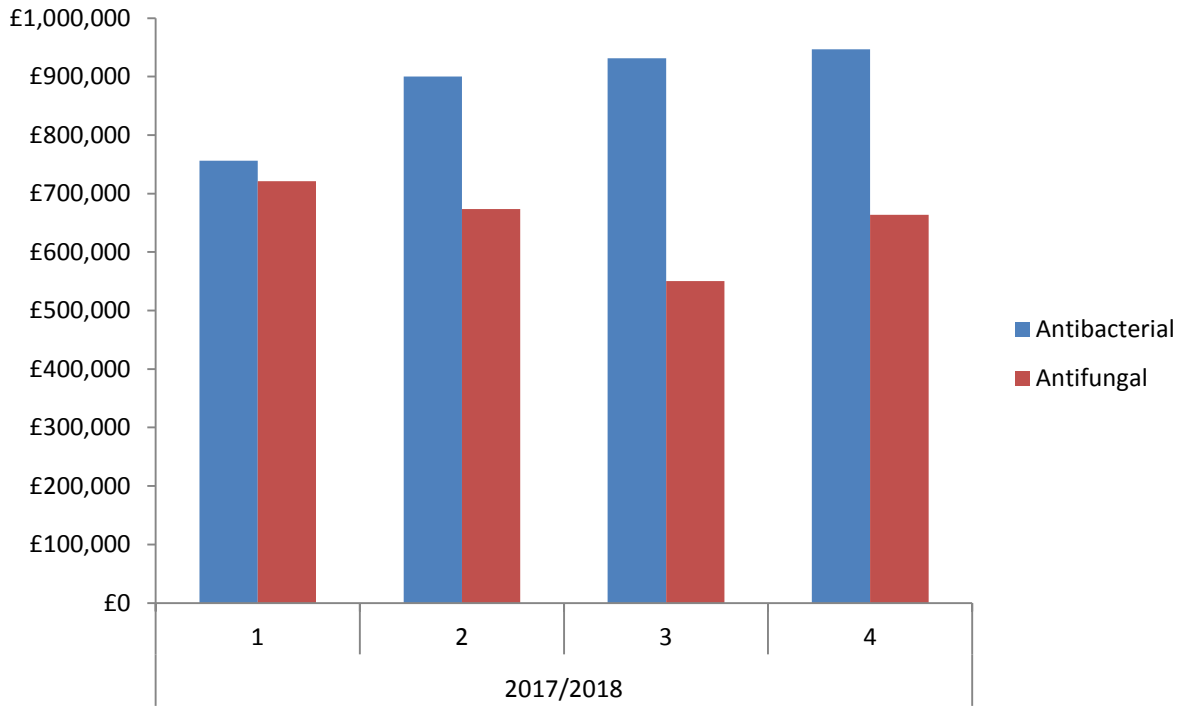

Figure 12: antibiotic expenditure for inpatients and outpatients by site and quarter 2017/18 FY to date.

2.4 Antibiotic Review Group

The Trust Antibiotic Review Group's (ARG) role is to support the improvement of antibiotic use within the Trust by promoting the safe, rational, effective and economic use of antibiotics by the multidisciplinary teams.

In Q4 the ARG reviewed the following:

- Human and Animal Bites: A Paediatric Guideline
- Strongyloides stercoralis: Protocol for treatment in patients with Human T-lymphotropic virus type 1 (HTLV-1)
- Bronchiectasis
- Surgical antimicrobial prophylaxis guideline
- Renal anti-infective guideline

A further Women's and Children's ARG sub-group reviewed the following guidelines:

- Placenta accreta
- Retained placenta
- Major obstetric haemorrhage (MOH) This includes both antepartum and postpartum haemorrhage

- Preterm labour (Chorioamnionitis)
- Congenital Cytomegalovirus (cCMV): Diagnosis and Management of Congenital Infection Guideline (under paediatric remit)
- Oseltamivir dosing in children
- Maternal Group B Streptococcal infection in pregnancy and labour
- Gentamicin - Guideline for the Prescribing and administration of once daily gentamicin in paediatric ward areas
- Conjunctivitis – Neonatal Guideline (under paediatric remit)
- Congenital Syphilis guideline: Investigation and Management of Infants born to Mothers with Positive Treponemal Serology in Pregnancy.
- HIV in neonates: prevention of vertical transmission
- Herpes Simplex Virus infection - Neonatal Guideline For Diagnosis & Treatment (under paediatric remit)
- Human and animal bites a paediatric guideline

2.5 Cerner Infection Collaborations

The Trust is working with other NHS organisations (Oxford, Royal Free, Wirral, St Georges) around how best to utilise Cerner for infection management activities. This includes designing core antimicrobial reporting to automatically alert healthcare professionals when antibiotics need reviewed. All involved are benefiting from this shared learning and helping to improve patient care.

It is expected that the Trust will have antimicrobial patient specific reports in Q1 2018/19. This will further aid antimicrobial stewardship interventions by highlighting restricted antibiotic prescriptions and helping to manage extended antibiotic durations.

2.6 *Sepsis*

The identification and clinical management of sepsis remains a Trust priority. The Trust's overall approach to sepsis was outlined in the Q3 report. In order to support this process, a sepsis module in Cerner has been piloted within the Trust and will be rolled out across the Trust for adult patients in Q1 18/19. Work to improve the care of patients with suspected sepsis will continue after the launch in the Sepsis Big Room. The module supports clinical staff in early recognition and management of sepsis, incorporating Trust Adult Treatment of Infection Guidelines and sepsis management principles. Reports from the module related to the time to prescribing antibiotics and other metrics linked to sepsis care standards are now available to help drive improvement around sepsis management, thus supporting antimicrobial consumption reduction.

The proportion of patients with a sepsis diagnosis who were either on antibiotics before the alert fired or within one hour of the alert firing is shown in Figure 13 (CXH emergency department) and 14 (SMH emergency department). 70% of patients with a sepsis diagnosis received antibiotics in the correct timeframe at CXH compared with 56% at SMH. The Sepsis Big Room is leading investigations to understand the reasons for this variation. These metrics are being fed back to ward areas via the Sepsis Big Room where the sepsis alert is live to provide a feedback loop for local improvement initiatives. The proportion of patients who were either on antibiotics before the alert fired or within one hour of the alert firing has been selected as a new monthly quality metric for the Trust board.

A revision of the Trust sepsis policy is being undertaken via a multi-stakeholder engagement process. This work to improve sepsis care has been shortlisted for both the HSJ Patient Safety Awards and the Trust's Chairman's Award.

The changes in the way that sepsis is identified and managed will be complemented by a new programme of communications related to improving hand hygiene and sepsis commencing on May 7 to co-ordinate with the 2018 WHO Global Hand Hygiene Campaign. The theme of this campaign is “It’s in your hands – prevent sepsis in healthcare.”

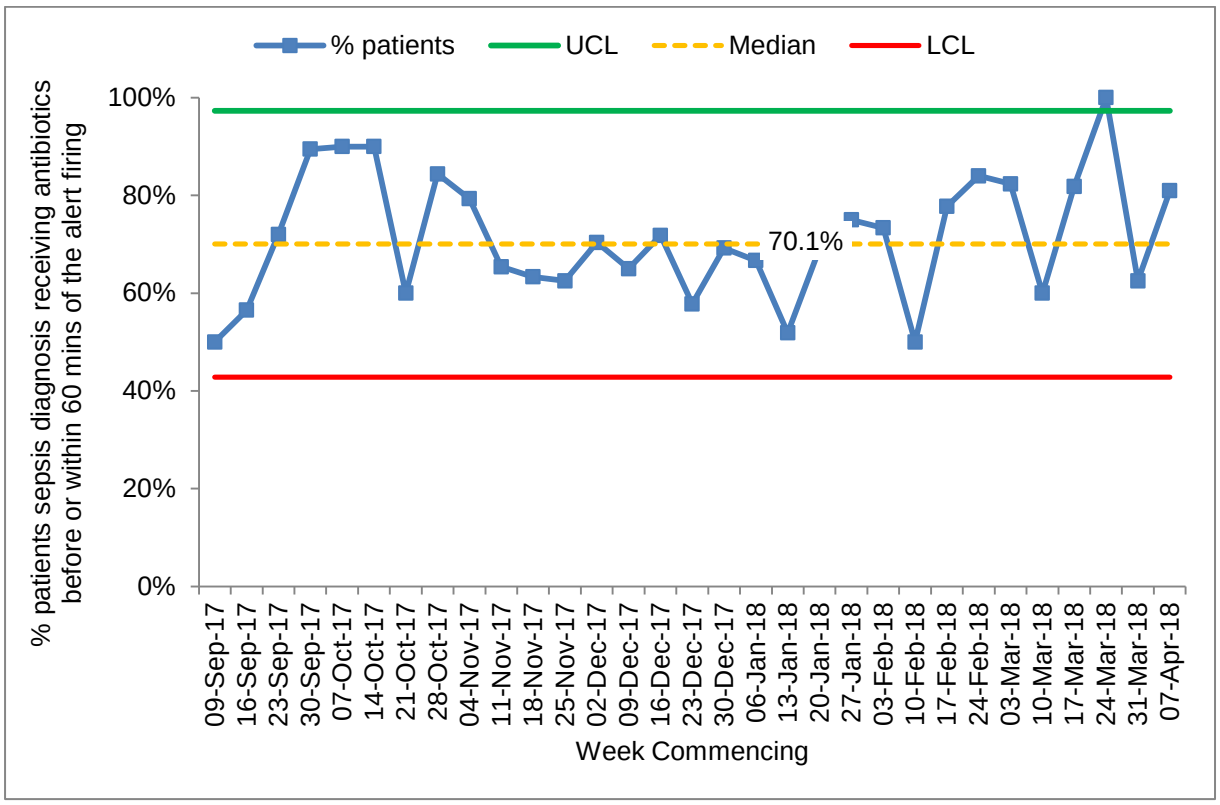

Figure 13: Percentage of patients with a sepsis diagnosis receiving antibiotics either before the sepsis alert or within 60 minutes of the alert firing at the CXH emergency department.

