NHS
Imperial College Healthcare
NHS Trust

Quality account
2018/19

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 112.

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.

Part 1: Statement from the chief executive

Statement from the chief executive

Welcome to our quality account. This is an important document as it gives us the opportunity to describe the progress we are making in constantly trying to improve our services, to provide the highest possible quality of care to our patients. This report is transparent, open and honest and shows what we have achieved but also the areas in which we have improvements to make.

We face the same challenges as other trusts in the NHS, with growing demand, changing care needs, challenges around our workforce, and the need to ensure that we are making the most of advances in treatment. And like other trusts, we have to do this whilst ensuring that our services are financially sustainable. Again this year, we increased the number of 'contacts' we had with patients, carrying out more operations and seeing more patients in our A&E departments and ambulatory emergency care units than last year. This despite the continuing issues we have with our ageing estate and the limited potential to expand our sites. These space and financial challenges mean that to continue to improve services for our patients we must genuinely transform our services, developing better ways of working, keeping our focus on continuous improvement, and working collaboratively with our NHS and other partners across north west London.

Despite the challenges, this report details a whole range of ways in which we have been able to do more for our patients, local communities and importantly, our staff, while progressing along the path back to long-term sustainability. I believe that we have made real progress this year and I write this with a great sense of pride in what our staff have achieved and the care they provide to patients.

As I set out in the annual report, 2018/19 produced some important milestones in terms of future direction and priorities. NHS England published the NHS Long Term Plan, setting out a clear and coherent direction of travel for the whole of the NHS; one that promotes collaboration over competition, continues the shift to more accessible services, puts health centre stage, champions the role of digital and research and recognises the need to do much more to develop and support staff. It represents the NHS side of the deal to match the Government's commitment of higher funding increases over the coming five years.

We are well placed to respond to the plan as we completed our own major piece of work setting out the foundations of a new organisational strategy, making stronger connections between our day-to-day work and priorities and the delivery of our vision, 'better health, for life'. In addition, we developed our first behaviours framework, shaped by staff and partners, setting out what we should and should not expect from each other and what our patients should be able to expect from all of us.

Central to this is our quality improvement methodology, which encourages continuous improvement by building capability amongst our staff. Three and a half years into this journey, many aspects of the programme are now embedded across the organisation and leading to outstanding results. Highlights include our flow coaching academy, and our nine safety streams which are focused on reducing avoidable harm. These are producing real improvements for our patients. Some examples include a reduction in falls with harm and significant improvements in mortality for patients diagnosed with sepsis.

We continue to have some of the lowest mortality rates in the country and have reported fewer incidents causing the most significant harm to patients when compared to last year. We have built on our work to ensure that safety is a universal priority for all our staff and that they feel confident and supported to raise any concerns they might have. I am pleased that our work on improving our safety culture has been recognised nationally by being shortlisted for a HSJ award.

Unfortunately this year we reported seven 'never events', which are serious, largely preventable incidents that should not occur if the available preventative measures have been implemented. We have developed actions in response to make sure we are reducing the likelihood of similar incidents occurring again, including a tailored simulation and coaching programme for all staff involved in invasive procedures.

I am proud that we have managed to make sustainable improvements in all aspects of our operational performance and finances. We have seen more patients and treated them more quickly, with much better delivery against the A&E four-hour access standard, we have eliminated waits of more than 52 weeks for treatment, and we have maintained one of the best performances nationally for cancer care and diagnostic waiting times. Whilst all this work was going on, we have also continued to improve the experience of our patients.

Our improvement work has been supported by innovative uses of technology, including the launch of 'Streams' an app which allows staff to view patients' test results directly from their mobile devices and a project to improve patient experience using a technique called natural language processing. This means that a computer can now extract themes from thousands of patients' comments so we can better respond to what our patients are telling us and make improvements. This work won the BMJ Award for Digital Innovation in 2019.

We have been working hard to improve our organisational culture and the experience of our staff. We have begun to respond to a clear message from our people – through our staff survey – that we need to do more about fairness and equality. We have launched a programme to implement the NHS workforce race equality standard and another set of actions to promote and support diversity more widely, including the development of a number of increasingly influential staff networks. Our vision, values and behaviours programme, which led to our new behaviours framework, is being embedded across the Trust to ensure we achieve real change, helping all our staff to challenge and respond constructively.

We are looking forward to receiving the feedback from the CQC following their inspections in early 2019, which we will use to identify and deliver further improvements for our patients and staff. We recognise that we have much more to do, but I am optimistic that if we can continue to harness the combined expertise and commitment of our staff, patients, partners and communities, we will achieve our vision. I hope this quality account paints a clear picture of our commitment to continuous improvement, and of how important the safety and experience of our patients are to us all at Imperial College Healthcare NHS Trust.

We would like to thank everyone who helped us complete the document including members of the public, Healthwatch, our lay partners, local authorities, non-executive directors 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 them we would not be making the progress that we are.

Professor Tim Orchard
Chief executive officer
Imperial College Healthcare NHS Trust
27 June 2019

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

- Data are 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 are 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 limitations noted above. We are working to improve data quality across the organisation, as described on page 32. Following these steps, to the board's knowledge, the quality account is a true and fair reflection of the Trust's performance.

The report complies with the requirements set out by the Department of Health for quality accounts in the following format:

- **Part 1**: Statement from the Chief Executive and About Our Trust
- **Part 2a**: Our quality improvement plan and priorities for 2019/20
- **Part 2b**: Statements of assurance from the Trust Board – these are mandatory statements relating to specific aspects of the quality of our services. This information is common to all quality accounts.
- **Part 3**: A review of our quality progress for 2018/19 – how we performed in relation to the priorities we set ourselves last year. This includes statements our external stakeholders have provided in response to the document.

The quality account is subjected to a limited assurance engagement carried out by the external auditor; this includes testing of two key indicators (VTE risk assessment and incidents causing severe and extreme harm). This year, it was recommended by NHS England that we also consider auditing SHMI (a mortality indicator) in line with foundation trusts. Following discussion with our external auditors, including a review of the potential benefits and the additional costs required, it has been agreed that we will not be auditing a third indicator this year. We will review whether we should move to comply with all elements of the foundation trust requirements going forward in 2019/20.

We have tried to make this document as straightforward and reader-friendly as possible, but in such a complex organisation some abbreviations are inevitable. A glossary of terms used throughout the document can be found on page 112.

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 and the 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 2018 to May 2019;
    - Papers relating to quality reported to the Trust board over the period April 2018 to May 2019;
    - 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 2019;
    - The annual governance statement;
    - The national inpatient survey 2018;
    - The national staff survey 2018;
    - The General Medical Council's national training survey 2018;
    - 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 2019 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 Audit, Risk & Governance Committee meeting held in May 2019, 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

Professor Tim Orchard
Chief executive officer

Paula Vennells CBE
Chair

27 June 2019

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 over 12,000 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 the Western Eye Hospital.

Our Trust in numbers

Our services

1,225 million
Patient contacts

312,000
Emergency attendees

10,000
Babies born

40,000
Operations

97%
Inpatients would recommend us to their friends and family

Our staff

12,000
Staff including:

2,700
Doctors

4,800
Nurses and midwives

770
Allied health professionals

1,200
Scientists and technicians

130
Pharmacists

900
Medical students

500
Nurses in education, pre-registration

Our finances

£1.213bn
Turnover

£28m
Control total surplus

£44m
Efficiencies

£55m
Capital investments including buildings, infrastructure and IT

Better health, for life: our vision and strategy for 2019-2029

In 2015/16, we worked with our staff and partners to define our vision and values. Since then, we have sought to embed them in everything we do, for example by incorporating them in our quality improvement methodology and our appraisal framework. There is still more to do and, alongside more recent work on our strategy, we have now developed a behaviours framework that sets out how we want to see and be seen to live our values in practice.

Our vision

Better health, for life

Our values

- Kind – we are considerate and thoughtful so everyone feels valued, 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

In 2017/18, we began to articulate three new and overarching strategic goals to create a stronger connection to the delivery of our vision. These were refined in 2018/19, following feedback and analysis of the long-term challenges facing our organisation and the wider NHS.

Our strategic goals:

- To help create a high quality integrated care system with the population of north west London
- To develop a sustainable portfolio of outstanding services
- To build learning, improvement and innovation into everything we do

We will continue to engage with staff, patients and partners and have begun to link these three strategic goals to specific priorities and developments, starting with our quality improvement priorities for 2019/20. Through our organisational strategy, we will now set out what we plan to do over the next 3-5 years and ten years. This will include developing new clinical models and clinical roles, a focus on quality improvement and development of estates, digital and workforce.

In addition to our organisational strategy, we are working with our NHS partners in north west London to re-shape and improve services. Since 2012, this work has been done under the banner of 'shaping a healthier future'. With the publication of the NHS Long Term Plan in January 2019, followed by a Government announcement in March, the North West London health and care partnership agreed to draw the shaping a healthier future programme to a conclusion. As part of our response to the NHS Long Term Plan, we will bring our on-going efforts to improve health and care together in a new programme called the NHS North West London long term plan.

Our Governance framework and structures

Management structure

We put in place an organisational structure in July 2016 to reduce the number of management layers and devolve more authority to clinical staff. Services are organised into 24 clinical directorates, each with its own 'triumvirate' of lead doctor, nurse and manager. The directorates are organised into three clinical divisions, each led by a practising clinician, who is an executive director reporting to the chief executive. They are:

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

In addition, 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

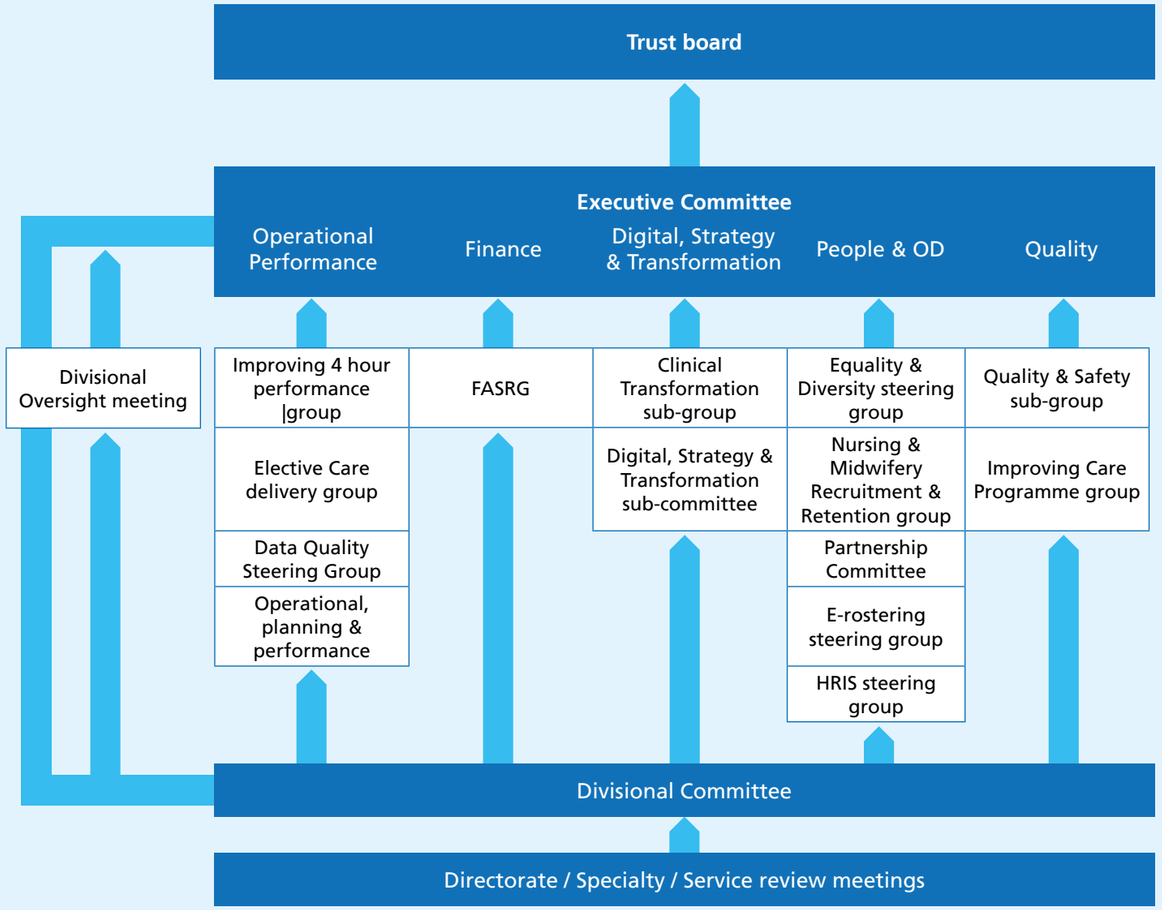
There are five board committees overseeing specific aspects of our work:

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

Below these board committees is an executive committee which meets every week. In addition, executive sub-groups meet monthly to allow time for detailed work to deliver improvements. For example the sub-group to the executive quality committee reviews the work of the divisional quality committees and brings divisions together to consider trust themes.

Our governance structure is shown in figure 1 below.

Figure 1 – Trust Governance Structure



This year we implemented divisional oversight meetings. These are where the three clinical divisions are formally held to account for four key areas: quality, people, performance and finance. At these meetings the divisions present a summary of their performance across all domains, celebrating achievements and raising any areas of risk or concern.

Our key strategies

Quality strategy

Our previous quality strategy came to an end in 2018. A number of key successes were achieved throughout its lifetime, many of which are outlined in this document. They include:

- Creating a standardised quality improvement methodology, supported by an improvement team.
- Creating a culture of safety programme. This includes work streams to improve incident reporting, serious incident investigations, and nine 'safety streams' which are addressing key areas of clinical risk.
- Strengthened processes for clinical audit, including a priority audit plan.
- Complaints improvement, which has seen an increase in timely responses and a reduction in the number of complaints escalated to the Parliamentary & Health Service Ombudsman.

We are currently developing our new quality strategy which will align with our organisational strategy. See page 10 for more information.

Patient and public involvement strategy

In 2016, we developed a trust-wide approach to increasing and improving patient and public involvement. We set out ambitious goals for achieving meaningful involvement in strategic developments, service improvements and health and wellbeing.

Implementation of this strategy is overseen by our strategic lay forum, a diverse group of lay partners and senior trust staff, as well as Imperial Health Charity and Imperial College London, and is actively engaged in our work and plans. It played an important role in the co-design and development of our vision and strategy.

People & organisational development strategy

Published in 2016, this strategy is designed to develop skills and capabilities amongst our staff. It focuses on attracting, developing and retaining quality people through continuous improvement and closer engagement with our workforce. Detailed work is currently underway to refresh our people strategy so that it describes how we are intending to align this work with our organisational strategy to help us to achieve these goals.

Clinical strategy

Our clinical strategy sets out how we develop, organise and connect our services and specialties. This year we completed our speciality review programme (SRP) as the foundation for a new five-year clinical strategy. Information on the SRP is included on page 47. This important work has given us better understanding of the clinical pathways, quality outcomes, workforce implications and financial sustainability issues within each specialty. The new clinical strategy is currently being finalised and will align to our new organisational strategy.

Estates strategy and redevelopment programme

We have the largest backlog maintenance liability of all trusts (£1.3 billion), largely due to the age of our estate. We have had to close beds and departments to react to structural issues, and failures of obsolete equipment where repairs are challenging or spare parts unobtainable. This is a key risk for us, is challenging for our staff, affects patient experience, impairs service provision and, at times, creates a risk to patient safety.

The scale of these challenges are substantially beyond the resources of the Trust, but our estates strategy for 2016 to 2026 considers every realistic option to ensure that, insofar as possible, we continue to provide safe, secure, high-quality healthcare buildings capable of supporting current and future service needs.

Digital strategy

We are progressing well with our digital strategy, spanning the five years from 2015 to 2020. We are moving from paper records to digital data capture and processing, so that staff and patients can easily and securely access, update, analyse and share information to provide best patient care. This is driving more productive working internally and across the local health system by:

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

Part 2a: 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 2019/20.

Our approach to quality improvement

We launched our quality improvement methodology and our approach to creating a culture of continuous improvement with our 2015-18 quality strategy. We use the Institute for Health Improvement's (IHI) model for improvement[1]. This ensures that all improvement work has a clear aim and that at the start of any work, we have identified clear measures to track improvement. Driver diagrams are used to articulate why certain work / projects / initiatives will logically lead to achieving the aim and are co-designed with our staff, patients and wider communities. In collaboration with them, we can then undertake rapid tests of change using multiple Plan-Do-Study-Act (PDSA) cycles which help to roll out sustainable improvement at scale and pace.

The programme is underpinned by seven key objectives for 2019/20:

Over 6000 staff have taken part in our education programmes, and are encouraged to use their skills to make local improvements within their teams. We now have over 170 improvement coaches in the organisation who have participated in our Coaching and Leading for Improvement Programme (CLIP).

Three and a half years into our quality improvement journey, many aspects of the programme are now embedded across the organisation and leading to outstanding results. For some examples, please see the sections on our safety streams (page 50-53) and our Flow Coaching Academy (page 42-43).

Developing our Improving Quality Strategy

We are developing our new 'Improving Quality Strategy', which will cover 2019-2023. It will make the crucial link between all of our work on how we gather quality insights, govern and improve quality, and our organisational vision and strategy. It will set out our plans for quality over the next five years with the aim to be consistently providing outstanding and sustainable care during its lifetime. It will clearly define what we mean by high quality and how we measure it. It will give a clear narrative around how we will put our standardised improvement methodology into action in everything we do. The strategy will focus on getting the basics right as well as fulfilling our role of pushing the boundaries of innovation.

The strategy will be based on:

- an evidence scan to ensure it is designed to meet a range of national, system-wide and community needs and priorities;
- the learning and insights we have gathered through the co-design of our organisational strategy and vision;
- what we heard during a listening campaign with over 1,000 people which commenced in December 2017. We plan to repeat this exercise every year so that we can ensure that patients, staff and community groups are involved in setting our priorities and in the co-design of improvement initiatives.

1 IHI model for improvement http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Our quality priorities for 2019/20

Our goals

We measure quality using the five domains the Care Quality Commission (CQC) use. They're designed to ensure that we focus on the things that matter to people, and that we make improvements which are aligned to the CQC's regulatory requirements. They are:

- **Safe**: people are protected from abuse and avoidable harm
- **Effective**: people's care, treatment and support achieves good outcomes, helps them to maintain quality of life and is based on the best available evidence.
- **Caring**: staff involve and treat people with compassion, kindness, dignity and respect.
- **Responsive**: services are organised so that they meet people's needs.
- **Well-led**: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around people's individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

We have included one more domain, which was defined by the National Quality Board (NQB) and which is monitored by NHS Improvement and included in CQC inspection reports, to ensure that we deliver value for money for our patients, communities and taxpayers:

- **Use resources sustainably**: we use resources responsibly and efficiently, providing fair access to all, according to need, and promote an open and fair culture

Each quality domain has an aim and a suite of metrics so that we can measure improvement. The metrics for 2019/20 are set out over the following pages. A driver diagram is included for each domain which describes the drivers, change ideas and improvement which will support delivery of the metrics.

Last year, we identified thirteen priority improvement areas using the driver diagrams for each domain, feedback from our listening campaign and CQC inspections as well as our operational objectives. Recognising that we still have work to do to make and sustain improvements in a number of areas; we plan to continue the following into 2019/20:

- To reduce avoidable harm to patients
- To continue to define, develop, implement and evaluate an organisation approach to reducing unwarranted variation
- To improve access to services across the Trust through a focus on increasing capacity and improving emergency flow (this is a combination of two previous priorities)
- To improve access for patients waiting for elective surgery
- To improve compliance with the equality and diversity standards

Two of last year's priorities are being changed slightly for 2019/20. These are:

- To improve the behaviours across the Trust related to safety. This has changed from 'to improve the safety culture across the Trust' to better fit with the work we are doing around our organisational strategy – see page 10 for further information
- To improve staffing levels for permanent nurses and non-consultant doctors. We have included non-consultant doctors to bring us in line with national requirements.

These are described in more detail on pages 35-47, setting out progress made in year and outlining plans for further improvements into 2019/20.

We are also introducing an additional priority for the coming year:

Improvement priority	To review our approach to inspection, accreditation and reviews
Rationale for inclusion	Learning from the work undertaken in the lead up to the recent trust inspection by the CQC it is timely to review the approach and plans to support teams to improve against key lines of enquiry and expected standards.
What will we do?	We will review our current approach and roll out a new improving care assurance programme. This will be an annual inspection of all core services and will include staff interviews, patient and staff focus groups, observation of practice, documentation review and an inspection of the care environment. Through this process we will celebrate what is being done well, sharing and spreading these examples to other areas through the improving care programme group. We will mobilise improvement coaches to areas with improvement opportunity identified during this process.
Measureable target for 2019/20	The success of this priority would be an improvement in the Trust's CQC rating overall.

Monitoring quality

Our governance arrangements for quality are led by the medical director who has executive responsibility. These are included in figure 1 on page 11. Progress with our quality metrics and priorities are reported through this framework, to enable monitoring from ward to board.

Our metrics are reported in our integrated quality and performance scorecard (IQPR). Each month, our executive team and the trust board reviews these core indicators, which are organised into the Care Quality

Commission's five quality domains, with an additional domain on use of resources. For each indicator, we look at how we are performing against national standards and/or our own targets. In 2018 we introduced exception reporting, which incorporates action plans for areas that need to return to trajectory, with gradual introduction of measurement for improvement methods.

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

Our improvement priorities are varied in nature and scope and are therefore not fully covered by the IQPR. As a result, each priority has a confirmed executive lead with separate reporting arrangements through an executive committee. Every quarter we provide a summary of progress with all the improvement priorities to the executive quality committee so that we are considering them together and to allow the executive team to take stock of progress and support improvements.

An annual summary of our progress in delivering our quality metrics and priorities is provided in our quality account (see section 3 – pages 34-73).

We also work closely with our commissioners to monitor performance in all areas of quality through the monthly Clinical Quality Group. We monitor progress with delivery of the quality strategy and work collaboratively to develop the annual quality account, acute quality schedule (see glossary on page 112) and priorities. This ensures that our quality agenda aligns with local and national priorities.

Quality Domain 1:

Safe

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

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	To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing moderate 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 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 prevention and control	We will achieve a 10% reduction in healthcare-associated BSIs caused by E. coli	10% reduction (n=65)
Infection prevention and control	We will have no healthcare-associated BSIs caused by CPE	0
Infection prevention and control	We will ensure we have no avoidable MRSA BSIs and cases of C. difficile attributed to lapse in care	0
Infection prevention and control	We will meet flu vaccination targets for frontline healthcare workers as part of the national seasonal flu campaign	National target
VTE	We will assess at least 95% of all patients for the risk of VTE within 24 hours of their admission	95%
Sepsis	We will ensure at least 90% of our patients receive antibiotics within one hour of a new sepsis diagnosis	90%
Maternity standards	We will maintain postpartum infections (puerperal sepsis) to within 1.5 per cent or less of all maternities	1.5 per cent or less
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 the number of reactive maintenance tasks completed within the allocated timeframe	70%
Estates and facilities	We will ensure our cleanliness audit scores meet or exceed the required standards	95% (very high risk areas)
Workforce and people	We will achieve compliance of 90% with core skills training	90%
Workforce and people	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%

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 and staff and proactively learn from mistakes and best practice	Systems and processes for alerting and recording safety related risks and issues are in place and being used
		There are strong quality governance arrangements from ward to board
		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
		We 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 reviews	We will ensure structured judgement reviews (SJRs) 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.	SJRs undertaken in 100% of relevant cases 100% of SJRs completed within 30 days of date of commencement
Readmissions	We will reduce the unplanned readmission rates for patients aged 0-15 and be below the national average	Better than national average
Readmissions	We will reduce the unplanned readmission rates for patients aged 16 and over and be below the national average	Better than national average
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%

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 at 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 into 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.

Area	Description	Target
Friends and family test	To maintain the percentage of inpatients who would recommend our trust to friends and family (FFT) to 94% or above	94%
Friends and family test	We will achieve and maintain a FFT response rate of 15% in A&E	15%
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	90%
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

Quality domain 4:

Responsive

Aim/CQC definition: Services are organised so that they meet people's needs

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
Length of stay	We will reduce the percentage of patients with length of stay over 21 days	25% reduction
Length of stay	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%
Outpatients	We will reduce the proportion of patients who do not attend outpatient appointments to 10%	10%
Outpatients	We will reduce the proportion of outpatient clinics cancelled by the trust with less than 6 weeks' notice to 7% or lower	7%
Complaints	We will maintain the numbers of formal complaints at less than 90 per month	Less than 90 per month
Complaints	We will ensure that we respond to complaints within an average of 40 days	40 days
Complaints	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 our non-emergency patient transport service	Collection within 60 minutes: 97%
Data quality	Data Quality Maturity Index	TBC

Goal	Primary driver	Secondary driver
Responsive: Services are organised so that they meet people's needs	1. Care and treatment 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 supported 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 patient groups
	3. Patients have timely access to our services	Patients have access to timely planned care (from pre-referral advice and outpatients, to diagnostics and 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 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%
NHS Improvement (NHSI) segmentation	We will maintain or improve NHSI provider segmentation	3

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
		Ensure effective and high quality management capability
	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
		Ensure high levels of staff mental and physical wellbeing
		Improve equality and diversity through embedding the new work programme
	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

Quality domain 6:

Use resources sustainably

Aim/CQC definition: We use resources responsibly and efficiently, providing fair access to all, according to need, and promote an open and fair culture

Area	Description	Target
Finance KPIs	Monthly finance score (1-4)	N/A
Finance KPIs	In month position	N/A
Finance KPIs	Year to date position £m	N/A
Finance KPIs	Annual forecast variance to plan	N/A
Finance KPIs	Agency staffing	N/A
Finance KPIs	CIP (cost improvement programme)	N/A

There will be further development of the use of resources domain during 2019/20.

Part 2b: 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 2018/19. 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 2018/19, Imperial College Healthcare NHS Trust provided and/or sub-contracted 99 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 2018/19 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2018/19.

The income generated by patient care services associated with the services above in 2018/19 represents 84 per cent of the total income generated from the provision of services by the Trust for 2018/19.

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 2018/19, 55 national clinical audits and two national confidential enquiries covered NHS services that Imperial College Healthcare NHS Trust provides. During that period we participated in 89 per cent of national clinical audits and 100 per cent of national confidential enquiries in which we were eligible to participate.

The national clinical audits and national confidential enquiries that Imperial College Healthcare NHS Trust was eligible to participate in are included in the table in appendix A with the number of cases submitted presented as a percentage where available.

We did not participate in the five BAUS audits in 2018/19. This decision is currently being reviewed by the Trust executive team.

We have now joined the inflammatory bowel registry and have been participating since April 2019.

The reports of twenty-six national clinical audits and confidential enquires were reviewed by the provider in 2018/19. The majority of these have provided a satisfactory level of assurance; however the exceptions are listed in appendix B 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 313 local clinical audits were reviewed by the provider in 2018/19. Some examples of the actions we have taken or intend to take can be found in appendix C.

Participation in clinical research

We continue to develop ambitious and world-leading programmes of clinical research, partnering closely with Imperial College London as Imperial College Academic Health Science Centre (AHSC). In collaboration also with industry, the charity sector and government, this partnership drives the biomedical and clinical research strategy in the Trust. It ensures we remain at the forefront of scientific discovery, and can then apply that new knowledge to the clinical needs of our patients and wider population.

Through the AHSC we also work closely with the Royal Brompton & Harefield NHS Foundation Trust and the Royal Marsden NHS Foundation Trust, coordinating and aligning our priorities across North West London.

Much of our innovative clinical and biomedical research is made possible because of significant infrastructure funding, awarded through open competition by the National Institute of Health Research (NIHR). This includes our NIHR Biomedical Research Centre (BRC), Clinical Research Facility (CRF), Patient Safety Translational Research Centre (PSTRC), Experimental Cancer Medicine Centre (ECMC) and MedTech & In Vitro Diagnostics Cooperative (M&IC). Funding from our own Imperial Health Charity ensures this work is directed towards the benefit of our NHS patients, as well as providing career development opportunities for our medical staff and for those working in professions allied to medicine.

Since April 2017, the BRC has funded more than 250 individual experimental medicine research projects. In total, 605 new clinical studies were initiated in 2018/19, including those with external funding from the commercial, government and charitable sectors.

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2018/19 that were recruited to participate in research approved by a research ethics committee was 18,988. 15,300 patients have been recruited into 377 NIHR Portfolio studies in 2018/19. This included 2,820 patients within 75 studies sponsored by commercial clinical research and development organisations.

In 2018/19, we also launched a strategy to develop our capacity for research led by non-medical staff communities, including research nurses, allied health professionals and clinical research practitioners. It aims to support and build research awareness, research involvement, research activity and research leadership across the Trust.

Through joint working with our academic partner, we have continued to make significant scientific advances in 2018/19, translating discovery into patient benefit. Highlights include:

- A first-in-human, commercially-sponsored gene therapy trial showed remarkable success in treating patients with haemophilia A. The success of the study has led commentators to hail this as a potential cure for haemophilia A;
- ORBITA – the first, placebo-controlled double-blind randomised controlled trial of percutaneous coronary intervention (PCI) – demonstrated the potential placebo effect of heart stents. The trial exposed the flawed position of PCI in current clinical recommendations;
- A unique CAR-iNKT cell treatment strategy, developed by scientists in the Imperial BRC Cancer Theme, has proved more effective than conventional treatments;
- In 2014, Imperial established a Faecal Microbiota Transplantation (FMT) unit with support from the BRC and Imperial Health Charity. A number of patients with antibiotic-resistant C. difficile infections (CDI) saw improved health and normal wellbeing after a single dose of FMT. Recently, the first-ever UK FMT Guidelines were published (which Imperial FMT clinicians contributed to), providing evidence-based advice of best clinical FMT practice. FMT has now been accepted as an appropriate treatment option for recurrent/refractory CDI by the National Institute for Health and Care Excellence (NICE);
- The NIHR Imperial BRC, in collaboration with the University of Edinburgh, have developed new software capable of detecting small vessel disease (SVD), a leading cause of stroke and vascular dementia. Based on Artificial Intelligence (AI) techniques, the new method allows for precise and automated measurement of the disease;
- Our research has provided new insights into the transmission of Group B streptococcus, a very common bacteria which is normally harmless. In newborn babies, the bacteria can cause serious infection, with transmission occurring during birth. In late-onset cases, the source of infection is often unclear. In our study, genomic analysis of 11 late-onset cases provided evidence to suggest a greater role for transmission between patients. As a result, a range of interventions have now been introduced to reduce the risk to patients;
- Imperial BRC researchers have developed an Artificial Intelligence (AI) system that could be used to personalise the treatment of patients with sepsis in real time. The computational model learned the best individual treatment strategy from medical records of almost 100,000 sepsis patients and provided recommendations that proved more reliable than decisions made by doctors. The system will now be trialled in UK hospitals. This cutting-edge work is a direct result of the Imperial ethos that brings together engineers and clinicians to solve real health problems and improve healthcare;
- In February 2019, as part of a collaboration with other UK and international universities and hospitals, one of our patients became only the second person ever reported to have been cleared of HIV after receiving a stem-cell transplant that replaced their white blood cells with HIV-resistant versions. The patient was able to stop taking antiretroviral drugs, with no sign of the virus returning 18 months later;
- A new research centre – the first of its kind in Europe – will accelerate research to reduce and prevent the risk of premature birth. The March of Dimes Prematurity Research Centre, will be funded by the US charity March of Dimes and supported by a grant from Ferring Pharmaceuticals, who specialise in reproductive medicine and women's health. March of Dimes support research, lead programs and provide education to improve the health of mums and babies.