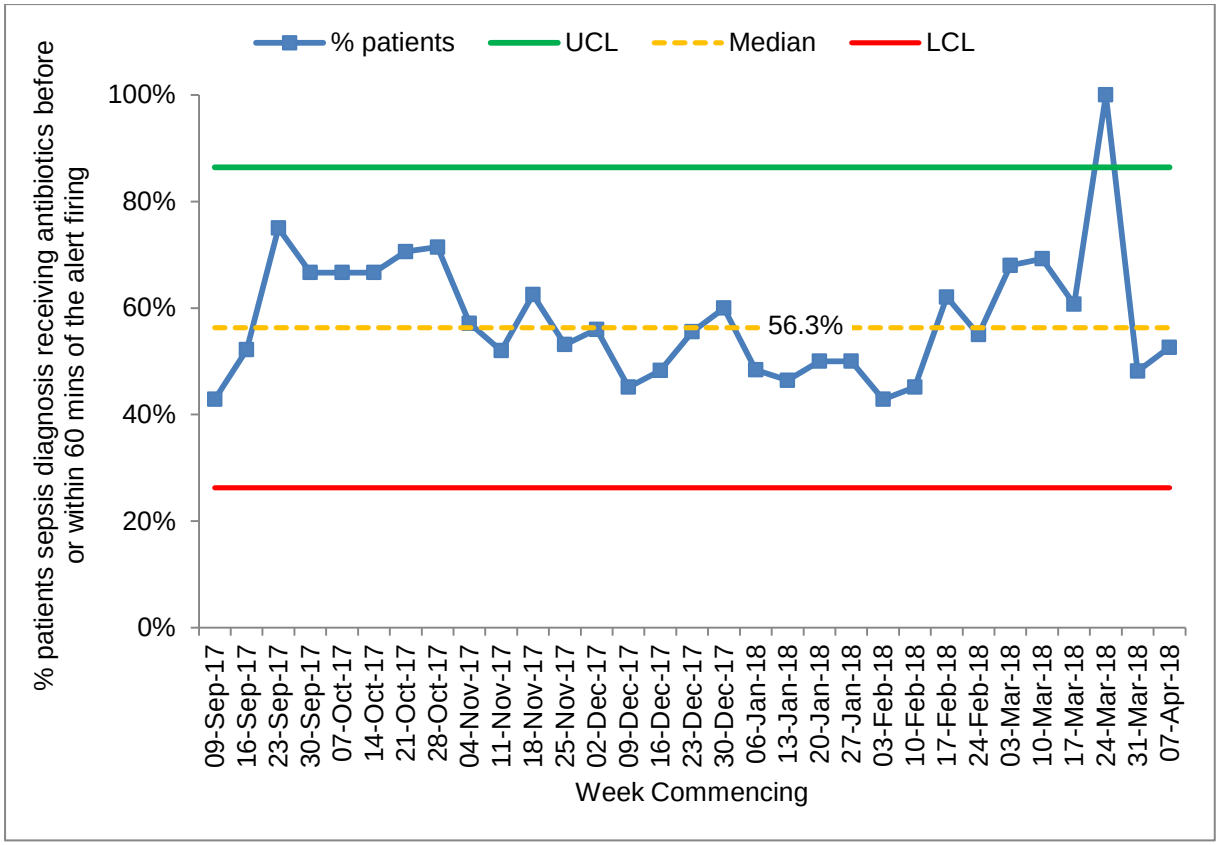

Figure 14: Percentage of patients with a sepsis diagnosis receiving antibiotics either before the sepsis alert or within 60 minutes of the alert firing at the SMH emergency department.

3 Aseptic Non Touch Technique (ANTT)

The Trust has a requirement that ANTT assessment is undertaken and documented for all staff working in a clinical environment. ANTT has become the term to describe a local competency assessment approach including i) practical assessment of hand hygiene ii) the use of personal protective equipment for all staff who work in a clinical setting, and an iii) assessment of Aseptic Non-Touch Technique (ANTT) for staff who require this skill. The target for compliance with ANTT training for Trust clinical staff is set at 95%; currently the compliance rate has increased to 82.7% from 75.8% in the last quarter (6549/7924 clinical staff). During Q4, 1961 clinical staff were assessed, which is an average of 653 per month. The revised policy for ANTT was ratified in Q4 and is available on the Source. The assessment is now valid for three years and this is reflected on WIRED and Moodle. In addition to creating improved local models of ANTT competency assessment and streamlining the uploading of completed assessments, Divisions are working with HR to cleanse the denominator of those health care professionals with honorary contracts that no longer work at Imperial to ensure a more accurate denominator.

4 Hand hygiene

4.1 *Background*

Prior to April 2017, the Trust monitored compliance with only one of the five WHO 'Moments' for hand hygiene (immediately before patient contact), which reported rates of compliance that were much higher than would be anticipated based on published literature (usually >95%). Although this provided pragmatic data capture across all sites and clinical areas, a new approach was implemented in April 2017 to move to audit all five WHO

Moments. It was envisaged that this would result in lower level of compliance being reported, to prompt focussed attention on clinical areas that require improvement. However, rates of compliance continued to be higher (>95%) than would be expected based on published data (typically 40%). Furthermore, the IPC team performed validation hand hygiene audits over the month of September 2017 in a selection of wards across the Divisions. This was to compare compliance reported by wards with audits performed by the IPC team. Overall compliance was 56% in the IPC audits (122 compliant observations from a total of 223), compared with 97% (457 compliant observations from a total of 471 observations) as reported by clinical areas on Synbiotix. IPC and the Divisions agree that, based on these findings, a new approach to hand hygiene auditing and improvement is required.

The proposal is to transition away from monthly ward and department-led hand hygiene auditing to expert auditing undertaken by IPC and senior Divisional staff. This will prompt improvement focussed on the areas with the lowest levels of hand hygiene. The changes will be complemented by a new programme of communications related to improving hand hygiene and sepsis commencing on the 4th of May to co-ordinate with the 2018 WHO Global Hand Hygiene Campaign.

A weekly Task and Finish Group is in place to oversee changes in hand hygiene audit, improvement, and communications.

4.2 *Audit and reporting:*

4.2.1 Hand hygiene (5 Moments) auditing

- The first round of auditing will take place over the five Back to the Floor Thursdays (BTTFT) in May 2018.
- The initial rounds of auditing will focus on inpatient areas.
- Each site will be audited on one day with Divisional and IPC staffing resources centred on the site being audited. Audit teams will be comprised of two team members and each team will audit two wards per day.
- A cross-section of all 5 Moments is required with a target of 50 observations per ward.
- There will be a briefing session at each BTTFT site meeting in the morning, focusing on the 5 Moments audit methodology. Briefing packs will also be provided to the audit teams to refer to during the day. The schedule for future and follow-up audits will be agreed during the weekly Task and Finish meetings with each Division.
- Audit data will be uploaded to Synbiotix by the auditor.

4.2.2 Reporting

The IPC data team will prepare a report of hand hygiene compliance by clinical area, including compliance by staff group, and compliance by WHO Hand Hygiene Moment. This will be shared with the Divisions to be cascaded to each Directorate and clinical area. A monthly summary of hand hygiene audit data and improvement progress will be co-designed with the Divisions and presented to the Quality and Safety Sub-Group and Executive Quality Committee. A summary of the findings of each audit will be included in existing IPC report (e.g. quarterly and annual reports).

4.3 *Improvement plans*

Rather than a prescriptive approach to hand hygiene improvement, the DDNs have requested a ‘Hand Hygiene Toolkit’, which can be used to build a local strategy to improve hand hygiene. This will be supported by IPC and the Improvement Team.

The Hand Hygiene Toolkit will include:

- Communications materials (e.g. posters).
- Guidance on the identification of champions in the clinical areas that reflect the diversity of the professional groups working together in the ward areas to lead on implementing the improvement plan, supported by IPC and the Improvement Team.
- Face-to-face education from both IPC experts and improvement experts.
- Tools to analyse the area specific problem in more depth, using a mixed method approach; perception survey to understand local barriers to IPC practice.
- A survey to ensure that the appropriate facilities for hand hygiene (e.g. alcohol gel location) are in place. This is audited annually by IPC, but this local version will be more detailed.
- Materials to support local repeated audit and feedback to track whether improvement initiatives are taking effect

An illustrative improvement plan is included in Table 4, recognising that each clinical area will need to develop a local plan using the tools described above.

This plan has no direct cost implications as the actions can be achieved within current resources.

The weekly hand hygiene Task and Finish group will co-ordinate the improvement work initially before handing over to the Hand Hygiene Steering Group (with appropriate Divisional representation).

Table 4: Hand hygiene improvement plan

	Score*	Champions:	Inform team:	Diagnose :	Actions:	Share:	Improve:	Share:	Evaluate:
Improvement needed	**50% or above**	Area to agree/provide Hand Hygiene Champions: minimum: 1x Nursing 1x Clinical 1x Lead	Champions & area leads receive email with results and invite to drop in session to discuss results and next steps. Team asked to add hand hygiene to all handover discussions for a min of 7 days moving to weekly	Champions & area leads emailed a hand hygiene improvement bundle of tools: • Perception survey • Facilities survey • Dates for quality improvement workshop dates offered etc. • Other support available	Champions & area leads to agree next steps after identifying barriers to hand washing in their area.	Champions & area leads share back with team on; • diagnosis of problems and actions taken so far • reiterate importance • ask for support from wider team on initiatives/ tests of change	Champions & area leads with rest of team work on improving hand hygiene in their area: using quality improvement methodology. Self-assessment and robust measures e.g. Number of HCAIs	Champions & area leads share back with team in handovers. Team written to and asked to update on interventions taken to improve hand hygiene compliance on the ward. Interventions captured and shared with other champions.	Team encouraged to self –assess compliance – or could be paired up with another ward Once measured: Champs & leads inform team and ask what can we do to further improve?
Moderate improvement needed	**30% to 49%**	Area to agree/provide Hand Hygiene Champions: minimum: 1x Nursing 1x Clinical 1x Lead	Champions & area leads receive email with results and invite to drop in session to discuss results and next steps. Team asked to add hand hygiene to all handover discussions for a min of 7 days moving to weekly	Champions/ ward leaders given a hand hygiene improvement bundle of tools: • Perception survey • Facilities survey • Dates for improvement workshop dates offered	Champions & area leads agree next steps after identifying barriers to hand washing in their area. Team members invited to book on to a hand hygiene refresher session run by ICP	Champions & area leads share back with team on; • diagnosis of problems and actions taken so far • reiterate importance • ask for support from wider team on initiatives/ tests of change	Champions & area leads with rest of team work on improving hand hygiene in their area: using quality improvement methodology. Self-assessment and robust measures e.g. Number of HCAIs	Champions & area leads share back with team in handovers. Team written to and asked to update on interventions taken to improve hand hygiene compliance on the ward. Interventions captured and shared with other champions.	Team encouraged to self –assess compliance – or could be paired up with another ward Once measured: Champs & leads inform team and ask what can we do to further improve? Spot checks carried out by divisional leads & ICP throughout year
Significant immediate improvement needed	**29% or below**	Area to agree/provide Hand Hygiene Champions: minimum: 1x Nursing 1x Clinical 1x Lead	Champions & area leads to meet in person with IPC & improvement colleagues to discuss results and next steps. Bespoke plan worked up together and 4 weekly ward based huddles booked in. Area given named ICP & named improvement colleague Key messages will be dependent on the results of the audit and will be specific for the clinical area and staff groups.	Champions/ ward leaders given a hand hygiene improvement bundle of tools (some of which will be mandated): • Weekly huddles • Perception survey • Facilities survey • E-learning • Dates for improvement workshops • Other support available	ICP with ward leaders to provide ward/area based hands on teaching sessions with staff (light box/ 5 moments) : aim to capture as many staff as possible. Record of interactions captured. Champions & area leads agree next steps together after identifying barriers to hand washing in their area.	Champions & area leads share back with team on; • diagnosis of problems and actions taken so far • reiterate importance • ask for support from wider team on initiatives/ tests of change With support from IPC & improvement colleagues	Champions & area leads with rest of team work on improving hand hygiene in their area: using quality improvement methodology. Self-assessment and robust measures e.g. Number of HCAIs (with ICP & improvement support) IPC to help staff expedite any problems	Champions & area leads share back with team in handovers. Recognition to key influencers / team players etc. Team written to and asked to update on interventions taken to improve hand hygiene compliance on the ward. Interventions captured and shared with other champions.	Reassessment of compliance – 50 observations ICP with divisional colleagues Champions and area leads share results back with team and ask the question: what can we do to further improve?