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

Our CQUIN performance – CQUIN framework

A proportion of our income in 2018/19 was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) framework. The value of the schemes was 2.8 per cent of the contract value for NHS acute healthcare services as agreed with NHS England and 2.5 per cent of the contract value for agreed Clinical Commissioning Group (CCG) schemes. This equated to £7.2M (NHS England schemes) and £10.05M (CCG schemes) of our planned income. A summary of the 2018/19 CQUIN goals and achievements can be found in appendix D.

Our CQUIN goals for 2019/20 have not yet been agreed, however they are likely to focus on similar issues to our current goals.

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 did not take enforcement action against Imperial College Healthcare NHS Trust during 2018/19.

We have not participated in any special reviews or investigations by the CQC during 2018/19.

All trusts are captured in CQC patient surveys, of which two were published during 2018/19: adult inpatients and maternity. Our performance in the maternity survey, carried out during 2018, was the same as or better than the results of the previous survey. For the adult inpatient survey, carried out during 2017, the Trust's performance was generally better than the results of the previous survey.

The CQC inspected four of our core services in February 2019:

- Critical care at St Mary's and Charing Cross and Hammersmith hospitals
- Services for children and young people at St Mary's and Hammersmith hospitals
- Maternity at St Mary's and Queen Charlotte & Chelsea hospitals
- Neonatal services (the neonatal ICU) at Queen Charlotte & Chelsea Hospital.

Our inspection of the well-led domain took place from 2-4 April 2019. We expect to receive the inspection reports for the core services and well-led inspections in draft form in July 2019, and published by the CQC in their final form in August 2019.

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 focus on data quality improvement in 2018/19 through our data quality framework which we introduced in 2017/18.

Key data quality indicators are reported weekly and are included in our performance scorecards to ensure data quality governance is aligned with our performance management framework. A monthly executive-led Data Quality Steering Group is in place to provide leadership and oversight of the development and delivery of all aspects of our data quality framework.

A key component of the data quality framework is a quality assurance and audit process to inform training, learning and development. We carry out routine audits of referral to treatment (RTT), A&E performance, diagnostics and cancer waiting time information to identify recurrent errors with data entry. Currently three out of four waiting time audits are reporting under the agreed 5 per cent threshold agreed by NHS Improvement.

Our director of operational performance is leading a refresh of our approach to data quality which will be completed by June 2019. The priorities are:

- Expanding the routine audit programme to include length of stay, the inpatient waiting list and the outpatient new and follow up waiting lists;
- Developing a quality assurance process to routinely analyse income and activity data sets; and
- Improving the accuracy of the Secondary Users Service (SUS) submission, particularly in relation to the reporting of bed occupancy.

We will produce a monthly data quality report from April 2019 to inform senior leaders of the current status of data quality within the Trust.

NHS number and general medical practice code validity

The Trust submitted records during 2018/19 to the Secondary Users Service for inclusion in the Hospital Episode Statistics (see glossary on page 112 for definitions) which are included in the latest published data. The percentage of records in the published data to month 10 2018/19 (most recent available) which included the patient's valid NHS number was:

- 97.5 per cent for admitted patient care;
- 99.2 per cent for outpatient care;
- 91.7 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;
- 99.7 per cent for accident and emergency care.

Information governance toolkit scoring

The data security protection toolkit is an online self-assessment tool that all organisations must use if they have access to NHS patient data and systems to provide assurance that they are practicing good data security and that personal information is handled correctly. This replaced the previous information governance toolkit from April 2018.

We met all the mandatory standards of the toolkit and therefore produced a 'satisfactory' return. This was published to the Department of Health and verified as 'low risk' and 'reasonable assurance' following independent audit.

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 2018/19. There are no payment by results audits currently planned.

North West London clinical commissioning groups reviewed our non-elective clinical coding and day case haematology data quality in 2018/19 and the cases with an error were found to be 4.4% and 61.7% respectively. This is under discussion with our commissoners.

Learning from deaths

We comply with all elements of the national learning from deaths process with a policy that sets out standards and measures reported up to Trust Board. Through this process, 93 per cent of deaths which occurred at the Trust between April 2018 and March 2019 have been reviewed so far. Of these, 14 per cent have gone forward for structured judgment review (SJR). This is a validated methodology and involves trained clinicians reviewing medical records in a critical manner to comment on phases of care and determine whether the death may have been due to problems with the care the patient received. We have identified avoidable factors in eleven deaths this year.

The SJR process includes presentation to the monthly mortality review group where we identify learning opportunities and themes and share these across the Trust. Where the review identifies avoidable factors in a death, we also complete a serious incident investigation.

Our target is to undertake SJRs for all selected cases within 30 days of death. For next year, we will move to reporting from date of death to date of SJR request as this will allow us to monitor performance more transparently.

In late 2018, we identified some improvements to the process which will support us in the lead up to the implementation of the nationally mandated role of a medical examiner (ME). We have established a Learning from Deaths steering group to oversee this work.

We are required to provide the following statements in this document based on our findings as part of the learning from deaths process.

Deaths which occurred in 2018/19

During 2018-19, 1,702 of our patients died. This comprised the following number of deaths which occurred in each quarter: 413 in the first quarter; 408 in the second quarter; 440 in the third quarter; 441 in the fourth quarter.

223 case record reviews (structured judgement reviews) and 15 serious incident investigations have been carried out in relation to these 1,702 deaths.

In 12 cases, a death was subjected to both a case record review and a serious incident investigation. The number of deaths in each quarter for which a case record and a serious incident investigation was carried out was: 7 in the first quarter; 2 in the second quarter; 1 in the third quarter; 2 in the fourth quarter.

Eleven (0.65%) of the 1,702 patient deaths which occurred in 2018/19 are judged to be more likely than not due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 4/413 (0.97%) for the first quarter; 2/408 (0.49%) for the second quarter; 0/440 (0%) for the third quarter; 5/441 (1.13%) for the fourth quarter.

These numbers have been estimated using our structured judgment review process described above.

Themes for deaths deemed to have avoidable factors link to five of our safety streams (see pages 50-53 for more information); 'falls and mobility', 'responding to the deteriorating patient', 'safer medication', 'safer surgery', and 'fetal monitoring'. Additional themes include poor communication and treatment delays. Cases are shared with the safety stream leads to ensure the improvement work covers the findings of the SJRs. Actions taken by the safety streams linked to the SJRs, and the impact of these, are included on pages 50-53.

Individual action plans are also developed in response to each case. Examples of these actions include:

- Review of the venous thromboembolism protocols in renal;
- Repatriation guidance in trauma patients to be considered;
- Multi-disciplinary learning undertaken for management of hyperkalaemia;
- Emergency department exit checklist to be incorporated into Cerner;
- Local teaching on treatment of pulmonary embolism.

We expect that the impact of these actions will be improvements in the overall quality and safety of care provided to our patients. On a trust-wide level, we continue to have some of the lowest mortality rates in the country and have seen a reduction in both avoidable deaths and patient safety incidents causing extreme harm/death compared to last year.

Deaths which occurred in 2017/18

248 case record reviews and 38 serious incident investigations that related to the 1,895 deaths that took place during 2017/18 were completed. Of these, 18 of the deaths reviewed or investigated during that year were judged to be more likely than not due to problems in the care provided to the patient. This represents 0.95% of the deaths that occurred during that financial year.

In total, for financial years 2017/18 and 2018/19 combined we have reported 29 deaths for which we have identified avoidable factors through our learning from deaths process.

National outcomes framework indicators 2018/19

The NHS Outcomes Framework 2018/19 sets out high level national outcomes which the NHS should be aiming to improve. For full information about our performance, please see pages 74-81.

Part 3:
A review of our quality progress 2018/19

This part of the report shares the quality improvement priorities and metrics that we set ourselves for 2018/19 and reports our progress against each of these. It also outlines our performance against the NHS Outcomes Framework 2018/19 and national targets and regulatory requirements.

As described on page 15, for 2018/19 we identified 13 areas where we wanted to prioritise our improvement activity. Progress against these is outlined below. They are not described under a quality domain as many of them span multiple.

Improvement priority 1	To reduce avoidable harm to patients
Executive lead	Medical director
Why this was included for 2018/19	Although our incident reporting rates and harm profile are good we take avoidable harm seriously and strive to continuously minimise it.
What we achieved	This year, we have seen **a reduction in the number of incidents causing the most harm to patients**, whilst maintaining high numbers of incidents reported. We reported 11 severe and extreme harm incidents compared to 27 last year. We have also reported **fewer avoidable deaths** – 11 this year, compared to 18 last year and continue to have **some of the lowest mortality rates** in the country. We have improved outcomes for patients in several key areas, including a **reduction in mortality for patients diagnosed with sepsis** from 18 per cent to 14 per cent, and a 22 per cent **reduction in falls with harm.** However, this year we also reported **seven never events**, compared to one last year. We have developed actions in response to make sure we are reducing the likelihood of similar incidents occurring again.
What we did	**Progress with the 'safety streams'** Work continued in our nine safety streams which address the key risks identified from our most frequently reported serious incidents (SIs) – progress with each of these is outlined in more detail in the safe domain (see pages 50-53). Each stream is chaired by an experienced clinical lead with dedicated support from an improvement team lead. **Implementation of our Sepsis policy and alert** 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 the outcome for patients. In 2018 we launched a sepsis policy, to support the early recognition, management and treatment of sepsis. This was accompanied by a live alert in our electronic patient record designed to improve the identification of adult patients at high risk of sepsis and a treatment care plan for when sepsis is identified. This work was implemented through our sepsis 'big room' (see pages 42-43 for more information) and has resulted in a reduction in mortality for patients with sepsis. We started reporting on our performance with our target to ensure at least 50 per cent of our patients receive antibiotics within one hour of a new sepsis diagnosis in November 2018 and have achieved it every month since then. The work is continuing, with recruitment of new sepsis nurses underway and the development of a training programme for staff which will roll out in 2019. **Our response to the never events** Never events are defined as serious, largely preventable incidents that should not occur if the available preventative measures have been implemented. The seven never events we reported this year are: • wrong route medication in May 2018 (emergency medicine at Charing Cross Hospital) • retained swab in July 2018 (maternity at Queen Charlotte's and Chelsea Hospital) • retained foreign object in September 2018 (cardiac surgery at Hammersmith Hospital) • wrong site surgery in October 2018 (urology at Charing Cross Hospital) • wrong site block in November 2018 (plastic surgery at Charing Cross Hospital) • wrong site block in January 2019 (CT radiology at St Mary's Hospital). • retained swab in January 2019 (maternity at Queen Charlotte's and Chelsea Hospital) Six of the seven were related to invasive procedures. All of them have been investigated and have action plans in place. We have had agreement from our commissioners that the never event which occurred in May will be re-classified to a serious incident as following investigation, it was found that the swab concerned had been intentionally retained. We also implemented a trust-wide action plan. This included the medical director visiting theatres, talking to staff on the frontline about how to make improvements and encouraging staff to support each other to work safely; the roll out of a tailored coaching and simulation training programme for all areas where we undertake invasive procedures, starting with the specialties where we've had never events; actions to improve, monitor and provide assurance around compliance with key safety checks, including the five steps to safer surgery, and a review of all trust policies and processes related to invasive procedures. At our request, Dr Fowler, the national director of patient safety visited us to discuss our plans. He was supportive of the actions and approach we are taking.

Further work we need to do	This will continue to be an improvement priority, with work continuing in the nine safety streams, the implementation of recommendations to improve both our learning from deaths and serious incident processes, and the continued roll out of sepsis monitoring across all areas of the Trust.
Measurable targets	• Reduction in the most commonly occurring SIs which have caused or have potential to cause harm • Increase in the percentage of patients receiving antibiotics within one hour of a sepsis diagnosis in line with our trajectory, with the aim to achieve 90 per cent in line with new national requirements. • Reduction in the number of incidents resulting in harm • Reduction in never events

Improvement priority 2	**To improve the safety culture across the Trust**
Executive lead	Medical director
Why this was included for 2018/19	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, and is in place to ensure that safety is a universal priority for all staff groups.
What we achieved	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. Since we started our incident reporting improvement programme we have seen an **increase in the numbers of incidents reported** by 746, from 16,166 in 2016/17 compared to 16,912 in 2018/19, while maintaining low levels of harm. Our incident reporting rate per 1,000 bed days has however reduced and is below the top quartile when compared nationally, this is due to a number of issues with our published bed day data for quarter three which is used to calculate our reporting rate for the last six months of 2018/19. The quarter four bed occupancy data is expected to reduce, bringing our reporting rate up. In our staff survey we saw a further **improvement in the percentage of staff feeling able to raise concerns** (77 per cent compared to 75 per cent in 2017), with performance being maintained for staff being encouraged to report patient safety concerns (85 per cent) and for staff feeling that the Trust encourages staff to report incidents (78 per cent). We have also improved how we are enacting the duty of candour and being open with our patients when things go wrong, with **patients receiving both a verbal and written explanation and apology for all appropriate incidents in over 90 per cent of cases,** which is an improvement on last year, though below our 100 per cent target. We are reviewing how we measure this target. We are very proud that our safety culture work has been **shortlisted for a HSJ award** in the category of 'Changing Culture'.