* These score thresholds may be modified as accurate hand hygiene compliance data is reported

4.4 *Hand hygiene and sepsis communications plan for Global Hand Hygiene Day*

As recommended by the CQC, a new hand hygiene campaign will be developed covering organisation-wide consistent messaging for colleagues and patients. As part of the start of this work, IPC will be joining forces with members of the Sepsis Big Room and together taking part in this year's Global Hand Hygiene Day in the second week of May. This year, the campaign is focused on both hand hygiene and sepsis, under the tag line: *"It's in your hands – prevent sepsis in healthcare"*. A week of activities and messaging around hand hygiene and sepsis has been planned across all sites *(see Table 5 for more detail).*

Key messages for the week to include;

- when, where, and how to perform hand hygiene (including reinforcement of the need to be bare below the elbow in clinical areas), and the planned changes in hand hygiene auditing and improvement
- the importance of asking *"Could it be sepsis?",* and the launch of the Cerner Sepsis alert to assist with the identification and management of sepsis

As well as delivering messages and promoting awareness, the week will also be an opportunity to speak to both patients and staff and gather intelligence on; what some of the perceived barriers are, baseline knowledge and what colleagues and patients would like to see done differently and ideas they have; we will be running a series of short questionnaires and using this to inform the further development of campaign materials.

Work has started on the wider campaign; the Hand Hygiene team joined the Imperial Improvement Design Sprint on the 11th April, joining forces with designers and a behavioural science experts and others to start co-developing ideas and messaging. More work is being planned, including additional time with a behavioural science expert from the Health Foundation and Graphic Designer, to develop a consistent messaging/ look and feel. More detail to on wider campaign to follow in future reporting.

Date	Channel	Audience	Content
Commencing 4 May	Screensavers on Trust computers	Trust staff	A hand hygiene related and sepsis related screensaver launched
Commencing 4 May	Twitter and Facebook	General public, patients, staff, students, visitors etc	Social media posts from the College, Trust and AHSC. HH/Sepsis project team to run 'Imperial People' twitter feed
Fri 4 May	Press release, also published on the news section of the website	Media and members of the public	Story announcing the Trust's hand hygiene and sepsis plans
Fri 4 May	Blog post	The public	Why hand hygiene and sepsis are linked, and what we are doing to improve
Fri 4 May	The Source	Trust staff	Hand hygiene piece
Mon 7 May	Bank holiday		
Tues 8 May	In Brief	Trust staff	General message

			about the campaign, similar to the blog post on the external site. Banner confirmed.
Weds 9 May	The Source	Trust staff	Sepsis related piece

Table 5: Digital plans for the WHO World Hand Hygiene & Sepsis awareness week

In addition to these digital resources, a physical campaign stand will be run in the 5 hospital main foyers (Table 6):

Day	**Location**
Fri 4 May	SMH
Tues 8 May	HH (steering group)
Weds 9 May	CXH
Thurs 10 May	QCCH
Fri 11 May	WEH

Table 6: Campaign stand locations

This will be complemented by a walk-around of selected wards by the campaign stand team.

1.1 Seeking sepsis and hand hygiene champions

One of the focuses of the week will be to seek (and sign up) multi-professional front-line sepsis and hand hygiene champions on wards. The hope is that this will be a voluntary multi-professional network of interested clinical staff who will take a leading role in promoting and improving the identification and management of sepsis and hand hygiene in clinical areas.

Sepsis and hand hygiene champions will be expected to:

- Take an active role in reviewing sepsis-related metrics, and prompting local improvement in the identification and management of sepsis.
- Take a leading role in the hand hygiene audit and improvement in their area.

Sepsis and hand hygiene champions will receive:

- A ‘sepsis and hand hygiene champion’ badge.
- Additional education on the Cerner Sepsis alert.
- Additional education on hand hygiene auditing and improvement methods.
- An email signature that they can cut and paste in addition to their usual one.

1.2 Campaign materials and costs for Global Hand Hygiene Day

The communications around Global Hand Hygiene Day and the subsequent package of Trust-wide communications will have a cost attached. Costs are currently being finalised.

1.3 Coordination of the WHO awareness week

The week of activities will be coordinated as a sub-group of the Sepsis Big Room and the Hand Hygiene Steering group, including stakeholders from IPC (Jon Otter [operational lead], Tracey Galletly, Jan Hitchcock, Mark Gilchrist, Eimear Branningan), communications (Nadene Marlborough, Jenny Stott), the sepsis big room (Anne Kinderlerer), and Divisional representatives (one from each Division, to be agreed) and Improvement Team representation from Hannah Parker & Chris McNicholas both Improvement Leads.

5 Serious incident investigations

Serious incidents (SIs) reported during Q4 are listed in Table 7. Table 7 summarises key learning points arising from HCAI-related SIs reported so far this financial year.

6 Compliance and Policies

6.1 Compliance

- Cleaning audits are performed by Facilities. Facilities, supported by the Divisions and IPC, are undertaking a review of cleaning policies and processes across the Trust in order to improve standards of cleaning and disinfection in the Trust.
- The Trust has two tiers of annual core skills IPC training: Level 1 for all staff, and Level 2 for clinical staff. Compliance with Level 1 is 85% (up from 81% in Q3), and with Level 2 is at 85% (up from 82% in Q3). This data is now included in the monthly IPC Scorecard to prompt improvement in the Divisions, and the issue has been raised on the HCAI Taskforce to support improvement. Also, a Trust wide group is being convened by the Core Skills team to improve compliance with all core skills training.

6.2 *Policies*

Policies and Guidelines approved at the Trust Infection Prevention and Control Committee (TIPPC) in January 2018:

- Aseptic Non Touch Technique – Clinical Competency Assessment for Patient Safety: An Infection Prevention and Control Policy.

Policies and Guidelines requiring review during Q1 of FY 18/19:

- Viral haemorrhagic fever policy, and Ebola virus disease clinical guideline.
- Blood culture guideline.
- Measles policy.
- Hand hygiene policy

Table 7: HCAI-related SIs reported during FY 17/18.

STEIS	Location	Summary	Date reported	Lessons learnt
2017/11780	7N	CPE (*Klebsiella pneumoniae* NDM)	19/04/2017	1. Ensuring enhanced ward cleaning is implemented effectively and reflected in scheduled and unannounced cleaning audits 2. Awareness of the policy and practice relating to the management of patients with CPE organisms 3. Improve the environment to enable effective cleaning and IPC practice
2017/11143	NNU	Parainfluenza	19/04/2017	1. Development of a flow chart for processing urgent samples, and their transport to the virology laboratory at Charing Cross Hospital. 2. Training at junior doctor induction for respiratory virology samples
2017/17331	HJW	CPE (*Citrobacter freundii* OXA48)	19/06/2017	1. Improve the process for microbiology cross infection turnaround times 2. Improve the practice relating to the isolation of patients with infections in single rooms 3. Awareness of the policy and practice relating to the use of personal protective equipment
2017/16902	15N	CPE (*Citrobacter freundii* OXA48)	08/05/2017	1. Inconsistent approach to CPE screening. 2. ANTT compliance was deteriorating and this was not addressed in a timely manner. 3. Replace the furniture and furnishings that were not compliant with cleaning/IPC recommendations
2017/17894	11W	2 CDT in 7 days VRE Transmission	11/06/2017	1. Pre-emptive isolation and testing patients for *C. difficile* if they have risk factors for *C. difficile* in line with Trust policy 2. Management of clinical waste with regard to full bowel management system equipment 3. Ensuring enhanced ward cleaning is implemented effectively and reflected in assurance measures reviewed
2017/19226	ZCO/Albert	CPE (*Klebsiella pneumoniae* OXA48) x8 (same as ALB)	25/07/2017	Panel took place in March 2018 – report currently being finalised.
2017/22957	SLA	CPE (*Enterobacter cloacae* OXA48) x2	07/08/2017	None identified

2017/22986	RPO	CPE (*Klebsiella pneumoniae* OXA48) x2	15/08/2017	1. Process of use of computers on wheels in isolation rooms and how these are then cleaned/decontaminated
2017/22053	Weston	CPE (*Klebsiella pneumoniae* NDM) x2 CPE (*Enterobacter cloacae* VIM) x3 CPE (Enterobacter cloacae IMP1) x2	23/08/2017	Panel rescheduled for April 2018.
2017/25234	8W	CPE (*Klebsiella pneumoniae* OXA48) x 13	22/09/2017	1. Timely completion of IPC recommendations made as a result of IPC outbreak meetings 2. A joint investigation should be undertaken with the mental health Trust into the management of patient 2. 3. Estates & Facilities review to provide a response to the recommended renewal work for 8 West.
2017/22962	JHW	2 CDT in 7 days	08/09/2017	1. Awareness of the policy and practice relating to the management of patients requiring isolation
2017/26464	CBW	CPE (*Citrobacter freundii* OXA48) x2	24/09/2017	1. Reiterate the importance of hand hygiene and adhering to the five moments and reaudit
2017/24672	7N	CPE Bloodstream infection	16/09/2017	1. Antibiotic advice should be sought from microbiology in a patient with complex medical co-morbidities.
2017/25258	OPAT/Albert	CPE Bloodstream infection	17/09/2017	1. All management decisions should be clearly documented in main clinical notes to avoid confusion surrounding MDT treatment decisions
2018/8735 2018/8747	7S	MRSA joint (TKR) infections X2	28/03/2018	Under investigation.