Below national average

for incidents causing extreme and severe harm

What we did	We investigate all patient safety incidents (see glossary on page 112 for definition and harm levels) which are reported on our incident reporting system, Datix. Those graded at moderate harm and above are reviewed at a weekly panel chaired by the medical director. Incidents that are deemed to be serious (SIs) or never events then undergo an investigation which involves root cause analysis (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 incident improvement programme** This was launched in 2017 to improve the way we investigate, manage and learn from serious incidents (SIs). Key improvements as a result include: • Over 140 staff members trained as investigators and a new role of lead investigator agreed with divisions. • A suite of new products to support staff to complete quality investigations, including new templates for the 72 hour report and the final SI report. By improving the initial investigations into the incidents, this has supported a decrease in the total number of SIs we reported (145 this year, compared to 184 last year) and a decrease in the number of de-escalation requests we made to our commissioners (4 this year, compared to 9 last year).The use of these documents has been evaluated throughout the Trust during 2018 and further changes will be made in the coming months. **Incident reporting improvement programme** In 2017 we launched this programme to plan, develop and oversee improvements to our reporting and management processes. Progress made this year includes the launch of 'Learning from excellence' (LfE) – positive incident reporting. Traditional incident reporting focuses on identifying and learning when things go wrong; LfE aims to capture learning from when things go well, with the added benefit of improving staff engagement and motivation. The programme went live in five pilot areas in August with over 114 reports submitted and was rolled out across the Trust in the Autumn. We are now focusing on how we are spreading and showcasing the good practice highlighted through these reports. We targeted interventions aimed at increasing and sustaining our incident reporting rates including communications, focused awareness and education with staffing groups that have been identified as low reporters and local engagement work within individual directorates. Through collaboration with software developers, healthcare staff and clinical academics and in partnership with the Patient Safety Translational Research Centre (PSTRC), we have developed an app-based incident reporting system called CareReport. The aim is to assess whether CareReport increases the number of incident reports and improves staff experience of the reporting process. We are planning to trial this in the Accident & Emergency Department at St Mary's Hospital in early 2019/20. The achievements of the first phase of the Incident Reporting Improvement Programme were published in a peer-reviewed journal 'Health Affairs' in November 2018. **Safety culture communications** In response to staff feedback, we developed a safety communications plan. This includes a number of safety communications templates, designed with staff, which have been in use since April 2018. There is evidence that these are being used in practice by frontline staff.
Further work we need to do	Culture is not something that changes quickly so it is important that we continue our focus on this programme. However for 2019/20 we will refocus this on improving the behaviours related to safety. We will focus on the behaviours we expect staff to display. These include being open and transparent when things go wrong, being encouraged to report, reflect and learn and being supported in a just and caring way. Metrics related to SI submission and action completion show that more work is required around improving the quality of our investigations. We completed a 'stock take' of progress, which involved interviews with staff involved in investigations, and identified next steps for further improvement. This includes establishing a new central investigation team with expert investigators. We are also reviewing how we can best support staff psychologically following a SI. We will continue to develop and co-design communications with staff, including creating an Imperial safety campaign and video.
Measurable targets	• An increase in our incident reporting rate, maintaining our position within the top quartile when compared with other trusts • Improvements in the percentages of staff responding positively to the relevant staff survey questions • Improvements to the quality of SI investigations as measured by a reduction in the number of reports returned from the commissioners with queries before they can be closed, an increase in the number of reports submitted on time and a reduction in the number of de-escalation requests made • An increase in the number of 'Learning from Excellence' reports made by staff

Improvement priority 3	To improve permanent nurse staffing levels
Executive lead	Director of P&OD
Why this was included for 2018/19	Feedback from the listening campaign conducted in December 2017 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 in 2017/18 were above target with variance across departments.
What we achieved	We have **not achieved our target of 13 per cent**, reporting an average vacancy rate for nursing and midwifery staff of 15.56 per cent across the year. Despite this, we have e**nsured 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. We have achieved a number of other key performance indicators, including **an increase in conversion rate for students** who train with us and take up employment, and an **increase in the internal/external hire ratio**. Internal targets to recruit international nursing and midwifery staff, and nursing associates and graduate nurse apprenticeships have also been met.
What we did	In March 2018 we launched a strategy to improve our nursing retention and recruitment. Our action plan for 2018/19 consisted of six workstreams, highlights of which include: • Refer a friend scheme launched in October covering hard to fill roles. • Re-launch of the internal transfer scheme in September 2018. • Careers clinics were piloted successfully and ran until December 2018. • International recruitment is underway, with a pipeline of over 300 nurses who are all expected to have joined by the end of quarter two 2019/20. • Recruitment and retention premiums are being offered across a number of hard to recruit areas and have resulted in an increase in applications. • 8 nurse associate apprenticeships are now in place. • Additional practice educators have been recruited to support the student nurses and the nurse workforce. We have also run recruitment and retention campaigns for other areas and staff groups with high vacancy rates, including radiographers, middle grade critical care doctors and started one for middle grade doctors in the emergency department in March 2019.
Further work we need to do	Further work will continue with our recruitment and retention plan into 2019/20. We will maintain this as a priority for 2019/20 given the challenge we face. We will also widen this to include non-consultant doctors.
Measurable targets	Achievement of our vacancy rate targets for all staff groups.

Improvement priority 4	To ensure our staff are up to date with the mandatory skills to do their jobs
Executive lead	Director of P&OD
Why this was included for 2018/19	Core skills and core clinical training rates have previously been below target despite many interventions. Core skills are mandated training programmes which all our staff must complete in accordance with the requirements of their roles.
What we achieved	The percentage of staff who have completed all the core skills modules has increased significantly this year and has been **above our 90 per cent target** since November 2018.
What we did	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. Actions taken to achieve this include: • review of all modules, leading to a reduction in the total amount by removing duplicates. • review of all staff profiles to make sure that everyone was doing the right core skills training based on their role. • a communications campaign and focused targeting of staff who were non-compliant.
Further work we need to do	A new learning management system which will further support staff to undertake the training and provide more accurate data has been procured and is mid-implementation. Work is on-going to cleanse data, upload historic records and convert e-learning content, and a soft go live is planned for late April. This will return to business as usual monitoring through the integrated quality performance report with reporting to the executive people and organisational development committee.
Measurable targets	Maintenance of core skills compliance at over 90 per cent

Improvement priority 5	To ensure our equipment has planned maintenance in line with targets
Executive lead	Director of nursing
Why this was included for 2018/19	We recognise that the safe and appropriate use of medical devices is critical to the delivery of high quality patient care. Equipment maintenance, oversight and management have been problematic in the past including assuring it is completed within manufacturing recommendations.
What we achieved	Our targets for planned maintenance are monitored monthly through the IQPR and are being **consistently met for medium risk and low risk equipment** (performance in March 2019 was 82 per cent for both against targets of 75 per cent and 50 per cent respectively). There has been a **significant improvement for high risk equipment,** with 96 per cent of equipment being reviewed in line with the requirements by March 2019, compared to 72 per cent in April 2018.
What we did	All our medical equipment has a planned maintenance programme at a frequency determined by the manufacturer's instructions or on a risk based strategy by clinical technical services. An e-learning package to inform staff of essential safety aspects prior to using a medical device went live in December.
Further work we need to do	This is now business as usual so it is proposed that this is monitored through routine governance processes.
Measurable targets	Maintenance of compliance with our targets for equipment maintenance

Core skills training above

90%

Improvement priority 6	To improve the management of medicines
Executive lead	Director of nursing / Divisional Director for WCCS
Why this was included for 2018/19	Medicines are the most common intervention in healthcare and can be associated with risk and harm. 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 given, recorded and stored well. The CQC report of 2018 identified similar concerns. A new approach was implemented to support improvement.
What we achieved	We audit 33 standards around storage and security of medicines, controlled drugs and medicines fridges weekly. Results show **98 per cent compliance with the medicines standards,** with **sustained improvements in the management of medicines fridges.** We reported a **reduction in serious incidents** related to medications (2 this year compared to 4 last year).
What we did	In response to the audit results, we have taken action to make it easier for staff to do the right thing including: • A standardised controlled drug (CD) key fob • An algorithm regarding the disposal of CDs on wards • A new fridge monitoring form and fridge temperature action lists • An algorithm regarding fridge checking actions • A list of roles and responsibilities of pharmacy, nursing, midwifery and operating department assistant staff These were co-designed with clinical staff from a range of professional groups, colleagues from the PSTRC and a design company and launched at a trustwide 'medicines matter event'. We have also revised our policies and procedures for destruction of medicines at ward level and 'returns to pharmacy' and changed our medicines management training from face-to-face to an online module – compliance is currently on target at 90.56 per cent. We identified a risk around medicines shortages, with concerns that this will worsen with the impact of Brexit. The pharmacy team have a database of all 'medicines in shortage' and work with the clinical teams to identify alternatives.
Further work we need to do	This will move to business as usual monitoring through routine governance processes, with the medicines safety stream continuing as part of improvement priority 1. Phase 2 of the medicines safety stream has been scoped and agreed and will focus on improving the management of high risk medicines to reduce harm to patients, specifically insulin and anticoagulation. This will be monitored through the priority to reduce avoidable harm.
Measurable targets	A reduction in incidents with harm associated with high risk medications

Improvement priority 7	To ensure hand hygiene compliance is measured accurately with focused improvement to support staff where risk exists
Executive lead	Medical director
Why this was included for 2018/19	Our hands are the prinicpal route by which cross-infection happens, and hand hygiene is the single most important factor in the control of infection. Monthly point prevalence hand hygiene audits had been completed by front line nurses for their own areas for the last 10 years up to 2018. Results consistently showed excellent performance (over 90 per cent) however independent audits did not always give the same results. This and feedback from inspections had raised concerns about consistency of compliance. When published research is considered compliance would be expected to be lower than that seen in our point prevalence results.
What we achieved	Audits were conducted in May 2018, November 2018 and February 2019. **Compliance with hand hygiene improved on the wards selected for focused improvement support** (29 per cent in the May audits, to 69 per cent in the February audits). Overall, the results did not improve on the wards which did not receive intensive support. We have seen a **decrease in the number of infection control serious incidents,** with 9 reported this year compared to 16 last year.
What we did	Our new approach to audit started in May 2018 with all inpatient areas. This new model involved a partnership between the infection prevention and control team (IPC) and divisional staff in collecting hand hygiene audit data for compliance with the WHO's five moments for hand hygiene (the key moments when healthcare workers should wash/gel their hands). Overall compliance in the May audits was 56 per cent (published evidence suggests that hand hygiene in clinical areas is typically around 45 per cent). The results prompted a Trust-wide hand hygiene improvement programme, and the identification of a small number of 'focus wards', which received intensive support in developing local improvement plans. The inpatient areas along with some other high risk areas were re-audited in November 2018 and February 2019. The focus wards were the most improved, with compliance increasing from 29 per cent in the May audits to 69 per cent in the February audits. Overall compliance did not improve, falling to 55 per cent in February. The hand hygiene improvements across the Trust are being supported by an upgrade of the hand hygiene dispensers, and a new hand hygiene communications campaign, which was piloted on the focus wards during February and March 2019.
Further work we need to do	The February audit results show that when supported to do so, ward areas can make a real improvement in their hand hygiene compliance. We have therefore identified more wards for focused improvement support. We will also ensure that all areas have an agreed improvement plan in place with regular reporting of progress through the divisional governance processes. We will evaluate our new communications campaign and gel dispensers and roll this out trustwide if successful. A hand hygiene celebration event will be held in the Trust in May 2019 to coincide with world hand Hygiene Day and an improvement sprint is also planned to explore with our patients and the public how we can better involve them in hand hygiene improvement work. Hand hygiene improvement is a safety stream and so we propose to manage this under that priority rather than it sitting separately.
Measurable targets	• Continued improvements as shown through our hand hygiene audits (target is 70 per cent) • Reduction in serious incidents related to infection prevention and control

Improvement priority 8	To continue to define, develop, implement and evaluate and organisational approach to reducing unwarranted variation
Executive lead	Medical director
Why this was included for 2018/19	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. The reduction of unwarranted variation across patient pathways is a key part of how we will improve sustainability and experience for our patients. One of our approaches to reduce variation is the use of 'flow coaching' within a clinical pathway. This involves coaching pairs taking part in training and using what they learn to coach weekly 'big rooms' – a face-to-face session bringing together a range of staff and patients involved in the pathway to discuss, plan and review improvements.
What we achieved	Our Flow Coaching Academy (FCA) has resulted in improvements for patients in several pathways, including: • *Sepsis* – Sustained **reduction in mortality** for all patients coded with a diagnosis of sepsis from 18 per cent to 14 per cent from June 2017 onwards; Increased percentage of patients receiving antibiotics within an hour of screening. • *Diabetes* – **Decreased length of stay** for diabetic foot patients from 24 days to 18 days in 2018 • *Paediatric Asthma and Wheeze* – **Increased percentage of written management plans** received by paediatric asthma and wheeze patients from 25 per cent average to 60 per cent from September 2018 onwards • *Lower Urinary Tract Symptoms* – **Increased proportion of new LUTS patients either discharged or listed for surgery** from 24 per cent to 91 per cent; reduced DNAs (patients who did not attend their appointment) from 19 per cent to 2 per cent • *Recovery* – **Reduced number of patients staying overnight** in recovery per month from average of 70 to under 30 from August 2018 onwards; and reduced average total time in Recovery per patient from 8 hours to 3 hours from September onwards • *Antenatal* – **Reduced length of stay** in maternity triage/day assessment units from average of 154 minutes to 110 minutes from November 2018 onwards • *Vascular* – **Reduced length of stay** average by 2 days for all elective patients; increased number of total discharges per week in Zachary Cope ward from a mean of 11 to 18 patients; secured £100,000 funding to pilot a supportive discharge model • *Acute Respiratory* – Trend indicating **the percentage of NIV patients dying in hospital has decreased** from 24 per cent to 17 per cent from May 2018 onwards • *Young People* – Established **a new renal transition clinic** at Hammersmith to provide focus care for paediatric patients transitioning to adult services.
What we did	**Flow Coaching Academy (FCA) Imperial** Building on the success of the three pilot pathways with Sheffield Teaching Hospital, in 2018 we launched our own flow coaching academy. FCA Imperial has so far trained 24 flow coaches within the Trust, and established five staff as faculty who are able to deliver the programme training autonomously. It has generated ~£90k income for the Trust by offering places to external organisations, and influenced the establishment of other 'big rooms' including Digital; Strategy; Faster moves (part of the 'keeping care flowing collaborative' – see page 43-44 for more information); Paediatric Flow Collaborative; and Frailty. **GIRFT** Getting It Right First Time 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, led by frontline clinicians who are expert in the areas they are reviewing. We are fully engaged with GIRFT, with 15 specialties participating so far. We have used GIRFT data to inform our internal speciality review programme (see page 47 for more information). In areas where both have been completed, we have implemented combined action plans, such as urology co-location onto one site, delivery of innovative mass knee and hip clinics in trauma and orthopaedics and establishing high-volume theatre lists for cataract surgery. GIRFT data is also being used to support changes in the FCA pathways.
Further work we need to do	Each of the current pathways' big rooms will continue and become part of 'business as usual' to identify, test and implement changes to improve care. The improvement team will continue to provide support and direction as part of the overall programme management. This will include ensuring agreed reporting processes for each pathway with clear measurement of impact against their specific aims. The nine internal pathways which form part of cohort three began their teaching sessions in April 2019. As well as continuing to develop the FCA programme we will further develop our trustwide approach to unwarranted variation, including how we use clinical audit data, quality insights and other indicators to identify variation and how we build capability to respond appropriately using improvement methodology.
Measurable targets	Each of the pathways have defined measurable targets for improvement. Progress will be reviewed through our governance structures throughout the year.

Improvement priority 9	Emergency flow through the hospital
Executive lead	Divisional Director, MIC
Why this was included for 2018/19	In early 2017 we launched a programme 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. Although significant work was completed, we did not meet the four hour A&E target in 2016/17 or 2017/18.
What we achieved	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 attendances 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). The measure is important as it shows how well 'flow' through the whole of our care pathways is working and is a reflection of collaboration and co-ordination across services and teams. Although we have not met our target, in March 2019 **our A&E four-hour access performance was significantly better (5.2 per cent) compared to March 2018,** despite having 4.3 per cent more attendances. Overall, we achieved an average of 88.11 per cent across 2018/19, compared to 87.11 per cent last year. We also saw a **reduction in delayed beds,** an **increase in patients discharged before noon,** an **increase in the use of our discharge units** (from 10 per cent in 2017/17 to 14 per cent in 2018/19). Average discharge time has been brought forward by 46 minutes. We delivered **pathway efficiencies equivalent to creating an additional 35 inpatient beds.** We do still have issues with capacity and increased lengths of stay.

What we did	We have made improvements through our 'keeping care flowing collaborative' – a network of staff, partners from the community and our lay partners, working across the trust who have come together to deliver the improvements seen. For example: • Ambulance handover action plan which sets out agreed protocols, escalation processes and action cards to ensure that reducing ambulance handover delays is embedded into everyday practice. Currently, patients wait an average of around 230 minutes between when their ambulance arrives to when they are first assessed, which we are working to reduce. Additional actions have been added in response to new national guidance. • 'Keeping care flowing' intranet site now live, with all relevant policies and operating procedures and the latest materials available in one place for staff to access, to support improved flow through our hospitals. • New 'Majors area' opened at Charing Cross A&E. • Introduction of an electronic live bed state so we can better track our capacity. • Implementation of the 'red to green' approach – which helps teams identify delays by flagging days when a patient does not receive enough 'value-adding' care - and the SAFER care bundle, which blends five elements of best practice for discharge, leading to improvements in discharging patients when they are clinically ready. • Expansion of Ambulatory Emergency Care services; with a 30 per cent increase in the amount of patients seen, helping reduce growth in emergency admissions. • Expansion of our frailty services – including OPAL (older persons assessment liaison service), frailty at the front door, the "red bag" project which helps improve communication between care homes and hospitals – avoiding admissions and reducing length of stay. • Active participation in the development of a North West London-wide Delayed Transfers of Care escalation procedure. • Frequent attenders programme – working alongside voluntary sector colleagues and mental health trusts to manage high users of our emergency departments. The service has had significant success in reducing the A&E attendances of the initial 13 patients selected to participate, supporting them to access the services they need for long-term support.
Further work we need to do	We will focus on delivering the keeping care flowing collaborative 2019/20 work programme. The aim of the programme is: to meet the 4hr wait standard, our urgent and emergency care system supports staff to deliver safe, compassionate and high quality care to our patients in the right setting and at the right time.
Measurable targets	Improvements in our performance with the four hour target. In May, we are testing a proposed new A&E standard, as one of 14 pilot sites so we will also measure progress against this.

Improvement priority 10	**To improve access to services across the Trust through a focus on increasing capacity**
Executive lead	Chief executive officer
Why this was included for 2018/19	Emergency and Referral to Treatment (RTT) performance continued to be challenged during 2017/18 with deterioration over the winter period. To achieve these important access targets, additional capacity was needed as well as efficiency improvements in 2018/19.
What we achieved	**Although we have seen improvements in emergency and RTT performance, these continue to be challenged,** with both being below target and off trajectory in March 2019 (see improvement priorities 9 and 11 for detail). We are **meeting our target for cancelled operations** (0.89 per cent against a target of 1 per cent).
What we did	In 2018 we identified a 100 bed shortfall. Since then we have invested in 50 additional beds whilst delivering another 35 through efficiencies in A&E and patient flow.
Further work we need to do	This work will continue into 2019/20; however it will be merged into improvement priority 9.
Measurable targets	Reduction in the number of cancelled operations (below 1 per cent). Improvements in occupancy levels and the number of days where black escalation is in place.

Improvement priority 11	**To improve access for patients waiting for elective surgery**
Executive lead	Divisional director of surgery, cardiovascular and cancer
Why this was included for 2018/19	Over a sustained period of time, the Trust had encountered a number of data quality and operational performance challenges to delivering a balanced position on elective care.
What we achieved	**We did not meet the standard of 92 per cent of patients treated within 18 weeks of referral** in 2018/19, although we have improved since last year reporting an average of 84.12 per cent in 2018/19 compared to 83.34 per cent in 2017/18. Improvement trajectories were agreed with our commissioners and NHS Improvement and a number of workstreams are in place to drive improvement. We are pleased to have **significantly reduced the number of patients waiting over 52 weeks for surgery,** with 573 reported in 2018/19 compared to 1,854 in 2017/18, and **none in March 2019.** There were **no cases of confirmed clinical harm** for patients waiting over 52 weeks in 2018/19; four have been confirmed since the process began in August 2016.
What we did	We have had a wide ranging programme of work for improving the management and delivery of Referral to treatment (RTT) standards since July 2016. The programme remains patient focused with a clinical harm process monitoring the impact waiting for treatment is having on our patients to ensure that they are not coming to harm. The current programme is focused on 3 key priorities: 1 People (through developing training programmes and learning management system development) 2 Systems (data validation, correction and visualization tools being implemented to support efficient and proactive tracking of pathways) 3 Processes (to ensure a performance management and accountability framework is developed and embedded in the organisation to ensure appropriate actions are taken at all levels to support meeting the RTT standards and improve waiting times for patients).
Further work we need to do	We will continue to implement our improvement programme as above to improve performance against the standard. We will review our clinical harm review process and the specialties included, and develop a clinical harm review policy for the Trust.
Measurable targets	Achievement of our trajectories for RTT performance. Reduction in the number of patients waiting 52 week waits.

0 patients

waiting over 52 weeks in March 2019

Improvement priority 12	To improve compliance with equality and diversity standards
Executive lead	Director of P&OD
Why this was included for 2018/19	We want to provide a better working environment, free from discrimination, for our staff. The results of our staff survey highlighted that we have more work to do to improve equality and diversity across the Trust, with performance lower than we would want.
What we achieved	**Our performance with the workforce race equality standard (WRES) has improved since the previous year.** Some of the improvements include: • The likelihood of Black, Asian and minority ethnic (BAME) staff being involved in a formal disciplinary procedure has reduced from 2.125 times more likely than white staff to 1.439 times more likely. • The percentage of staff experiencing harassment, bullying or abuse from staff has dropped from 32 per cent to 28 per cent. • The percentage of staff believing that we provide equal opportunities for career progression or promotion has increased for both groups, BAME from 74 per cent to 83 per cent, White from 87 per cent to 88 per cent • Staff having personally experienced discrimination at work from other staff members has dropped by 2 per cent for both BAME and White staff to 17 per cent and 5 per cent respectively.
What we did	Our 2017-18 annual equality and diversity (E&D) report and workforce race equality standard report (WRES) was submitted to executive committee and approved in September 2018. It showed that whilst the experience of our staff is similar to that in other organisations, there was still a significant difference between the experience of white staff and ethnic minority staff. In response we developed an E&D work programme with sets of actions covering the main protected characteristics groups (ethnicity, gender and disability). In 2018 we formed two staff networks: a women's network and a nursing and midwifery BAME network, which have helped shape our plans. We are planning to establish a trustwide network for ethnic minority staff in 2019.
Further work we need to do	**WRES:** Based on the results of our annual WRES report in 2019/20 our WRES work stream will: • Improve workforce BAME representation in Band 7 and above roles. • Mitigate against a disproportionate number of BAME staff entering formal workforce procedures. • Reduce the relative likelihood of BAME colleagues receiving a lower PDR rating compared with people from a white background. • Address harassment and bullying issues reflected in the NHS staff survey. We will also: • Introduce ethnically-mixed interview panels for the recruitment of band 7 + roles • Develop an 'unconscious bias' training programme • Establish a 'reverse mentoring' programme for executive directors. The national strategy - a *Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS* - gives individual targets for each NHS Trust, based on its most recent WRES report. These will be included in our work programme. **Gender equality:** The gender equality work stream will: • Improve female workforce representation at Band 8A+. • Reduce the difference in the amount of bonus paid to female staff in comparison with male staff. **Disability:** The Workforce Disability Equality Standard (WDES) work stream will: • Improve quality of disability data on our electronic staff record. • Identify Trust priorities for disability equality work
Measurable targets	Achievement of the key deliverables outlined in our E&D action plan.

Improvement priority 13	Specialty review and clinical strategy development
Executive lead	Medical director
Why this was included for 2018/19	The specialty review programme (SRP) is our clinically led process which is being used to inform the bottom-up development of a refreshed Clinical Strategy.
What we achieved	We have used this process to identify opportunities for improvement and to help make our services more efficient. This has worked best where we could link it with the GIRFT reviews and the Flow Coaching Academy (FCA). For example, we have achieved a **2 day reduction in elective stay for vascular patients**. Opportunities identified in ten 'early adopter' specialities have helped **save £14.6 million** since the programme began. We have completed reviews of all 37 specialties with individual strategies in place in many. These are being used to inform the clinical strategy which will link these to the organisational strategy approved in March 2019.
What we did	Each specialty participated in three workshops focused on improving financial, operational and clinical sustainability. As the programme was clinically led, we had high levels of engagement throughout the process, with positive feedback. In several specialties we have been able to start conversations with other providers across the sector to better plan how services should meet the needs of the patient population. We have also been able to collaborate with other providers to start discussions with national commissioners around how we can make services more sustainable.
Further work we need to do	The clinical strategy will be published in early 2019/20. The director for transformation is now the executive lead for the SRP and is taking forward the next stage where we translate the specialities' visions into tactical plans to implement during FY19/20 ('Realising the Vision'). These sessions are currently being scheduled for 11 of the specialties which have moved through the SRO process. As this is being taken forward as part of the development of the organisational strategy, this has been stepped down as an improvement priority.
Measurable targets	Strategic objectives and action plans in place for each specialty

In addition to our 13 priorities, last year's document set out a number of metrics to support improvement in the five quality domains, and the additional domain of 'use of resources'. Our performance with these is described below, along with other key workstreams being undertaken.

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.

Seven of our improvement priorities are closely aligned to this domain:

- To reduce avoidable harm to patients
- To improve the safety culture across the Trust
- To improve permanent nurse staffing levels
- To ensure our staff are up to date with the mandatory skills to do their job
- To ensure our equipment has planned maintenance in line with targets
- To improve the management of medicines
- To ensure hand hygiene compliance is measured accurately with focused improvement to support staff where risk exists

Progress with these has already been described on pages 33-47. To avoid repetition we have not included these here again.

Introducing 'Streams' results viewing

In January 2019 we began to roll out the use of 'Streams', which is an app-based results viewing platform to allow staff to view their patients' latest blood test and radiology results securely from a mobile phone. This will support quick decision-making if test results show changes to someone's health condition, without staff having to leave their patient's bedside to log into a hospital computer. We plan to roll this out across the Trust in 2019/20.

Response to the Gosport Independent Panel report

The Gosport Independent Panel report, published in June 2018, concluded that the lives of over 450 patients were shortened while an inpatient at Gosport War Memorial Hospital and that concerns raised by staff and families were not appropriately taken into consideration. We reviewed the report and identified key learning points, and examples of systems and governance processes we have in place that would help prevent a similar situation happening here. In addition to our existing processes (which include incident reporting and investigation, mortality review, complaints, duty of candour and freedom to speak up), we took several actions for additional assurance, including a review of our opioid prescribing. The new medical examiner role will provide further assurance when we implement it in 2019 (see page 33 for further information).

Pressure ulcers

A pressure ulcer is a type of injury that affects areas of the skin and underlying tissue. They are caused when the 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. We reported twenty four category three and un-stageable Trust acquired pressure ulcers in 2018/19, which is seven more than last year. We have not reported a Trust acquired category four, the most serious of pressure ulcers, since March 2014. We have nominated skin champions in each of our clinical areas and we run quarterly study days for our staff in the prevention of pressure ulcers and wound care.

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 on the next page. We are undertaking a full evaluation of each of the safety streams which will inform further improvement plans for each.

22%

reduction in falls with harm since April 2016

Safety Stream	Rationale	Progress to date	Key areas for improvement
 **Abnormal results**	Recognition of and response to abnormal results is a key patient safety priority. We previously reported a number of serious incidents (SIs) which related to delays in the management of abnormal results. We took immediate action in response to these SIs including escalation of unsuspected abnormal results to the clinician and to the appropriate multidisciplinary team; however we recognised that the issue of endorsement of results was a key risk area.	This year we built on the large amount of background work previously undertaken to understand the difficulties and variations in practice. This included an evidence scan and investigation into other Trusts' processes and procedures which allowed us to build reporting systems designed to monitor the endorsement of results. These will launch in May 2019, supported by a standard operating procedure which includes agreement on abnormal ranges of results. When this is implemented into our electronic patient record this should lead to all normal results being automatically endorsed. We have designed communications campaign, including a podcast, to provide staff with guidance on the new process and to emphasise the importance of endorsement from a safety perspective.	Our priority is to use our reporting systems to help us identify variation, so we can learn from areas who have got it right and to focus improvement work related to the endorsement of results in those areas where there are still delays. As the endorsement processes have only just been finalised, we cannot yet monitor the impact of this work. Going forward, we will measure improvement through: • Increase in endorsement of results • Reduction in incidents causing harm
 **Falls**	For patients, a fall can result in pain, injury, loss of confidence, loss of independence and increased morbidity and mortality. The aim of this safety stream is to support patients to mobilise safely and to reduce the rate of inpatient falls with harm.	We have piloted 90-day cycles of improvement on key wards, addressing local risk factors, with the support of the improvement team. This has resulted in improvements, including a reduction in falls with harm on several of the pilot wards. Data from the latest national falls audit shows that we are below average both for the rate of falls in total and for the rate of falls resulting in moderate/severe harm. Overall, we have seen a 22 per cent decrease in falls with moderate and above harm since 2016 when the safety stream started, and a 73 per cent reduction in SIs.	In 2019/20 we will focus on the following: • Embedding falls assessment and care plans in the electronic patient record and monitoring the completion. • Staff engagement in identifying falls as a trigger for incident reporting. • Improving risk assessments and environment checks. • Engaging with and encouraging patients to minimise actions which result in an increased likelihood of falls. We have reviewed the governance arrangements for falls prevention and a quarterly falls steering group, chaired by the director of nursing is being formed to oversee and join up all falls activity across the trust.
 **Fetal monitoring**	This safety stream aims to reduce the number of infants delivered with poor outcomes as a result of misinterpretation of the fetal heart rate – also known as 'CTG'	The original work of this safety stream focused on introducing a central monitoring system called 'Fetalink'. This provides remote monitoring of key clinical metrics (including the fetal heart rate) allowing rapid escalation of issues. The system is now fully implemented and staff are trained to use it through local induction and within the labour ward environment. Further improvements include: • Weekly educational meetings (per site) with presentation and CTG interpretation including case outcomes and learning points. • Updated clinical guidelines and CTG learning package in line with current NICE (National Institute for Health and Care Excellence) guidelines. • Improved training for staff, with 94 per cent of medical staff at Queen Charlotte's & Chelsea Hospital and 93.2 per cent of medical staff at St Mary's Hospital having received training in CTG. For midwifery staff, 98 per cent of midwives cross site are trained and assessed in fetal monitoring. • Introduction of 'Fresh Eyes' – a 'buddy system' where a second midwife confirms the fetal heart rate pattern. • Weekly fresh eyes audits using consistent methodology. We have reduced the number of incidents where misinterpretation of CTG as a contributing factor, with none since August 2018. There has also been a reduction in complaints and claims relating to CTG interpretation, with no current complaints and any existing claims relating to previous serious incidents.	The improvements made so far will continue to be embedded through changes to the electronic patient record, a review and refresh of guidance, and the rolling training programme. The impact will be monitored through on-going audit as well as a continued reduction in incidents causing harm.
 **Hand hygiene**	For information on the work we have done as part of this safety stream, see improvement priority 7 (page 41).		