7 Risks

New risks:

- None.

Updated risks:

- The score of the corporate CPE risk has been downgraded, since it was placed on the corporate risk register at a time before the Trust had a specific CPE policy in place, and few clinical infections with CPE are being identified. However, CPE will remain on the corporate risk register.
- The occupational health risk has been upgraded due to slow progress on a number of IPC-related issues.
- The estates risk has been upgraded due to slow progress on a number of IPC-related issues.

8 Other issues

8.1 *Neonatal PVL-positive MSSA*

An investigation is on-going into seven babies identified with the same strain of a PVL *Staphylococcus aureus* on the neonatal unit between December 2016 and February 2018. Actions taken to date on advice of Public Health England have included administering suppression therapy to all staff across both units on two occasions and a proactive screening programme for all babies. Screening of staff for this organism is now underway.

8.2 *Launch of IPC-LIVE and LIMS changeover challenges*

IPC have launched a new case flagging system called 'IPC-LIVE'. This has been developed in-house and replaced some proprietary software with similar functionality ('ICNet').

The Trust laboratory has upgraded its LIMS (Laboratory Information Management System) platform. This has resulted in problems with extracting data from the laboratory database (unconnected to the launch of IPC-LIVE), and has meant that it has not been possible to produce some of the usual sections (specifically the BSI surveillance section). This will be reported at next month's ExQu as a stand-alone report.

8.3 *Legionella* at HH

A case of *Legionella* pneumoniae has been identified at another hospital in London. The patient had an inpatient stay at HH. An extensive review of possible sources of *Legionella* along the patient pathway has identified several water outlets contaminated with *Legionella*. These outlets have been managed as per the Water Safety Plan. Hospital acquisition of *Legionella* at HH cannot be ruled out.

8.4 *Bronchoscopy issue at HH*

Eight patients who have had bronchoscopies at HH site between early December and the end of March have grown an unusual environmental fungus; there are no signs of clinical infection in any of the patients. A mixed group of immunocompromised patients are affected. The source of the environmental fungus is under investigation. Routine bronchoscopy at HH

is currently suspended whilst the issue is investigated; the respiratory physicians have contingency plans for urgent cases in patients who would not be able to travel to other ICHT sites.

8.1 *MRSA joint infections at CX*

There have been two MRSA joint infections (both TKRs) at CX due to unrelated strains of MRSA. This led to a temporary suspension of joint surgery, which has now resumed. This is being investigated as a Serious Incident (STEIS 2018/8735 and 2018/8747).

9 Publications in Q4

Rawson TM, Moore LSP, Castro-Sanchez E, Charani E, Hernandez B, Alividza V, Husson F, Toumazou C, Ahmad R, Georgiou P, Holmes AH. Development of a patient-centred intervention to improve knowledge and understanding of antibiotic therapy in secondary care. Antimicrob Resist Infect Control. 2018 Mar 20;7:43.

Rawson TM, Charani E, Moore LS, Gilchrist M, Georgiou P, Hope W, Holmes AH. Exploring the use of C-Reactive Protein to estimate the Pharmacodynamics of Vancomycin. Ther Drug Monit. 2018 [Epub ahead of print]

Hawkey PM, Warren RE, Livermore DM, McNulty CAM, Enoch DA**,** Otter JA, Wilson APR. Treatment of infections caused by multidrug-resistant Gram-negative bacteria: report of the British Society for Antimicrobial Chemotherapy/Healthcare Infection Society/British Infection Association Joint Working Party. J Antimicrob Chemother. 2018 Mar 1;73(suppl_3):iii2-iii78.

Jauneikaite E, Kapatai G, Davies F, Gozar I, Coelho J, Bamford KB, Simone B, Begum L, Katiyo S, Patel B, Hoffman P, Lamagni T, Brannigan ET, Holmes A, Kadhani T, Galletly T, Martin K, Lyall H, Chow Y, Godambe S, Chalker V, Sriskandan S. Serial clustering of late onset Group B Streptococcal infections in the Neonatal Unit – a Genomic re-evaluaton of causality. Clin Infect Dis. 2018 [Epub ahead of print]

Tosas Auguet O, Stabler RA, Betley J, Preston MD, Dhaliwal M, Gaunt M, Ioannou A, Desai N, Karadag T, Batra R, Otter JA, Marbach H, Clark TG, Edgeworth JD. Frequent undetected ward-based Methicillin-resistant Staphylococcus aureus transmission linked to patient sharing between hospitals. Clin Infect Dis. 2018 Mar 5;66(6):840-848.

Knight GM, Costelloe C, Murray KA, Robotham JV, Atun R, Holmes AH. Addressing the unknowns of antimicrobial resistance: Quantifying and mapping the Drivers of Burden. Clin Infect Dis. 2018 Feb 1;66(4):612-616.

Rawson TM, Castro-Sánchez E, Charani E, Husson F, Moore LSP, Holmes AH, Ahmad R. Involving citizens in priority setting for public health research: Implementation in infection research. Health Expect. 2018 Feb;21(1):222-229.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	23 May 2018

CQC Update

Executive summary:

- **Overview of key CQC activities impacting the Trust**
- The CQC's regulatory framework for NHS trusts was updated in March 2018 to reflect changes in relation to; the Use of resources assessment and the fit and proper persons test.
- On 1 March 2018 the CQC emailed the Trust to advise that a new weekly monitoring requirement was being introduced for all NHS trusts in England which have an emergency department.
- Any exceptions from the CQC insight report will be included in the integrated performance report which is currently being revised.
- The CQC have now moved to a more structured engagement approach with providers.
- **The Trust's approach to CQC during 2018/19**
- The Board will recall that prior to the publication of the Trusts CQC inspection reports in February 2018, the Trust had already established four key work streams to address the on-going issues identified by the CQC. These relate to; statutory and mandatory training, medicines management, medical devices and hand hygiene.
- Work continues to be undertaken in these areas with progress reported to the Executive Quality Committee each month.
- The Executive team are currently taking stock of the Trust's approach to CQC
- Emerging themes from discussions undertaken to date include; strengthening site based leadership and to focus on delivering improvements by site and at core service level using QI methodology, given the CQC inspect the Trust by site and core service.
- Core services with a 'requires improvement' rating yet to be inspected by the CQC (since the 2014 inspection) are; critical care and children's and young people.
- In addition to at least one core service inspection during 2018/19, the Trust will have a use of resources assessment (undertaken by NHSI) and its second trust level well led inspection.

Update for leadership briefing:

As above in the Executive summary

Quality impact:

This paper applies to all five CQC domains.

Financial impact:

This paper has no financial impact.

Risk impact:

This paper relates to the following risk on the corporate risk register:
Risk 81: *Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC.*

Recommendation(s) to the Committee:

- To note the updates.

Trust strategic objectives supported by this paper:		
• To achieve excellent patients experience and outcomes, delivered with care and compassion. • To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.		
Author	**Responsible executive director**	**Date submitted**
Priya Rathod, Deputy Director of Quality Governance	Janice Sigsworth, Director of Nursing	16 May 2018

CQC Update

1. Purpose

The following report is an update on CQC-related activity at and/or impacting the Trust since the previous update to the Board in March 2018.

2. Overview of key CQC activities impacting the Trust

2.1. Key changes to the CQC's Regulatory Framework for NHS Trusts

The CQC's regulatory framework for NHS trusts was updated in March 2018 to reflect the two changes outlined below.

2.1.1. NHS Improvement use of resources assessments

The committee will recall that CQC and NHS Improvement (NHSI) undertook a joint consultation in late 2017 relating to a proposed joint approach to assessing and rating how NHS trusts use resources. This included how CQC inspections would take account of NHSI use of resources assessments, and how use of resources ratings would impact CQC quality ratings.

The CQC has updated its 2016 – 2021 regulatory framework for NHS trusts to reflect the outcomes of the consultation.

- NHSI will carry out its use of resources assessment at each trust before the CQC carries out its inspection of the well-led domain at trust level.
  - If any concerns are identified by NHSI which relate to the CQC's standards for well-led, they will be shared with the CQC which will take them into account during its inspection.
- NHSI will publish use of resources reports at the same time as CQC publishes inspection reports.
- A summary of the outcomes of the use of resources assessment will be included in CQC reports for inspections of its well-led domain at trust level.
  - If there are factual accuracy challenges to the use of resources summary, the CQC will forward these to NHSI for resolution.
- The use of resources became a sixth CQC domain from 5 March 2018 and will have its own domain level rating based on the NHSI use of resources assessment.
- The use of resources rating will have an equal weighting with the current five CQC domains (Safe, Effective, Caring, Responsive and Well-led) and all six will be combined into an overall rating for each trust.
  - To balance the impact of introducing a new, additional rating, the CQC has added a new ratings principle: when the six domain ratings are combined to generate an overall trust level rating, the rating will normally be limited to 'Requires improvement' if at least three of the domain ratings are 'Requires improvement'.
- The Trust will have its first use of resources assessment in 2018/19 and will receive its first use of resources rating.

In terms of the potential impact this may have on the Trust's ability to achieve a 'Good' overall rating:

- The Trust is currently rated overall as 'Requires improvement' based on three of the CQC domains being rated overall at the Trust as 'Requires improvement'.
- Based on the CQC's new ratings principle for combining the six trust ratings into an overall trust rating, in order to achieve 'Good' overall the Trust must either:
  - Improve one of its current 'Requires improvement' ratings AND be rated as 'Good' or 'Outstanding' for use of resources, or
  - Improve at least two of its current 'Requires improvement' ratings.

2.1.2. Fit and Proper Persons Test for Directors and Non-Executive Directors

- In January 2018 the CQC updated its guidance in relation to how trusts must check that people in director/NED level roles (regardless of job title) are fit to carry out the role.
- The guidance now provides a more detailed explanation of what CQC interprets as serious mismanagement and serious misconduct.
- It also offers greater clarity about the obligations and responsibilities of those holding director roles.
- The new guidance has been shared with the Trust's Director for People and Organisational Development when it was first published and is being taken account of in the Trust's processes for carrying out these checks.