Patient ID	Ensuring 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.	In 2018 we launched a new policy which incorporates national guidance and learning from incident investigations, which is starting to embed. Through a review of incidents, we identified a risk around 'wrong blood in tubes' (WBIT); this is where blood taken from a patient is mislabelled as having come from a different patient. Targeted improvement work has resulted in a 33 per cent reduction in WBIT incidents this year. We reported two serious incidents under the category of 'patient identification error', which is the same as last year.	In early 2019/20 we will be undertaking an audit of compliance with the policy which will support identification of further areas for improvement. A trust-wide campaign will be launched in quarter one 2019/20 to increase awareness of "right patient all of the time". Printer location is a key root cause of incidents and is being reviewed in areas where incidents are reported most often – we will focus on this as part of the campaign.
Care of mental health patients in the emergency department	This safety stream was established in 2018 in response to delays to treatment for mental health patients in the emergency department (ED) leading to extended waits for patients.	We continue to have significant delays for mental health patients in the emergency departments. This year, we had 68 patients who waited in A&E over 12 hours before being admitted. The majority of these were patients waiting for a mental health bed to become available. We are working closely with Central North West London NHS Foundation Trust to improve the patient pathway and reduce delays. We established this safety stream in November 2018 to drive improvements internally. Actions taken so far have been successful in improving documentation and transport delays. We have also identified other issues, including patients absconding, Registered mental health nurse (RMN) cover, staff training, limited home treatment team and authorised mental health professionals to review and refer patients, and lack of appropriate environment. To help ensure the safety of these patients, our mental health waiting suites in our A&E departments have been refurbished so we have separate, quiet spaces for patients with mental health issues waiting to be seen. We have also developed an educational video for staff.	We have established a multi-stakeholder steering group which is leading on delivering an action plan to address these root causes. The steering group will initially focus on the St Mary's Hospital emergency department (ED) but have cross-site representation and strong links with work at Charing Cross Hospital ED. On 1 May, we are hosting a mental health pathways education day for our staff and stakeholders which includes presentations on safety, safeguarding and crisis management in the ED. The main outcome measure for this safety stream will be a reduction in 12 hour delays for mental health patients.
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.	This year we focused on the implementation of NEWS2 which was completed in March 2019. This is the latest version of the National Early Warning Score which enables staff to calculate a standardised score helping them to more effectively respond to acute illness. As a result of work undertaken by this stream, we have seen a 30% reduction in out of ICU cardiac arrests. Overall, we have seen an increase in reporting of incidents where there was a failure to respond to the deteriorating patient, with a 64 per cent reduction in incidents resulting in moderate or above harm in 2018/19 compared to 2016/17 when this safety stream began.	We will regularly audit the use of NEWS2 to inform the next phase of improvement work. We are planning further small tests of change to encourage staff to discuss and escalate deteriorating patients, including escalation ladders, an acute dashboard in the electronic patient record and a patient escalation project.
Safer medicines	For information on the work we have done as part of this safety stream, see improvement priority 6 (page 40).		
Safer surgery	Following a series of surgical 'never events' in 2016/17, we set up this stream 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.	Throughout 2018/19, we developed and piloted a simulation and coaching programme for interventional procedure areas to support teams to focus on improving how we carry out safety checks, teamwork and behaviours to support a safe and efficient working culture. This was planned for a slow roll out in 2019/20. Given the increasing number of invasive procedure never events (we reported six between April 2018 and January 2019), we agreed to speed up the roll out of the programme, starting with the five specialties where we have had never events. All of these had completed their first training sessions by 15th May. For further information on our response to the never events, see pages 35-26.	From June 2019, we are rolling out an 18-month programme called the 'HOTT' programme (Helping Our Teams Transform) to all other specialties where they do invasive procedures. It involves simulation training, in situ coaching, 'conversation cafés', and human factors training. Each specialty has assigned leads responsible for providing leadership and training for the programme within their specialty. Progress with the programme will be monitored through training data, feedback from staff in response to the training and ultimately in a reduction in SIs and never events.

Safe quality highlights and challenges

Appendix E sets out our performance with the metrics under the safe domain in 2018/19. Where applicable, it presents national targets and averages and information about our performance in 2017/18.

Highlights and challenges in performance are shown below. To avoid repetition, we have not included information about metrics which have previously been described under our 'quality improvement priorities' section.

Although we met our VTE assessment target in the first three quarters of this year, we have been below target since December 2018: 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.

From April 2018, we met the 95 per cent target consistently until December 2018, with average compliance across the year of 95.42 per cent. We are working with the areas that are below target to support staff to complete the assessment, including additional training for staff and introducing VTE 'champions'. We are also addressing technical issues with the electronic system that prompts staff to undertake the assessment.

In addition, we are reviewing our compliance with national guidance and are developing reports which will allow us to better monitor the percentage of patients who received appropriate prophylaxis and the outcomes of root cause analysis into VTE cases.

We are reviewing this metric in response to updated NICE guidance. We expect to return to meeting the target in May 2019.

We did not meet our infection prevention and control targets: Despite seeing a reduction in the number of cases of *Clostridium difficile* compared to last year (51 compared to 63), and maintaining the same number of MRSA blood stream infections (3), overall we have seen an increase in avoidable infections (cases of MRSA BSI occurring 48 hours after admission and cases of *Clostridium difficile* related to lapses in care) in 2018/19, reporting 14 compared to 10 last year.

Last year, we were one of only 59 trusts who achieved a 10 per cent or greater reduction in *Escherichia Coli* bloodstream infections. Unfortunately this year we did not achieve our target of a further 10 per cent reduction, reporting 83 cases, which is more than last year. On reviewing the cases, many of them were a direct result of necessary interventions, or related to advanced malignant conditions, and were not preventable. Where they were preventable, they were often associated with urinary catheters so we are focusing on hydration, continence and promotion of early removal of catheters. We are also working with our commissioners to identify and mitigate community drivers of hospital-onset Gram-negative BSI.

We reported seven carbapenemase-producing Enterobacteriaceae bloodstream infection cases (CPE BSI), one more than last year. The seven cases this year all occurred in patients with advanced malignant disease or conditions; review of these cases has confirmed that no specific preventive action could have been taken. We have a CPE action plan to help prevent the spread of CPE which includes regular screening of high risk patients. Throughout the year we have improved our screening rates, which are currently over 90 per cent.

On-going work to improve infection prevention and control includes:

- our hand hygiene safety stream (see page 41)
- anti-microbial stewardship (ensuring the appropriate use of antibiotics) – we have seen a steady reduction in antibiotic use over the last four years, while increasing the percentage of antibiotics prescribed appropriately and for the correct duration, according to our latest six-monthly audit of anti-microbial prescribing.
- improving our cleaning processes. Since September 2018 we have been reporting our cleanliness audit scores in our scorecard. Although we have not met our target this year, reporting an average of 86.8 per cent in very high risk patient areas against a target of 98 per cent and 91.6 per cent in high risk patient areas against a target of 95 per cent, we expect to see improvements into 2019/20 as we continue to work to improve cleaning standards across the Trust.

We did not meet our target for flu vaccinations: In 2017/18, we were the most improved trust for vaccination take-up rates, with 60.5 per cent of our frontline healthcare workers vaccinated against flu. In 2018/19, our vaccination rate was about the same as last year's at 60.2 per cent and did not meet the national target of 70 per cent. We ran a communications campaign to encourage staff to have the vaccine, and we had a number of different ways in which staff could get vaccinated – through peer vaccinators, roaming vaccinators and at occupational health walk in centres. Overall, take up of the vaccination across London has been low this year, due to a milder climate and limited national news.

We met our maternity standards for puerperal sepsis and the ratio births to midwifery staff: We monitor two key maternity standards in our integrated quality and performance report. These are:

- 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. In 2018/19 our average ratio improved to 1:27.
- Postpartum infections (puerperal sepsis): our target is an infection rate of less than 1.5 per cent of all maternities, which we achieved, reporting an infection rate of 0.64 per cent.

We also monitor another twelve maternity metrics. These form part of the quality schedule, which contains quality metrics agreed with our commissioners which we are required to deliver as part of our contract. In quarters 1-4 this year, we achieved the following targets:

- 95 per cent of women receiving one-to-one midwife care in established labour.
- 100 per cent of women with a named midwife or named team.
- 14 per cent of women giving birth in a midwifery led unit.
- Less than five per cent of women smoking at the time of delivery.
- Less than three per cent of women experiencing third or fourth degree tears.
- 87.5 hours per week consultant presence on the labour ward at St Mary's Hospital and 98 hours per week on the labour ward at Queen Charlotte's & Chelsea Hospital, both of which meet the London standards for a minimum of 12 hours every day.

Home births

The number of women giving birth at home was below the threshold of one per cent in quarters one to three, however we met the target in quarter four. We continue to work to increase home birth choices where clinically appropriate and have recently increased the number of midwives who lead our homebirth service.

Breastfeeding initiation rate

At the end of 2017/18 we identified a recording error which was producing inaccurate results for this metric. Since then, data has been reported accurately. Our current breastfeeding initiation rate is 86 per cent, just below the target of 90 per cent. Attendance at breastfeeding classes is high and midwives and maternity support workers continue to advise and support women. We expect to see improved performance in early 2019/20.

Percentage of women having an elective caesarean

We were just above the target for this standard in quarter one and quarter three. NICE guidance states that a woman who requests a caesarean section should be fully counselled regarding the risks, but following this counselling if she still wants a caesarean it can be granted. We are ensuring that appropriate counselling occurs for all women.

Percentage of women having a non-elective caesarean

We met the target for this standard in the first three quarters of 2018/19, but were just above the 16 per cent target in quarter four. All cases of non-elective caesarean sections are reviewed by a consultant obstetrician.

Postpartum haemorrhage

A focused action plan is in place to improve performance; however we were above the 2.8 per cent threshold agreed with our commissioners for all four quarters this year, although we are below the north west London threshold of 3.6 per cent. Most postpartum haemorrhages occur during a caesarean section. We are looking at introducing a drug called carbetocin, which is used to help control bleeding after birth.

Maternity booking assessments in 12 weeks and six days

We met the 95 per cent in the first three quarters of 2018/19, but were below target at 94 per cent in quarter four. This was due to issues with capacity which have since been resolved.

We met our target to ensure that 90 per cent of eligible staff are compliant with level 3 safeguarding children training: we are committed to the protection and safeguarding 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. In 2018/19 we included compliance with level 3 children's safeguarding training in the IQPR. We have seen an improvement in compliance with safeguarding training for all levels meeting the 90 per cent target for all, including level 3 children's safeguarding, by February 2019.

We have met most of the targets we set ourselves for estates and facilities improvement: we have one of the poorest estates in the country, with a £1.3bn backlog maintenance liability. Through our estates strategy (see page 12) we are working to improve and to make sure we minimise potential disruption and inconvenience for our patients and staff. To monitor this we included five targets in our scorecard for 2018/19, four of which we have met:

- Over 90 per cent of our main passenger and bed lifts have been kept in service
- Over 70 per cent of our planned maintenance tasks have been completed within the allotted timeframe
- 99.9 per cent of relevant staff have completed the required estates training
- Performance against our planned maintenance targets for medical devices has significantly improved (see page 39 for more information).

With only an average of 37.38 per cent of reactive maintenance tasks completed within the timeframe we allocated, we did not meet our 70 per cent target. Uncompleted tasks are prioritised at a bi-weekly meeting. At the beginning of the year we had a large back-log of unfinished tasks, which is starting to reduce. We expect to see continued improvements in 2019/20.

We have achieved our target to have 10 per cent of staff trained as fire wardens and departmental safety coordinators in 75 per cent of clinical wards, clinical departments and corporate departments: These targets are included to drive improvements in health and safety. We are pleased to have met both in 2018/19. This is the result of improved training packages and a targeted approach to ensure coverage across all areas.

We have not met our target to have no reportable serious accidents, occupational diseases and specified dangerous occurrences in the workplace: in 2018/19, we reported 55 of these accidents, known as RIDDOR, which is a similar number to last year (51). The majority of these are 'slips, trips and falls' and 'dangerous occurrences' (mainly sharps injuries). Plans are in place to support a reduction in these types of incidents including the launch of a new online workplace inspection module to help staff identify areas of risk.

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.

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. We have made real progress this year and by February 2019 we had no overdue guidelines published on our intranet.

We identified some issues with the transfer of clinical guidelines to our new trust intranet when it launched in December 2018. We are completing an action plan to resolve these issues, with task and finish groups for each division to ensure that a full list of up-to-date guidelines and standard operating procedures are easily accessible to staff. We expect these changes to start having an impact in quarter one 2019/20.

Quality surveillance programme

The role of the quality surveillance team (QST) is to improve the quality and outcomes of clinical services through a programme of self-assessment and targeted peer review for all NHS England (NHSE) specialised commissioned services and all cancer services irrespective of how they are commissioned.

Our clinical teams completed the annual self-assessment process at the end of June for all 83 services which were required to report, with actions implemented where areas of risk or non-compliance were identified. In February 2019 we received our final results. 58 of our specialties were classified as 'routine surveillance', with 25 classified as 'enhanced surveillance', requiring action from us, our commissioners or both. We improved our performance overall, with fewer services requiring commissioner action (nine in 2018 compared to 25 in 2017).

Specialist services quality dashboards (SSQDs)

The quarterly SSQDs are designed to provide assurance on the quality of care by collecting information about outcomes from healthcare providers. SSQDs are used by NHSE, alongside the Quality Surveillance Programme (QSP) self-assessments to make judgements with regard to the quality of specialised services delivered by the Trust.

We have previously struggled to submit all the required data for the SSQDs; however we improved significantly this year, submitting 68.8 per cent in quarter two, compared to 34.9 per cent in quarter one. We will continue to work to ensure we are submitting all the required data.

Alerts are generated in response to the data we submit for the SSQDs – positive alerts where performance is above national average and negative alerts where it is below. In quarter two, we had 47 positive alerts and 25 negative alerts, all of which have actions in place to improve.

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. We have made progress in delivering the four core national standards; we are currently meeting three of them (seven-day access to diagnostic services; 24 hour, seven day as week access to consultant directed interventions; and twice daily consultant review for patients with high dependency needs).

We do not meet the standard that 'all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital'. When we first audited against this standard in September 2016, we delivered consultant led reviews within 14 hours to 64 per cent of patients during the week and 61 per cent of patients at weekends. By April 2018, this had increased to 81 per cent during the week and 82 per cent at weekends. We made a risk based decision not to increase investment for extra consultant rotas at weekends as we are confident that the medical model we offer provides appropriate specialist expertise if patients need it.

In order to reduce the burden of manual notes audits on trusts, NHS England has changed reporting of these standards to a 'Board Assurance' model for 2019. We will submit our first formal notification of assurance by the end of June 2019.

West London Genomic Medicine Centre

In December 2019 the national 100,000 genome project led by NHS England reached its target of sequencing 100,000 genomes for patients with rare disease and cancer. This makes the UK a world leader in genomics and also marks a major milestone in NHS England's mission to provide a truly personalised medicine service.

As one of the first Genomic Medicine Centres (GMCs), in partnership with the Royal Brompton & Harefield NHS Foundation Trust, The Royal Marsden NHS Foundation Trust and Chelsea and Westminster Hospital NHS Foundation Trust, we have been gathering samples and medical information from patients with cancer or inherited rare diseases for the last four years.

We have already used gene sequencing to produce life changing results – some patients with rare diseases have been provided with diagnosis for the first time after years of uncertainty and living with their symptoms. We are now able to develop personalised treatment plans so that patients get the right treatments at the right time. This work will transform how the NHS will diagnose, treat and care for patients. Some of our achievements include:

- Identifying the genes responsible for Huntington's disease and how they work to enable family members to be screened more easily and be given appropriate treatments.
- Identifying Lynch syndrome to help put patients on a bowel screening programme to reduce their cancer risk. This has also opened up new treatment options such as giving patients aspirin, which has been shown to cut cancer risk by 50 per cent.

To build on the legacy of the project, we have merged with Great Ormond Street Hospital to become a regional genomic laboratory hub for the north, east and west of London (London North GLH).

North West London Pathology

We host North West London Pathology across the sector. This is a new model for delivering pathology testing, merging the services from three North West London trusts into one modern, efficient operation that manages 25 million tests per year. The partnership between us, Chelsea and Westminster NHS Foundation Trust and The Hillingdon Hospitals NHS Foundation Trust has created an innovative and sustainable service that delivers outstanding quality to users and patients alike. In 2018, North West Pathology reported an increased number of patient safety incidents following the implementation of an electronic system for results processing due to IT issues. These have since been resolved and the number of incidents related to this has reduced.

Effective quality highlights and challenges

Appendix F sets out our performance with the metrics under the effective domain in 2018/19. Where applicable, it presents national targets and averages and information about our performance in 2017/18.

Highlights and challenges in performance are shown below. To avoid repetition, we have not included information about metrics which have previously been described under our 'quality improvement priorities' section.

Our mortality rates remain consistently low: 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 ourselves with our peers. Both of these have remained low, with our Trust having the lowest HSMR across the last year of data, and the fourth lowest SHMI. We also monitor the percentage of deaths with palliative care coded as this may affect the data. Our palliative care coding rates are high, and we are confident that they are accurate with a clinical coding review process in place.

The Trust participated in 27 out of 32 of the relevant national clinical audits which were published in 2018/19, and action plans have been implemented where required: Audits and service evaluations are important assurance and governance tools, producing data which can be used for improvement. Our Clinical Audit and Effectiveness Group (CAEG) oversees our participation in these audits and the action plans for improvement as a result.

Our aim is for all national clinical audit reports to be formally reviewed by the clinical lead within 90 days. We have improved over the last year, with 26 out of 27 reviews completed by the end of March 2019, 19 of which were done within the timeframe. Of these, two audits have been assessed as significant risk/little assurance and have action plans in place; these are described in appendix B, alongside other audits which identified areas for improvement.

Patient Reported Outcome Measures (PROMs): PROMs measure quality from the patient perspective and seek to calculate the health gain experienced following surgery for 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

Lowest mortality rate (HSMR)

of all acute non-specialist trusts across the last year of data

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

Final PROMs data for 2017/18 shows improved participation rates and good health gain across both procedures. Provisional data for April-September 2018 shows that our participation rates remain high, however health gain is unable to be calculated as there weren't enough post-surgery questionnaires returned by our external agency. We now have a dedicated nurse in post to oversee the process and have re-tendered the external agency which should lead to improvements when the data is next published.

We met our target to ensure that 90 per cent of clinical trials recruit their first patient within 70 days from quarter two this year: This metric provides assurance that we are giving patients the opportunity to participate in research in a timely way. Performance declined nationally following changes to the process and data introduced by the Department of Health in 2016/17, but the national trend is now upward again. Since Q2 2018/19, we have been above our 90 per cent target.

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 are pleased that despite long-standing pressures around demand, capacity and patient flow (see responsive section on pages 64-66) we are continuing to ensure that we treat and discharge patients appropriately so that they do not require readmission.

Unplanned readmission rates consistently

below average

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.

Improving how we use patient experience data – winner of a BMJ award

Traditionally, we have focused on using the quantitative data from the 'Friends and Family Test' (FFT) to drive improvements in patient experience. However, there is a lot of information in the free text comments from patients about their experience that we have found it harder to act on in a systematic way. Our improvement and patient experience teams have been collaborating on a project with the Patient Safety Translational Research Centre (PSTRC) funded by the Health Foundation using a technique called Natural Language Processing so that a computer can learn how to extract themes from thousands of free text comments. This will give us an additional source of qualitative patient feedback so that we are better able to respond and make improvements. This work won the BMJ Award for Digital Innovation in 2019.

Improving care for patients with learning disabilities

This year, we have continued to build upon our on-going work for patients with learning disabilities, including:

- Updating our learning disability 'purple pathways' developed in 2017 following learning from incidents to highlight the risk of aspiration pneumonia and constipation to staff.
- Holding a joint event with community learning disability teams and care home providers to share experiences and develop closer networks.
- Working with our safeguarding team and inclusion and vulnerability officer to deliver more training to staff on Mental Capacity and Deprivation of Liberty Safeguards (DoLS), in addition to our on-going training on caring for people with learning disabilities and autism.
- Continuing to promote the use of hospital passports and working with our community colleagues to increase their use.

Improving care for young people

One of our objectives is to improve care for young people moving from paediatric to adult services. Our initial focus has been on outpatient services, with improvements including the development of bespoke patient experience surveys and age appropriate information leaflets, and piloting transitional care tools to promote a consistent approach in clinics.

Wayfinding

In response to patients reporting issues with finding their way around our sites and services we implemented a wayfinding project in 2017 to make navigation easier. This has included improvements to signage and physical and digital wayfinding systems. This is a long-term project and will continue into the coming year.

Bereavement support

We reviewed how we provide support for people whose family members have died while they were a patient with us. Currently we have several services that provide support to the bereaved – our Patient Affairs Team, the chaplaincy service, complaints, our Patient advice and liaison service (PALs) and specialty-based services e.g. bereavement midwives. This can lead to people experiencing disjointed and inefficient support at an already difficult time. In 2019/20 we will form a comprehensive Patient Affairs and Bereavement Service which will provide holistic care, responding efficiently and compassionately when a patient dies. This service will deliver the current function of our Patient Affairs Team, as well as the functions required for the new Medical Examiner service (see page 33 for more information).

Caring quality highlights and challenges

Appendix G sets out our performance with the metrics under the Caring domain in 2018/19. Where applicable, it presents national targets and averages and information about our performance in 2017/18. Highlights and challenges in performance are shown below.

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 which asks patients whether they would be happy to recommend our Trust to friends and family if they needed similar treatment. Our average inpatient FFT rate was 97.42 per cent, similar to last year's performance.

We collect feedback through a range of different methods including text messaging; paper surveys; our website and our real time patient experience trackers. This system also means we can accurately track key protected characteristics (gender, age, ethnic group, religion and disability) and work to implement improvements based on any concerns that impact on

one group more than another. In April 2018 we introduced an easy read version of the survey and added in a non-binary choice in our gender category.

We also saw a slight improvement in the national inpatient survey, although our overall score remained the same. Out of 62 questions, we scored about the same as average in 60, better than average in one and worse than average in one. This is an improvement on the previous year when we scored worse than average in five questions and better than average in none. Overall this is a positive survey result and one of the best we've seen in a number of years, reflecting our continued focus on improving patients' experience of care.

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 the improvement workstreams outlined above, we have:

- Introduced patient support volunteers at St Mary's and Hammersmith Hospitals (kindly sponsored by Imperial Charity) following a successful pilot in 2018. These volunteers provide a 'listening ear' for patients and have proven to be very popular with our patients and staff. We are continuing to develop other volunteer roles including; meal time support volunteers; youth volunteers (aged 16-25 years); meet and greet roles and outpatient volunteers.
- Launched a project called 'Eat & drink, Move; Sleep'. Our patients continue to tell us that noise at night and the quality of our food is a problem. In response, we:
  - Reinstated weekly food audits, including food tasting and patient feedback, the outcomes of which are being used to improve food service locally.
  - Updated our guidelines around protected mealtimes, now called 'Time To Eat', to ensure that we are giving patients more opportunity to eat their meals without unnecessary interruptions and that staff can use this time to better support patients who are unable to eat independently.
  - Created a Food and Drink Strategy which launched in March 2019 and is going to support further improvements next year including the development of a Fasting Policy, and the implementation of MUST (Malnutrition Universal Screening Tool) in our electronic patient record from 1 May 2019.
  - Began quality improvement projects on three pilot wards to reduce general environment noise and staff talking at night. Improvements on the pilot ward at Charing Cross Hospital have resulted in a reduction in the number of negative comments about noise at night. The pilots on the other wards have been impacted by works to increase our bed capacity and relocate some of the clinical areas. The work finished in February so we renewed our focus on this in March and expect to see improved results in 2019/20.
  - Are actively encourage patients to be more active, building on the 'end PJ paralysis' work promoted nationally earlier this year.

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.

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 over 94 per cent of our patients would still recommend our A&E services.

We are working hard to improve the response rate to the FFT question in our A&E departments. Although our response rate is above national average, it remains below our target of 20 per cent, with St Mary's A&E particularly challenged. We have introduced a range of different collection methods, including a kiosk, handheld device and texting options. We began a 90 day improvement programme in March 2019 which is developing interventions to support sustained improvement.

We have improved the percentage of outpatients who would recommend our Trust since last year: Our outpatient FFT score has improved slightly this year from 91.06 per cent to 92.98 per cent. As we continue to make changes through our outpatient improvement programme, we are confident that we will carry on seeing improvements to outpatient experience.

We have improved the percentage of patients using patient transport who would recommend our Trust since last year: Patient transport has been a key issue for those who are not able to travel to appointments independently. We have a team dedicated to facilitating patient transport. As a result, we are consistently sustaining a likely to recommend score of over our 90 per cent target which is a big improvement compared to last year. Our new non-emergency patient transport contract, which was re-tendered with the CCG and with the help of patients and service users, will begin in June 2019 and will deliver further quality improvements for our patients.

We have not improved the percentage of patients who would recommend our maternity services: Our maternity FFT rate has dropped slightly this year to 93.6 per cent which is just below our target of 94 per cent. Some of the changes we've made to improve patient experience in this area include: volunteer support with managing queues and informing women about waiting times, 'quality rounds' delivered by a leads nurse who talks to all the women on the ward to discuss any issues they've identified; and new equipment, including chairs, fans, and ear plugs and ear masks. Imperial Health Charity have kindly funded redecoration of the parents room and the creation of a milk kitchen and private area to use breast pumps; this work will finish by the middle of 2019.

We have seen an improvement on our national cancer patient experience survey results: our results have slightly improved (8.7/10 for overall care this year compared to 8.5/10 last year). The number of questions which scored in the lowest range decreased from 23 to 17. We also scored above or within the expected range for 35 questions, compared to 29 previously. These improvements reflect our on-going work around the role of the clinical nurse specialist, who provide expert advice related to cancer and focus on improving patient care and developing services, consolidating our navigator service (a single point of contact for cancer patients, aiming to create a more streamlined service and positive experience for the patient) and strengthening links with primary care.

We have reported a significant number of mixed sex accommodation (MSA) breaches: The national standard for mixed sex breaches is none for level one patients (patients requiring ward-based care). In 2018/19, we reported 554 MSA breaches. All of these were because of patients whose condition had improved and were waiting to be discharged from critical care to a ward. We are reducing the number of delayed discharges from critical care as part of our on-going work to increase capacity and improve flow across our sites, which in turn will support reductions in MSA breaches.

97.42%

of our inpatients would recommend the Trust to friends and family

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.

Four of our improvement priorities are closely aligned to this domain:

- To continue to define, develop, implement and evaluate an organisation approach to reducing unwarranted variation
- Emergency flow through the hospital
- To improve access for patients waiting for elective surgery
- To improve access to services across the Trust through a focus on increasing capacity
- Specialty review and clinical strategy development

Progress with these has already been described on pages 35-47. To avoid repetition we have not included these here again.

PLACE

All patients should be cared for with compassion and dignity in a clean, safe environment. PLACE (Patient Led Assessments of the Care Environment) was introduced in 2013 as an annual patient led initiative that monitors and scores the environment based on six criteria. The assessments provide a clear message, from patients, about how the environment or services might be enhanced. PLACE 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.

This year's results showed an improved position, meeting the targets we set ourselves in five of the six areas reviewed:

- Cleanliness – scores above national average.
- Food and hydration – scores above average, and has improved since last year.
- Privacy, dignity and wellbeing – although our results remain below average, they have improved since last year.
- Condition, appearance and maintenance – scores above national average
- Dementia – scores have deteriorated slightly, and are now slightly below national average (78.7 per cent compared to 78.89 per cent).
- Disability – scores remain below average, but have improved since last year

The improvements made 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. Several areas have benefitted from major refurbishment programs including works to ensure areas meet the recommendations for dementia and disability.

We have completed a detailed analysis of the 2018 assessment findings to assess any recurring themes and develop actions to improve scores further next year. The focus is on improving the three key areas where we did not meet the national average – disability, privacy/dignity/wellbeing and dementia.

Responsive quality highlights and challenges

Appendix H sets out our performance with the metrics under the Responsive domain in 2018/19. Where applicable, it presents national targets and averages, and information about our performance in 2017/18.

Highlights and challenges in performance are shown below. To avoid repetition, we have not included information about metrics which have previously been described under our 'quality improvement priorities' section.

We have not met the national standard for critical care admission: The national standard is that 100 per cent of admissions of critically unwell patients should be admitted within four hours. Delays to admission can be harmful to critically ill patients who need to be urgently managed within a specialised environment with expert medical and nursing care.

We admitted an average of 92.74 per cent of critical care patients within 4 hours across 2018/19. Improvements we are making include identifying potential patients for step down earlier and improving 'turn around' times for each bed.

We met five out of the nine cancer standards in all four quarters of the year: Table A shows our performance with the national cancer standards. We met all except the 62 day screening and 62 day upgrade standard in quarter four (up to end of February 2019). An action plan has been agreed, supported by the CCG and screening commissioners from NHS England. Performance is expected to recover in the new financial year.

Table A: Performance with cancer standards

Standard	Target	Q1	Q2	Q3	Q4 (Jan-Feb)
Two week wait	93%	93.6%	91.8%	94.1%	93.50%
Breast symptom two week wait	93%	94%	94.6%	95%	93.60%
31 day first treatment	96%	96.6%	96.8%	98.2%	98.00%
31 day subsequent chemo	98%	100%	100%	100%	100.00%
31 day subsequent radiotherapy	94%	97.9%	99.2%	99.6%	100.00%
31 day subsequent surgery	94%	95.4%	97.2%	97.3%	99.20%
62 day standard	85%	82.3%	78.9%	86.3%	100.00%
62 day screening standard	90%	82.9%	77.3%	76.6%	84.30%
62 day upgrade standard	85%	93.2%	93.3%	93.7%	65.00%

The improvements we have seen to our cancer waiting times overall have been the result of actions taken across each of the targets, including:

- Improvements to specific pathways e.g. the prostate RAPID diagnostic pathway in joint working with Royal Marsden Partners, the lung nodule surveillance pathway, and the establishment of a TKI clinic (Tyrosine-kinase inhibitor – an anti-cancer drug used as an alternative to chemotherapy).
- Development of straight to test access for GPs for a number of services e.g. lower GI endoscopy and two week wait UGI referrals. We are also currently developing this for suspected colorectal cancer referrals.
- Development of a report to highlight cancer patients affected by hospital cancellations.