2.2. New Emergency Department monitoring

- On 1 March 2018 the CQC emailed the Trust to advise that a new weekly monitoring requirement was being introduced for all NHS trusts in England which have an emergency department, of key indicators which reflect how trusts are coping with winter pressures in the departments.
- The Trust has complied with this requirement; each submission is signed off by the division of Medicine and Integrated Care prior to being sent to the CQC.

2.3. CQC Insight report

- The Board will recall that over the last six months, the CQC have been producing and sharing their 'Insight' report with the Trust which includes a range of indicators and intelligence about the Trust's performance across the five CQC domains.
- The report is shared internally at divisional and directorate level at present.
- Going forward, any exceptions from the insight report will be included in the integrated performance report which is currently being revised.

2.4. Relationship management with the CQC

- The CQC have now moved to a more structured engagement approach with providers. To this end the following is now in place with the Trust:
    - The completion of a quarterly 'engagement form' (provided by the CQC and completed by the Trust) based on queries/intelligence the CQC holds about the Trust.
    - Quarterly meetings followed by a staff drop-in session/or staff focus groups.

3. The Trust's approach to CQC during 2018/19

- The CQC are committed to supporting the trust to improve ratings within core services, across sites and the Trust overall.
- The Board will recall that prior to the publication of the Trusts CQC inspection reports in February 2018, the Trust had already established four key work streams to address the on-going issues identified by the CQC. These relate to; statutory and mandatory training, medicines management, medical devices and hand hygiene.
- Work continues to be undertaken in these areas with progress reported to the Executive Quality Committee each month.
- The Executive team are currently taking stock of the Trust's approach to CQC and have:
    - Attended a 'getting to good' event hosted by NHSI
    - Talked with the Executive team at Cambridge NHST who has improved their

CQC ratings, to share any learning.
    - Invited key note speakers from Cambridge NHST and Bristol UHT to attend the leadership forum in May 2018.
- Emerging themes from discussions undertaken to date include; strengthening site based leadership and to focus on delivering improvements by site and at core service level using QI methodology, given the CQC inspect the Trust by site and core service.
- Core services with a 'requires improvement' rating yet to be inspected by the CQC (since the 2014 inspection) are; critical care and children's and young people.
- In addition to at least one core service inspection during 2018/19, the Trust will have a use of resources assessment (undertaken by NHSI) and its second trust level well led inspection.

4. Next Steps

- Further Develop the Trust's approach to CQC for 2018/19

5. Recommendations to the Board

- To note the updates.

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	23 May 2018

Board assurance framework

Executive summary:

Assurance goes to the heart of the work of any NHS Trust board. The Trust risk management policy and procedures provide the Board with a robust framework by which they ensure that risk is successfully controlled and mitigated. Assurance is then the bedrock of evidence that gives confidence to the Board that risk is being effectively managed, or conversely, highlights that certain controls are ineffective or there are gaps that need to be addressed. The purpose of the Board assurance framework is therefore to enable the Board and its committees to ensure that it receives assurance that all key risks are being effectively managed and to commission additional assurance where it identifies a gap in assurance. This process enables the Board to, inter alia, have confidence in its self-assessment of compliance with regulatory standards and in the year-end reporting.

The framework seeks to demonstrate the way in which the Trust seeks assurance from its reporting arrangements rather than an approach taking assurance from the direct control of individual risks.

The framework was last reported to the Trust board in November 2017. This version reflects amendments made since that date. In particular, following approval by the Trust board in March 2018 of the risk appetite statements, risk appetite ratings have been included on the board assurance framework. So the Committee can now consider the current level of residual risk in the context of the agreed level of risk appetite.

For example, the current level of residual risk for ‘recruitment and retention’ is high, yet the risk appetite is low. The Board should therefore consider the effectiveness of controls in place to mitigate this risk and the assurance being provided.

The framework should also be reviewed in the context of the assurances being provided in the self-certification declarations and executive assurance statements, also being considered at this meeting.

Quality impact:

Ensuring that we seek to continuing improve various areas of our corporate governance will demonstrate that the Trust strives to be a well-led organisation.

Financial impact:

The framework has no direct financial impact.

Risk impact:
Each of the work streams within corporate governance are regularly reviewed for risk impact, and risk register entries developed, including controls and mitigations as appropriate.
Recommendation to the Committee:
The Trust Board is asked to: • Discuss the proposed changes to the risks and agree (or otherwise) the proposed ratings, and assurance sources.
Trust strategic objectives supported by this paper:
To realise the organisation's potential through excellent leadership, efficient use of resources, and effective governance.

Author	**Responsible executive director**
Peter Jenkinson Trust company secretary	Julian Redhead Chief executive

Board Assurance Framework

Revised May 2018 (v3.4 - prep for May board)

Corporate objectives

1. To achieve excellent patient experience and outcomes delivered with care and compassion
2. To educate and engage skilled and diverse people committed to continual learning and improvement
3. As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care
4. To pioneer integrated models of care with our partners to improve the health of the communities we serve
5. To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance

CQC domain	Areas of activity	Corporate objective	Lead	Area of risk	Corporate risk register reference	Sources of assurance			Principal assurance committee(s)	Timetable of assurance reporting	Board reporting		Risk score		Risk appetite
						1st line Reporting	2nd line Internal assurance	3rd line External assurance			What	When	Inherent assurance risk	Residual assurance risk	Risk appetite
Safe	**Patient safety: Infection control**	1	DIPC	Risk of spread of CPE	2487	Reports on outbreaks reports against key metrics	Quarterly report to quality committee	CQC inspection	Quality Committee	Quarterly	Quality committee report to the board	Bi-monthly	High	Medium	Low
Safe	**Patient safety: Medicine management**	1 5	Medical director / chief pharmacist	Failure to: - adhere to medication safety policy - adopt best practice may lead to sub-optimal treatment - controlled medicines usage may lead to unnecessary costs	Following CQC inspection report, this is being added to CRR	Incidents raised on Datix, and investigated at directorate and division	Six monthly report to the executive committee	MRHA annual submission and review CQC inspection	Quality Committee	Six-monthly report	Update by exception through the quality committee report	Bi-monthly	Medium	Medium	Medium
Safe	**Patient safety: Staff: Fire**	1	Director of estates & facilities	Failure to ensure that required fire prevention and management systems are in place, including effective evacuation systems	2479	Incidents raised on Datix, and investigated at directorate and division	Six monthly report to the executive committee	Review and on-going oversight by London Fire Brigade	Quality Committee	Six-monthly report	Update by exception through the quality committee report	Bi-monthly	High	Low	Low
Safe Effective	**Patient safety: Critical care**	1	Divisions directors, DDC & MIC	Failure to achieve specific standards and specifications in delivering critical care standards	2476	Reporting to executive committee of issues and potential resolution. Any patient risk issues would be covered in	The Quality report (which reviews performance in all areas of quality) is presented to Executive monthly.	CQC inspections	Quality Committtee	Bi-monthly	Update by exception through the quality committee report	Bi-monthly	High	Medium	Low
Safe Effective	**Patient safety: Clinical governance**	1 5	Medical director	Failures of quality governance may allow poorer standards of care and may lead to non-compliance with statutory /contractual obligations	On local RR	Divisional governance leads review directorate and divisional arrangements	The Quality report (which reviews performance in all areas of quality) is presented to Executive monthly. Internal	Commissioner Quality Group have oversight CQC inspections	Quality Committee	Bi-monthly	Update by exception through the quality committee report	Bi-monthly	Medium	Low	Medium
Safe Effective	**Patient care**	1	Medical dir / dir of nursing/ divisional directors	Failure to safe and effective care affects CQC rating / incurs penalties/ impacts support for Trust strategic plans	2472 2490	Incidents raised on Datix Complaints Whistleblowing Service line self-assessments	Board member visits Core service reviews Deep dive reviews Internal audit support to core service reviews	CQC inspections PLACE audits	Quality Committee Ad-hoc risk reports are reported to the ARG Comm)	Bi-monthly	CQC report to Trust board CQC inspections	Bi-monthly	High	Medium	Medium
Safe	**Patient safety: Mental health**	1	Divisional director, MIC	Failure to maintain high quality patient care and experience in ED due to extended delays experieinced by mental health patients awaiting transfer	1992	Incidents raised on Datix Regularly reported at executive committee	Core service reviews	CQC inspections	Quality Committee	Bi-monthly	CQC report to Trust board CQC inspections	Bi-monthly	High	Medium	Low
Safe Effective Well-led	**Patient safety: Safeguarding**	1	Director of nursing	Failure of systems and processes (including training of staff) may under-identify safeguarding issues and/or may lead to a failure to respond appropriately	On Local RR	Incidents raised on Datix	Six monthly report to the executive committee	Serious case review outcomes Ofsted reports	Quality Committee	Six-monthly report	Update on safeguarding cases and position	Six-monthly	Medium	Low	Medium
Safe Caring Well-led	**Staff: Recruitment and retention**	1 2	Dir P&OD	Inability to recruit and retain appropriately skilled staff poses risk to quality of patient care Inability to deliver a workforce that enables the required changes for the clinical model	2499	Vacancy rates Time to recruit	Executive committee monitoring programme looks at the efficiency and effectiveness of the recruitment process Internal audit	Safe staffing reported to Commissioners and NHSI at Commissioners Quality Group	Quality Committee receives report on safer staffing and by exception on other risks associated with shortage of appropriate staff Also ARG	Bi-monthly	Safer staffing figures published monthly Update by exception through the quality committee report	Bi-monthly	High	High	Low
Safe Caring Well-led	**ICT: Data quality**	1 2 5	CIO, CFO, Divisional directors, Dir P&OD	Technology / human interface: failing to enable staff to input data in a consistently accurate manner Poor quality of patient information may undermine patient care Poor data quality of Trust information may undermine strategic and contractual	1660	Standardised business and reporting rules that are aligned to national policy with standard definitions and robust change control processes	Snap-shot audits via carried out at team and individual level Monthly audit of backing data at patient level and cross checking against clinical systems Programme of internal audit DQ Steering Group reporting to	The external auditors provide a limited audit of information reported as part of their work on annual report and accounts	Audit, risk & governance committee	Quarterly	ARG committee report to the board	Quarterly	High	High	Medium
Safe Responsive Well-led	**Patient safety: Availability of necessary equipment**	1	Dir of estates & facilities Divisional directors	Failure to provide safe equipment impacts patient and staff safety Equipment failure reduces ability to achieve operational targets	2479 2557	Incidents raised on Datix	Capital steering group oversees prioritisation of critical equipment spend Medical devices management group & quarterly report to ExQual Internal audit	Oversight of IRMER Regulations	Quality committee Finance & investment committee	Bi-monthly	Update by exception through the committee reports	Bi-monthly	High	Medium	Medium
Safe Responsive Well-led	**Patient safety: Staff safety: Management of estates**	1 5	Director of estates & facilities	Failure to: - provide safe estate impacts patient and staff safety - provide an appropriate environment (including cleaning impacting patient experience and outcomes - manage property portfolio impacts on financial position	2479 2480	Incidents raised on Datix Trust's outsourced hard FM have clear procedures for responding to priorities issues	Capital programme reports to executive committee External review of backlog maintenance identified £1.3bn of which £130m of high risk; programme in place to continually monitor priorities as issues are addressed	NHSI aware of external review outcome, and Trust's approach to managing the risk	Finance and investment committee	Bi-monthly capital report toF&I Comm	Update by exception through the report of the F&I Comm, the report of the Redevelopment Comm Specific report on Backlog maintenance	Bi-monthly	High	High	Medium

Safe Well-led	**Patient & staff experience: Stakeholder support for site redevelopment**	4 1 5 2 3	Dir of redevelopment	Failure to: - secure redevelopment support and approval from STP , NHSI etc - secure redevelopment funding - secure support for moving services	2498	Project board oversight and reporting	Reporting to executive committee and board redevelopment committee and commercila sub-group	Approval and programme oversight by NHS Improvement / STP / NHS England	Redevelopment Committee	Monthly	Update by exception through the redevelopment committee report	Bi-monthly	High	High	Medium
Safe Responsive Well-led Caring	**Staff: Health & safety**	5	Dir P&OD	Failure to ensure: - appropriate arrangements in place to protect staff - that staff are immunised fully against biological agents to which they may be exposed	2481	Incidents raised on Datix Incidents reported by Occ Health	Bimonthly report to the executive committee	HSE inspections CQC inspections Internal audits	Quality committee	Bi monthly	Update by exception through the quality committee report	Bi-monthly	Medium	Low	Low
Safe Well-led	**Research**	3	Medical director	Failure to: - secure development of NIHR BRC - ensure research embedded in divisions - to develop AHSC to potential	Held on medical director's risk register	Research lead in each division reporting through management reporting structure	Research and AHSC reports to executive committee	National research oversight bodies	Quality committee	Six monthly research report	Overview of AHSC and other research activity	Annual Six monthly	Medium	Low	High
Effective	**Patient pathway: Development of ACP arrangements & other STP arrangements**	4,1	Chief executive	Failure to deliver the clinical strategy programme to enhance acute services and support out of hospital care	2489	Clear governance arrangements across STP, with H&FGPF, and within Trust	Regular reports to Executive Committee	NHSI and commissioners have oversight of the plans, and engaged in development of ACP arrangements	Audit, risk & governance committee	Propose an annual review of governance arrangements	Annual seminar on integrated care developments; regular updates in CE report	Annual Bi-monthly	Medium	Low	Medium
Effective Caring	**Staff: Education and training (including mandatory training)**	2,3	Medical director / Dir POD / Dir of nursing	Failure to: - adequately train staff poses risk to quality of patient care - achieve benchmark levels of medical education performance	2475 2540	On-line register for all staff	Monthly reporting to the executive committee Internal audits of the systems and processes	Various Royal College and and GMC inspections and visits	Quality committee	Annual report of validation; performance report	Annual seminar on educational activities; mandatory elements in performance report; revalidation report	Annual Bi-monthly	Medium	Medium	Low
Effective Well-led	**Finance: Short-term financial performance**	5	Chief financial officer	Failure to deliver financial plan	2473	Divisional reporting Review financial review meetings for each division	The F&I scrutinise the financial position of the Trust The Exec Comm monitor delivery of achievement against savings plans, and performance against NHSI targets	External audit review during annual accounts preparation NHSI oversight, particularly in relation to Undertakings assurances	Finance and investment committee	Bi-monthly	Monthly finance report circulated Full reporting every other month in Finance report F&I Committee reports every other month	Monthly Bimonthly	High	Medium	Medium
Effective Well -led	**Finance: Long term sustainability**	5	Chief executive	Failure to deliver the transformation programme required to achieve long term efficiencies and financial sustainability	2473	Reporting arrangements will be developed on the appointment of a Director of Strategic development	Regular reports to Executive Committee and Trust board	External audit review during annual accounts preparation NHSI oversight, particularly in relation to control total and the STF	Finance and investment committee	Bi-monthly	Transformation programme report to be developed	Bi-monthly	High	High	Medium
Responsive	**Operational performance**	5 1	Divisional directors	Failure to deliver: - against NHSI targets (particular ED performance & emergency flow & RTT & elective performance)	2410	Divisional review / ICT reporting Senior level committees in place addressing ED / emergency flow, RTT/elective activity, and outpatient improvement	Executive committee reviews performance each month, including reports from committees	NHSI and commissioners - monthly reporting	Executive committee	Bi-monthly	Operations performance report reported to Trust board	Monthly	High	High	Medium
Well-led	**Finance: Financial control**	5	Chief financial officer	Failures of financial control risk leads to unanticipated budget overspends	Finance RR	Standing financial instructions; scheme of delegated authorities; discretionary spend controls	SFIs; SoDFA reviewed annually at executive and relevant board committee	External audit opinion CQUIN achievement	Audit, Risk & Governance Committee	Quarterly, and annual	Audit opinions reported as part of the annual accounts	Annual April/May	High	Medium	Medium
Well-led	**Counter fraud**	5	Chief financial officer	Poor systems and processes lead to financial loss	Finance RR	Cases raised Cases pursued	Internal audit	LCFS reports National benchmarking Home Office feedback	Audit, risk & governance committee	Quarterly	ARG committee report to the board	Bimonthly	Medium	Low	Low
Well-led	**ICT: Programmes & systems**	5 1	Chief information officer	Failure to: - optimise use of GDE award - maintain control may lead to overspend on major investments - potential distraction of shared ICO	ICT risk register	Clear governance arrangements within ICT and between Imperial and C&W to ensure planned progress achieved, and manage risk of 'shared ICO'	Dedicated Executive Digital Strategy Comm monitors delivery against key ICT projects, and ensure engagement Business cases and post-	NHS England - Global Digital Excellence oversight	Finance and investment committee / ARG Committee	Bi-monthly	Reports of the F&I Committee to each Trust board	Bi-monthly	Medium	Low	Medium
Well-led	**ICT: Information security and cyber crime**	5	Chief information officer / SIRO	Breaches indicate a detriment to patients or staff. Serious breaches may incur financial penalties Ransomware challenges Failure to comply with GDPR requirements	2482	Process in place for reporting breaches Clear awareness and actions in place to minimise the impact of cyber crime	Annual report on performance in the Annual governance statement Exception reports on serious breaches IG annual return	DH Information Governance return NHSIC have overview of all cyber crime issues External audit oversight of processes	Audit, risk & governance committee	Quarterly	Annual performance in the Annual governance statement Exception reports on serious breaches IG annual return	Annual	High	Medium	Low
Well-led Responsive	**Finance: Commissioning environment**	5	Chief financial officer	Failure to secure contracts impacts on the financial security of the Trust and may adversely affect quality of service	2473	Clear direction and guidance in place within commissioning team	Executive and F&I Comm receive regular updates on contract position Review as part of the Business	Monthly NHSI oversight, and review of contracts agreed with Commissioners	Finance and investment committee	Bi-monthly	Exception reporting through Committee report Considered as part of	Bi-monthly Annual	High	Low	Medium

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	23 May 2018

Annual report of use of the Trust seal

Executive summary:

The Trust standing orders require that the use of the Trust seal is reported to the Trust board on an annual basis.

Quality impact:

N/A

Financial impact:

The financial impact of this proposal as presented in the paper enclosed:
1) Has no financial impact.

Risk impact:

Reporting use of the Trust seal enables review of the contracts, property agreements and other documentation that has been entered into during the year, acting as a control to reduce risk of misuse.

Recommendation to the Trust board:

The Trust board is asked to note the report.

Trust strategic objectives supported by this paper:

To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Author	Responsible executive director	Date submitted
Jessica Hargreaves Deputy board secretary	Prof Julian Redhead Chief executive	11 May 2018

Use of the Trust common seal April 2017- March 2018

This table is a record of the use of the Trust seal as required by the Trust Standing Orders

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Witnesses to affixment of seal	Date of affixment of seal
188	R Naish, D Ross, R Campbell and R Adam (GPs at Hanwell Health Centre)	Two year leases (from November 2015) to share use of room for cardiology services	Tracey Batten Chief Executive Jan Aps, Trust Company Secretary	06/04/2017
189	John Loveland and Imperial Innovations Ltd	IP in software development DRIQ – digital imaging	Tracey Batten Chief Executive Jan Aps, Trust Company Secretary	27/04/2017
190	Oncall Interpreters Ltd	Provision of language translation services	Tracey Batten Chief Executive Jan Aps, Trust Company Secretary	27/04/2017
191	TIAA Ltd	Lease of occupation for one year of two offices at Hammersmith Hospital	Tracey Batten Chief Executive Jan Aps, Trust Company Secretary	05/05/2017
192	A2 Dominiou	Deed of variation to nominations agreement (30/06/99 Ref 160) for use of accommodation in A2 building stock at Charing Cross Hospital	Tracey Batten Chief Executive Jan Aps, Trust Company Secretary	19/06/2017
193	Community Health Partnerships Ltd	Under lease (8 years) to occupy part of Bridge House, SW6 2FE – community cardiology	Tracey Batten Chief Executive Jan Aps, Trust Company Secretary	12/07/2017
194	Princebuild Ltd	Construction works for improvement at Charing Cross Hospital outpatients department	Tracey Batten Chief Executive Jan Aps, Trust Company Secretary	25/07/2017
195	Abbott Laboratories	10 year laboratory services	Richard Alexander, Chief Financial Officer and Acting Chief Executive Officer Jan Aps, Trust Company Secretary	27/07/2017
196	Children's of St Mary's Intensive Care - COSMIC	15 year lease for parent accommodation at St Mary's Hospital	Julian Redhead, Medical Director/Acting Chief Executive Jan Aps, Trust Company Secretary	07/09/2017
197	Cuffe PLC	Enabling works for MRI replacement A Block Hammersmith Hospital	Ian Dalton, Chief Executive Officer Jan Aps, Trust Company Secretary	29/09/2017
198	R Naish, D Ross, R Campbell and R Adam (GPs at Hanwell	Five year lease (1/11/2017) plus side letter	Julian Redhead, Interim Chief Executive Officer	04/12/2017

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Witnesses to affixment of seal	Date of affixment of seal
	Health Centre		Jan Aps, Trust Company Secretary	
199	Eleanor Nursing & Social Care Ltd	Contract for the provision of a materials management top up service	Julian Redhead, Interim Chief Executive Officer Jan Aps, Trust Company Secretary	11/12/2017
200	EE Ltd & Hutchinson 3GUL Ltd	Deed of variation to an existing lease- telecoms antennae	Janice Sigsworth, Director of Nursing and Acting Chief Executive Officer Jan Aps, Trust Company Secretary	20/12/2017
201	City of Westminster	Variation of contract for the provision of GUM services 2017/18	Julian Redhead, Interim Chief Executive Officer Jan Aps, Trust Company Secretary	10/01/2018
202	Community Health Partnerships	Under lease (5 years) to occupy part of Park View Health & Wellbeing Centre, London W12 7FG	Julian Redhead, Interim Chief Executive Officer Jan Aps, Trust Company Secretary	15/01/2018
203	R Naish, D Ross, R Campbell & R Dhugold (GPs at Hanwell Health Centre)	3.5 year lease for rooms in GP practice re breast screening contract	Richard Alexander, Chief Financial Officer and Acting Chief Executive Officer Jan Aps, Trust Company Secretary	12/02/2018
204	Dr S Wassouf & Imperial Innovations Ltd (IP)	Assignment in relation to diabetes formula: for diabetes information and of insulin calculation	Julian Redhead, Interim Chief Executive Officer Jan Aps, Trust Company Secretary	22/02/2018
205	Xerox (UK) Ltd	Provision of record storage and back file storage/scanning services	Julian Redhead, Interim Chief Executive Officer Jan Aps, Trust Company Secretary	28/02/2018
206	De Lage London	Leasing of 78 Haemodialysis machines	Julian Redhead, Interim Chief Executive Officer Jan Aps, Trust Company Secretary	7/03/2018
207	Lauder & Rees Ltd	Lease renewal for optometrists premises at Charing Cross Hospital (backdated to 01/04/2017)	Julian Redhead, Interim Chief Executive Officer Jan Aps, Trust Company Secretary	14/03/2018
208	Lauder & Rees Ltd	Lease renewal for optometrists premises at Western Eye Hospital (backdated to 01/04/2017)	Julian Redhead, Interim Chief Executive Officer Jan Aps, Trust Company Secretary	14/03/2018
209	Alliance Medical Ltd	Provision of mobile MRI clinical solution at St Mary's	Julian Redhead, Interim Chief	22/03/2018

Seal number	Parties ICHT and…	Nature of transaction requiring affixment of seal	Witnesses to affixment of seal	Date of affixment of seal
		Hospital	Executive Officer Jan Aps, Trust Company Secretary	
210	CDW Ltd	Provision of intranet software and hosting services	Julian Redhead, Interim Chief Executive Officer Jan Aps, Trust Company Secretary	29/03/2018

Imperial College Healthcare NHS Trust

Report to:	Date of meeting
Trust board - public	23 May 2018

Board self-assessment review of effectiveness

Executive summary:

Trust Board effectiveness

As in 2016/17, a questionnaire, developed by the Audit Commission for use in NHS trusts, was sent to all Trust Board members and standing attendees for completion, to enable committee members to reflect on effectiveness of the committee. This is the second year that this process has been completed for Trust Board.

Scores were fairly consistent when compared with the previous year's results, showing marginal improvement in the responses from standing attendees but marginal decrease or no change in responses from non-executive and executive members of the Board. Of particular note is the increase in ratings of behaviours and the positive view of most aspects of the committee by the non-executive members.

Fuller results are attached at Appendix One, but the summary results are:

	Non-executive director mean	Executive director mean	Standing attendee mean
Behaviours	4.2 *2016/17 4.3*	3.8 *2016/17 3.9*	4.1 *2016/17 4.0*
Processes	4.2 *2016/17 4.2*	3.9 *2016/17 4.0*	4.2 *2016/17 4.0*

The most positive responses were in relation to:

- Understanding the risk management framework (behaviours)
- Open channels of communication (behaviours)
- Timely information (processes), and
- Right people invited to attend and present at meetings (processes).

The lowest overall mean score was given to 'Focus on strategic direction' (3.4). This feedback will be taken into account when reviewing the work plans for the Trust Board meetings and the Board seminars.

Low scores were also given to 'Concise, relevant and timely information' and 'Rigour of debate' (3.6). Improvement is therefore required in the quality of papers presented to Board and the Trust Company Secretary will work with executive directors on this, and the Board may wish to reflect on the feedback on the rigour of debate as part of its ongoing development.

Board committee effectiveness

A similar process of self-assessment has been completed for all Board committees, and the feedback and recommendations from this process has been reported to the respective committees. The Remuneration Committee and Redevelopment Committee will receive their respective results at their next meetings in June and the Audit, Risk and Governance Committee will receive its results at its next meeting in July.

The results from the individual committees show a general improvement in effectiveness, in both behaviours and processes. Common themes across committees show positive responses in committees having clear terms of reference, good chairing and the right people attending the meeting. Areas for continued improvement include ongoing personal development to keep up to date, understanding of how assurance is gained, and the need for concise and relevant information.

Quality impact:

No direct impact on quality of service, but related to the Well-led domain within CQC framework.

Financial impact:

The paper has no direct financial impact.

Risk impact:

Ensuring an annual self-assessment of the effectiveness of the Trust Board improves the effectiveness of the Trust's system of internal control and improves its effectiveness as a decision-making body.

Recommendation to the Committee:

The Trust Board is asked to:

- note the results of the survey
- note the improvement in the results since the previous survey
- consider if there are any particular areas of further improvement they would wish to see.

Trust strategic objectives supported by this paper:

To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance.

Author	Responsible executive director	Date submitted
Peter Jenkinson Trust company secretary	Julian Redhead Chief executive	16 May 2018

Appendix One

2018 Trust board self-assessment	NED mean	ED board Mean	Attendee mean	ALL mean
Behaviours				
1. Understanding of core business, business model and risks	4.0	3.7	5.0	4.2
2. Understanding the risk management framework	4.0	4.1	5.0	4.4
3. Understanding of how assurance is gained	3.7	3.6	5.0	4.1
4. Focus on appropriate areas	4.1	3.6	4.0	3.9
5. Rigour of debate	4.3	3.6	3.0	3.6
6. Reaction to bad news	4.6	3.6	4.0	4.0
7. Quality of chairmanship	4.7	4.0	4.0	4.2
8. Ongoing personal development to remain up to date	4.0	4.0	4.0	4.0
9. Frank, open working relationship with executive directors	4.4	3.9	4.0	4.1
10. Open channels of communication	4.1	4.0	5.0	4.4
11. Focus on strategic direction	4.0	3.3	3.0	3.4
12. Perceived to have a positive impact	4.3	3.7	4.0	4.0
13. Appropriate links with other board committees	4.4	3.9	4.0	4.1
14. Unitary board	4.3	3.9	4.0	4.0
	4.2	**3.8**	**4.1**	**4.0**
Processes				
15. Structured and appropriate agenda	4.1	3.9	4.0	4.0
16. Sufficient number and timing of meetings	4.3	3.6	5.0	4.3
17. Right people invited to attend and present at meetings	4.6	3.9	5.0	4.5
18. Concise, relevant and timely information	3.7	4.0	3.0	3.6
19. Timely information	4.1	4.0	5.0	4.4
19. Sufficient time and commitment to undertake responsibilities	4.1	4.0	4.0	4.0
20. Contribution at meetings	4.4	4.0	4.0	4.1
21. Adequate resources	4.4	4.0	4.0	4.1
22. Members with appropriate skills and experience	4.3	4.1	4.0	4.1
	4.2	**3.9**	**4.2**	**4.1**
MEAN OF ALL QUESTIONS	**4.2**	**3.9**	**4.2**	**4.1**

Imperial College Healthcare NHS Trust

Report to**:** **Trust board**

Report from**:** **Finance & Investment Committee (16 May 2018)**

KEY ITEMS TO NOTE

The Committee:

- Noted the draft year end position of the Trust being £0.14m favourable to the control total before STF and winter funding, with select underperformance in some areas. Including non-recurrent winter funding and Sustainability and Transformation funding the Trust was £7.5m favourable to plan with a surplus of £3.0m. The key risk remaining in the 2017/18 position related to commissioner challenges. The Trust had agreed a position with local commissioners but discussions with NHS England were continuing.
- Noted the draft lessons learnt from the 2017/18 year. Committee members welcomed the five key proposals to improve on the current processes which would include greater clarity on measurement and benefit tracking of transformation and other change programmes as well as more rigour around using GIRFT, model hospital and other benchmarks.
- Noted the business plan that had been submitted to NHSI on 30 April 2018, following board approval, as well as the mitigations in place to reduce the significant planning gap that remained.
- Noted the core capital plan for 2018/19 including the Charing Cross Emergency department redevelopment. Concerns were expressed regarding the restrictions placed on necessary investments by the capital resource limit and the increasing problems of the ageing estate. An application for additional funding has been submitted
- Were pleased to note the progress with the cash flow and optimisation work.
- Noted the update on and the lessons learnt from the patient transport tender which had included the Clinical Commissioning Group.
- Received a progress report on procurement from the Procurement Lead; welcomed the savings delivered for 17/18 and planned for 18/19; noted the on-going shift from a Trust focus to increasing use of purchasing hubs (eg Shelford) and national 'Procurement Towers'
- Noted the progress with the transformation programme and sought assurance that there were tangible benefits coming through the system; a further update would be presented to the committee in July.

The Trust board is requested to:

- Note the report.

Report from: Dr Andreas Raffel, Chair, Finance & Investment Committee
Report author: Jessica Hargreaves, Deputy Board Secretary
Next meeting: 18 July 2018

Imperial College Healthcare NHS
NHS Trust

Report to**: Trust board**

Report from: **Quality Committee (9 May 2018)**

KEY ITEMS TO NOTE

Divisional director's risk register update: The Committee reviewed the divisional risks:
Capacity - the Committee recognised that capacity issues continued to be of concern, despite no longer being in core 'winter' months. A programme of work to address this in the short, medium and long term was currently underway and an update on progress would be presented to the following meeting. Committee members acknowledged the impact that the capacity issues were having on staff and extended thanks to all staff for working to keep patients safe and services running.
E-referral system– the Committee noted that Trust processes were in place for the launch of e-referrals but noted concerns that GP practices would not be ready; this would be escalated to the CCG.
Continuing high levels of demand in imaging – the Committee noted the continuing issues in imaging relating to high levels of demand; the division were looking into possible managed equipment services to mitigate the risks relating to aged equipment.
Estates – the Committee noted the continuing estates concerns and the continuing work to address the backlog maintenance.

Serious Incident (SI) monitoring report: The Committee noted that there had been 7 serious incidents in the reporting period; the highest reporting categories were treatment delay due to a lack of availability of mental health beds and maternity/obstetric incidents, with two SIs reported for each. The Committee was pleased to note reductions in SI's relating to sub-optimal care of a deteriorating patient, pressure ulcers, slips/trips/falls and surgical/invasive procedures.

Higher level responsible officers assurance visit report: The Committee noted that the Trust had been visited by the London Revalidation Team on the 21 February 2018 to assess against the core standards framework for the supervision, support and management of medical staff by the organisation and the Responsible Officer. The Committee was pleased to note that the outcome of the visit was positive, with good clinical engagement and noted the action plan in place to address the suggested recommendations.

CQC update: The Committee noted the CQC's 2016-2021 regulatory framework for NHS acute Trusts had been updated to reflect how NHS Improvement's use of resources assessments would be taken account of during future CQC inspections. The Committee were pleased to note the programmes of improvement work, which included speakers from two Trusts who had gone from ratings of 'requires improvement' to 'outstanding'.

Health & safety report: The Committee was pleased to note the significant improvement demonstrated in the staff survey regarding staff on staff violence.

Quality account 2017/18: The Committee noted the final version of the quality account which would be presented for approval at the Trust board on 23 May 2018, and were pleased to note the improvements that had been highlighted.

Developing our 2018-2023 quality strategy: The Committee noted the progress in the development of the quality strategy for 2018-2013 and were pleased to note the significant staff and patient involvement. It is to be hoped that the high-level patient involvement would continue in other areas,

Imperial College Healthcare NHS Trust

and driving levels of influenza immunisation even higher was one which was highlighted

Infection prevention and control quarterly report: The Committee noted that there had been 2 cases of Trust attributed MRSA bacteraemia infections and 63 cases of Trust attributed C. difficile reported in quarter 4. The Committee were pleased to note that the Trust had met all best practice indicators for antibiotic prescribing. The first round of revised hand hygiene auditing would be performed throughout the Back to the Floor Thursdays in May. This programme sought to provide accurate hand hygiene compliance information for all inpatient areas to inform improvement initiatives. The Committee congratulated the team on being asked by NHSI to share their excellent practice with other Trusts to raise standards nationally.

Kirkup review assurance review: The Committee noted the executive assurance statements against the applicable actions that had arisen in the Kirkup review into issues at Liverpool Community Health Trust.

RECOMMENDATION:
The Trust board is requested to:

- Note the report

Report from: Prof Andy Bush, Chair, Quality Committee
Report author: Jessica Hargreaves, Deputy board secretary
Next meeting: 4 July 2018

Imperial College Healthcare NHS Trust

Report to**:** **Trust board**

Report from**:** **Finance & Investment Committee (16 May 2018)**

KEY ITEMS TO NOTE

The Committee:

- Noted the year end position of the Trust being £0.14m favourable to the control total before STF and winter funding. Including non-recurrent winter funding and Sustainability and Transformation funding the Trust was £7.5m favourable to plan with a surplus of £3.0m. The key risk remaining in the 2017/18 position related to commissioner challenges. The Trust had agreed a position with local commissioners but discussions with NHS England were continuing.
- Noted the lessons learnt from the 2017/18 year. Committee members welcomed the five key proposals to improve on the current processes which would include greater clarity on measurement and benefit tracking of transformation and other change programmes as well as more rigour around using GIRFT, model hospital and other benchmarks.
- Noted the business plan that had been submitted to NHSI on 30 April 2018, following board approval, as well as the mitigations in place to reduce the planning gap that remained.
- Noted the core capital plan for 2018/19 including the Charing Cross Emergency department redevelopment. Committee members noted that the executive had agreed to reduce all other budgets equally by the amount required (approx. 10%) to fund the Charing Cross ED project in 2018/19. This reduction would be considered a deferral and budgets would be topped up back to the original amounts if and when additional capital funding was received. Monitoring of the 2018-19 programme would continue to sit with the capital expenditure assurance group, overseen by the capital steering group.
- Were pleased to note the progress with the cash flow and optimisation work.
- Noted the update on the patient transport tender which was being led by the Clinical Commissioning Group.
- Noted the progress with the transformation programme and sought assurance that there were tangible benefits coming through the system; a further update would be presented to the committee in July.

The Trust board is requested to:

- Note the report.

Report from: Dr Andreas Raffel, Chair, Finance & Investment Committee
Report author: Jessica Hargreaves, Deputy Board Secretary
Next meeting: 18 July 2018

Imperial College Healthcare NHS Trust

Report to**:** **Trust board**

Report from**:** **Redevelopment committee report (25 April and 16 May 2018)**

KEY ITEMS TO NOTE

The committee received an update from the chief executive regarding strategy, Sustainability and Transformation Partnerships (STP) status and funding. Clarity around STP funding was required however the committee noted that the Trust's projects were now included in the STP capital list and further discussions regarding priorities would take place in due course.

The outline business case for a new outpatients and ophthalmology facility on the St Mary's Hospital site was submitted to NHS Improvement (NHSI) in March 2018 and comments received. The strategic planning vision document for St Mary's Hospital had also been shared with NHSI for comments.

The committee discussed the decant and design for outpatient and ophthalmology building (the Triangle), particularly the timelines and options for the decant programme including capacity options; structural issues and modular build. An update would be provided to the May 2018 board.

The progress of the Paddington cube and impact on ICHT was discussed.

Confirmation of the redevelopment programme financial outturn for the year ending 2017/18 and anticipated expenditure for 2018/19 was noted.

RECOMMENDATION:

The Trust board is requested to:

- Note the report
- Note that some of the discussion held at the Committee was considered 'commercial in confidence'.

Report from: Sir Richard Sykes, Chairman
Report author: Peter Jenkinson, Trust company secretary
Next meeting: 27 June 2018

Imperial College Healthcare NHS
NHS Trust

Report to: **Trust board**

Report from: **Audit, Risk & Governance Committee (23 April 2018)**

KEY ITEMS TO NOTE

2018/19 Draft internal audit plan

The Committee approved the internal audit plan for 2018/19 subject to further engagement with the chief executive officer, chief financial officer and executive leads. It was agreed that any significant risks that arose over the year would be escalated to Committee members and the plan would then be reviewed and changed as appropriate.

2018/19 Draft counter fraud plan

The Committee approved the counter fraud plan for 2018/19 and were pleased to note that there had been a comprehensive handover with TIAA, and significant input from the Trust's financial controller.

Internal audit progress report

The Committee noted the internal audit progress report and the handover plan with PwC; any open areas of risk would be captured and maintained during the handover process. The TIAA team were thanked for their work, contribution and support over the years.

Draft annual accounts – key statements

The Committee noted the draft annual accounts, with the key judgements being noted and accepted. Committee members were content for the draft to be submitted, subject to sustainability and transformational funding being included.

Draft annual report

The Committee noted the progress with the report and agreed that a statement about the continuing estates issues would be included in the accountability statement as one of the key issues.

Draft accountability statement

The Committee reviewed the draft accountability statement and the significant issues that had been agreed by the executive, and the key risks that had been agreed at the board seminar in October 2017. An updated version would be circulated before the following meeting.

Draft quality account

The Committee reviewed the draft quality account which had been circulated widely for comments; the final draft would be reviewed at the Quality Committee on 9 May, before being presented for approval at the Trust board on 23 May 2018.

Losses and special payments

The Committee noted the report which highlighted that there had been £3.4m in losses in 2017/18 which was a £1m increase from the previous year. Further information would be presented to the Committee in July 2018.

Overseas patients

The Committee noted the update in relation to an overseas patient's debt; a further update would be presented to the Committee in July 2018.

Annual report and accounts – approval

The Committee will meet again on 21 May 2018 to review the draft financial accounts and annual report, and to receive the auditor's opinion on both the accounts and reports. The Committee will then meet on 23 May 2018 for final approval of accounts and annual report prior to their submission by 29 May 2018. The Trust Board is asked to delegate authority to the Audit Committee to approve

Imperial College Healthcare NHS Trust

these submissions on its behalf.

Action requested by Trust board:
The Trust board is requested to:

- Note the report.
- Delegate authority to the Committee for the final approval of the annual accounts and report, for submission by 29 May 2018.

Report from: Sir Gerry Acher as Chairman, Audit, Risk & Governance Committee
Report author: Jessica Hargreaves, Deputy board secretary
Next meeting: 21 May 2018 (accounts review)

Imperial College Healthcare NHS
NHS Trust

Report to: **Trust board**

Report from: **Remuneration Committee 27 April 2018**

Key points to note:

Director of Strategic Development appointment

The Committee considered a paper providing an update on the appointment process Executive Director of Strategic Development and seeking approval for the appointment and remuneration package. The Committee discussed the proposed interim arrangement and the current needs of the trust, in the context of the appointment of a substantive chief executive, and agreed that this would be discussed further with the incoming substantive chief executive.

Director of People and OD appointment

The Committee confirmed the appointment of Kevin Croft as Director of People and OD and approved the proposed remuneration package. The Committee noted a confirmed start date of 14 August for Kevin and noted the cover arrangements for the role. David Wells will stay on in post for two weeks after his notice period, until 13 July, and the remaining month will be covered by the two deputy HR directors in the same way as leave cover.

Chief Executive appointment

The Committee thanked Professor Julian Redhead for his leadership and contribution as interim Chief Executive and noted progress in the appointment of a substantive Chief Executive.

Recommendation:

The Trust Board is requested to:

- Note the report.

Report from: Sarika Patel, chairman, Remuneration committee
Report author: Peter Jenkinson, Trust board secretary
Next meeting: tbc