Through the joint working led by the North West London Secondary Care Cancer Board we are committed to delivering the North West London Cancer Waiting Times recovery plan and are delivering the agreed actions to improve waiting times locally and across North West London.

We are below target for theatre management (touchtime utilisation), with overall performance of 79.43 per cent: One of the key areas to help increase our productivity is more efficient and effective scheduling of theatre lists – both the volume of patients booked and ensuring we are booking the right, properly prepared patients onto the right theatre lists and in the right order. Our surgical productivity programme has focused on coordinating the information flows between the different teams involved in surgical procedures, from pre-operative assessment to schedulers and the surgical teams and we're starting to see improvements in our oversight of elective theatre activity, and how we're using theatre sessions as a result.

We are pleased to have slightly reduced our percentage of operations cancelled for non-clinical reasons (at 0.89 per cent we are below our target and below national average), despite operational pressures, however we have not reduced the percentage of patients whose cancelled operations were not rebooked within 28 days (18.46 per cent in 2018/19 compared to 12.77 per cent in 2017/18). We have a number of workstreams in place to improve our understanding of and monitoring of cancellations and to reduce the root causes wherever possible.

We have seen improvements in performance with our outpatient targets: Around a million people come to the Trust's hospitals as outpatients every year, with a 5 per cent increase in attendances since 2017/18, and we have been running a major programme to improve the quality of their experience. As a result of this work, we are seeing improvements in performance in some key areas, with our average waiting time for the first appointment reducing by one week, a reduction in the average percentage of patients who do not attend their appointments from 11.68 per cent in 2017/18 to 10.69 per cent in 2018/19, and a reduction in the percentage of clinics we cancel with less than 6 weeks' notice from 8.01 per cent in 2017/18 to 7.93 per cent in 2018/19. We have also improved the percentage of outpatient appointments made within five working days of receipt of referral by over 10 per cent compared to last year, averaging just below our 95 per cent target at 94.87 per cent. Some of the highlights of this work include:

Using technology to improve our services

The way we communicate with our patients has improved to keep pace with mobile lifestyles. Examples include:

- Enabling and empowering patients to manage their own care using an outpatient portal, the Care Information Exchange (CIE), which also provides us with the opportunity to redesign outpatient pathways to better meet the needs of our patients and to enable supported self-monitoring, reducing the need for physical outpatient attendances. Over 25,000 patients have now signed up to this service.
- Text and automated voice reminders to remind patients of their appointments.
- Providing a video interpreting service, reducing the reliance on face-to-face interpreters and improving access to interpreting, at a lower cost.

- Implementing a ‘hybrid mail’ service, which enables patients to choose whether to receive appointment letters by post or email. 30 per cent of appointment letters are now sent by email.

Implementing the ‘Paper Switch Off Project’

Since October 2018, in line with the requirements of the NHS e-Referral Paper Switch Off project, all GP referrals to consultant led outpatient services are now received through our electronic referral service. This enables patients to schedule their own appointments online at a date, time and hospital that suit them. We also offer advice and guidance services to GPs for some of our services, giving them timely access to specialist opinion, without the need to refer the patient.

Thinking differently about outpatients – models of care

We are collaborating with all providers and CCGs across North West London in delivering an Outpatient Transformation Programme, redesigning and optimising clinical pathways, whilst reducing hospital outpatient attendances where clinically appropriate. The first phase of this programme is focusing on five services: cardiology, dermatology, gastroenterology, gynaecology and musculoskeletal, with further services to follow.

We have exceeded our target to respond to complaints within an average of 40 days: Our 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 had a further reduction in the number of complainants taking their complaint onto the Parliamentary & Health Service Ombudsman (PHSO). Overall, the volume of formal complaints has remained similar to last year, with values and behaviours of staff, care, clinical treatment and appointments continuing to be the main themes.

Throughout this year we have been redesigning the complaints questionnaire, which is sent to complainants six weeks after we have completed our response to their complaint. This will help us to continually improve our complaints handling by identifying the strengths and weaknesses in our processes. It will also allow us to measure our success in achieving our new metric in the IQPR of ‘Overall satisfaction with complaints handling’ for which we have set ourselves a target of 70 per cent.

In addition to the improvement made Trustwide, Imperial Private Health have revised their complaints process and are the first private patient unit to register with the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) who will assess the way they manage complaints.

We have maintained similar pick up and drop off times for patients using our non-emergency patient transport service to last year: We expect that our new non-emergency patient transport contract, which will begin in June 2019, will help drive further improvements for our patients over the coming months.

We have not improved performance against our data quality indicators: For 2018/19 we introduced two data quality indicators to our integrated quality and performance scorecard to help ensure we accurately record the number of patients we treat so we can plan appropriately. At the end of the year we were off trajectory for both indicators. We have agreed recovery plans with areas that aren’t meeting the targets.

Work we are doing to improve data quality is described on page 33.

Improved responsiveness to complaints – within

30 days on average

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.

Two of our improvement priorities are closely aligned to this domain:

- To improve permanent nurse staffing levels
- To improve compliance with the equality and diversity standards

Progress with these has already been described on pages 35-47. To avoid repetition we have not included these here again.

Staff engagement programme

We monitor staff engagement through the national staff survey and through our annual internal survey ‘Our Voice’ which was run in May and June 2018. 3,146 of our people responded, which represents 34 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. The percentage of staff who would recommend us as a place for treatment remained the same as last year, however we were disappointed that the percentage of staff who would recommend us as a place to work decreased slightly (70 per cent would recommend, compared to 72 per cent in 2017). This was mirrored in the national staff survey, the results of which were very similar between 2017 and 2018.

Like last year, teams created specific action plans to improve engagement in their areas in response to the survey results. To facilitate this, we supported managers to run ‘In our Shoes’ team based listening exercises where staff could talk freely about their experiences of working here. Over 1,000 staff participated. We also developed a workshop and toolkit to support mangers, called ‘Engage’. Around 100 managers took part.

As an organisation, we analysed our results and identified four key areas for action:

- Senior leadership behaviours
- Health and wellbeing
- Poor performance and behaviours
- Recognition

We refreshed a number of the plans we already had in place to drive improvements in these areas, including our health and wellbeing strategy, leadership development programmes, ‘make a difference’ staff award scheme, appraisal training for managers and our bullying and harassment/dignity and respect action plan. We implemented a board member site visit programme, to formalise walk rounds by our executive and non-executive directors and improve leadership visibility. We also reviewed our disciplinary process (see pages 68-69 for more details) to help tackle staff concerns about how we address poor behaviour. Further details on these can be found throughout this section.

We also looked at what we could do further to address leadership behaviours and the cultural issues raised by the survey results. Using a framework developed by NHS Improvement to guide local action on developing NHS staff, more than 2,000 staff took part in activities designed to explore themes around our vision, values and behaviours. Their views and insights have fed into work to develop our organisational strategy (see page 10). One of the first practical outputs is an updated ‘behavioural framework’, co-designed with staff, setting out clear examples of the behaviours that demonstrate when we are living our values, and those that show when we aren’t. This will support conversations with colleagues about when behaviours are helpful and when they are challenging. The roll out and embedding of our values and behavioural framework is a key priority in 2019.

In addition, we have made changes to our award-winning suite of bespoke leadership development programmes to support managers through each stage of their careers. Many of the issues raised in staff surveys link back fundamentally to the quality of day-to-day line management and leadership. We have focused on providing more high quality development for our new and existing managers. We now offer six internal programmes, including:

- First Steps preparation for management
- Foundations introduction into management
- Springboard nurse/midwife leadership
- Frontier Medical Consultant Leadership
- Headstart management into leadership
- Aspire the Leadership Way
- Horizons Leading across systems

We also train and develop our managers and leaders with coaching skills, including in quality improvement through our Coaching and Leading for Improvement programme (CLIP), and have commissioned a programme with Imperial College Business School for our most senior leaders working in partnership with our AHSC partners Royal Marsden NHS Trust and Royal

Brompton NHS Trust to run a Clinical leadership programme.

Next year, we are planning to make changes to the way we run our engagement surveys. Instead of running an internal survey for all staff and a national survey with a sample (10 per cent) of our workforce, we plan to run one full census national survey for all staff, with separate quarterly 'pulse' surveys in between focusing on particular areas of concern. This will allow us to better measure progress and track improvement.

Freedom to speak up strategy

Freedom to Speak Up (FTSU) promotes and encourages the raising of concerns from NHS workers, sub-contractors and volunteers to ensure patient safety is maintained at all times and to make the health service a better place to work. We are committed to embedding an open and transparent culture; one in which staff members and volunteers feel empowered to raise concerns, with confidence that these concerns will be acted upon and without fear of detriment for speaking up. This includes creating the appropriate structure and process that supports speaking up and ensuring that all staff members demonstrate the values and behaviours required to deliver this in practice.

In 2018, we recruited five volunteers within the Trust as FTSU guardians, one for each site, from a broad range of backgrounds. They are supported by a Non-executive director and the employee relations team. We carried out a self-assessment in September and identified some areas for improvement. In response we developed a draft FTSU strategy which will launch in 2019.

We also have a Raising Concerns policy which details the different ways in which staff can speak up, including through their immediate management team (most concerns are resolved this way), our Employee Relations Advisory Service, and our FTSU guardians. Staff who do raise concerns are given feedback promptly once an investigation has been completed, including any actions taken as a result.

Improvements to our disciplinary process

In August 2018 a report was published following an independent investigation into a disciplinary case that took place at the Trust in 2015. This report made recommendations for us to help improve our disciplinary process and better support managers who are undertaking the process, but also employees who are being managed through the process.

We put in place interim measures immediately following publication of the report, including a staff liaison officer to provide pastoral support. In 2019/20 we will implement a central investigation team who will be responsible for conducting all disciplinary investigations related to allegations of misconduct. This will mean a thorough investigation by an independent person who has the right level of training and experience.

Our aim is to reduce the number of cases requiring investigation by supporting staff to manage situations informally and handle low level conflict more effectively.

Patient and public involvement

We continue to make good progress with increasing and improving patient and public involvement in every aspect of our work. This year we collaborated with 53 lay partners across different projects, including the 'keeping care flowing collaborative' (see pages 43-44), improvements to palliative care, and facilities tenders.

We have also introduced a new annual award to our 'Make a Difference' scheme for staff scheme – a commemorative award in memory of Michael Morton, chair of our strategic lay forum who sadly passed away in November 2018. The award will recognise teams and individuals who have improved the outcomes and/or experience of patients through co-production.

Ward accreditation programme

Our internal annual ward accreditation programme (WAP) continues to support ward managers to understand how they are delivering care, identifying what works well and where further improvements are needed. Areas are assessed 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 2018 out of 109 areas reviewed, 35 had improved since last year. 39 per cent of clinical areas were rated as gold, 34 per cent were rated as silver, 19 per cent were rated as bronze and seven per cent were rated as white.

Key areas for improvement include environmental issues and medication storage and disposal. The outputs of the WAP have informed trustwide projects to improve these issues. Leadership is often identified as a problem in 'white' wards. In order to support our nursing staff further in preparation for leadership roles, we launched a leadership development programme 'Springboard' for band 5-6 nurses in 2017; 150 people have participated so far.

Medical education improvements

We aim to provide the best learning environment for our doctors. The General Medical Council's national training survey (GMC NTS) is one of the ways we monitor the quality of teaching we provide. In 2016, our results improvement significantly; since then we have largely maintained our performance overall. However in 2018 our results deteriorated, with an increase in red flags (negative outliers) and a decrease in green flags (positive outliers).

Following publication of these results in July, we met with trainees and unit training leads to understand the reasons for the results and share improvement approaches. Each specialty has developed a local action plan, with five specialties requiring action plans to be submitted to Health Education England for monitoring.

On an organisational level, we implemented a number of improvements including:

- A new education governance review process, including the addition of assurance meetings with the medical director for the five specialties where there are particular concerns, with supportive improvement plans in place.
- Improved focus on educational issues at divisional committees.
- Improvements to induction for junior medical staff to ensure they are 'day one ready' – this includes completion of core skills training, and training on how to use our electronic patient record.
- Improvements to our existing faculty development programme, focusing on resilience and coaching and mentoring skills.
- A process for monitoring gaps on medical staff rotas. We have 792 doctors in training working at the Trust, with 63 gaps on the rota. Twenty-seven of these gaps have been filled by locally employed doctors. We have 36 unfilled posts, 25 of which are being recruited to. The remaining eleven are going through the approval to recruit process. In addition to recruiting, we take action each month to make sure that the rotas are filled, including proactive engagement with Health Education England so we can accurately plan, targeted campaigns for hard to recruit specialties and the use of locums where necessary. From July 2019, we will report annually on rota gaps to our Trust Board as required by the Department of Health.

In September 2018, we formed a Task and Finish Group to resolve on-going concerns about junior doctor wellbeing and engagement, and the facilities available to them. The group has:

- Ensured all sites have communal rest facilities that are up to standard;
- Improved access to hot and cold healthy food at all sites;
- Developed new posts to support improved engagement and representation, including Senior Trainee Representatives for each specialty;
- Improved the junior doctor forum, including a junior doctor chair and regular presentations from the CEO and Medical Director.

As a result of improvements made, the General Medical Council advised us in March 2019 that they have removed Intensive Care Medicine at Charing Cross Hospital from Enhanced Monitoring.

Well-led quality highlights and challenges

Appendix I sets out our performance in 2018/19 with the metrics under the Well-led domain. Where applicable, it presents national targets and averages, and information about our performance in 2017/18.

Highlights and challenges in performance are shown below. To avoid repetition, we have not included information about metrics which have previously been described under our 'quality improvement priorities' section.

We have met our voluntary turnover rate and staff retention targets: A key aspect of reducing the voluntary turnover rate (the number of staff who choose to leave and work elsewhere) is to ensure staff have the opportunity for career progression, feel their job is worthwhile and fulfilling, and they are supported to develop. We are pleased to have met our 12 per cent target again this year and to have exceeded our 80 per cent staff retention rate target. Some of the ways we continue to work to ensure this include:

- Our nurse recruitment and retention strategy (see page 38 for more information);
- Improvements to our leadership development programme and training schemes for staff;
- Our workforce equality and diversity work programme (see page 46 for more information);
- Our talent management process which has been completed for all senior leaders in the organisation. This will ensure that all leaders have development plans in place, including those identified as potential successors of senior roles;
- "Great place to work week", which we ran for a second year in 2018, Trust magazine and our new intranet, which is easier for staff to use and includes a 'Working Here' section, featuring courses and seminars, pay and benefits, training and development and reward and recognition.

We have also introduced a working group to oversee preparations for Brexit and supported staff by providing guidance about the EU Settlement Scheme.

Our sickness absence rate remains low, but is slightly above our target: Over the past year we have seen a small but steady increase in the levels of recorded absence. Working in healthcare can be stressful and emotional at times. 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. We have a range of activities and services available including occupational health, staff counselling, stress management, yoga and meditation classes, and smoking cessation clinics. We also continue to run our annual Healthy Living Week event; over 1,300 attended in 2018.

We have increased the percentage of doctors who have had an appraisal, although we have not met our target: 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, 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. The percentage of doctors who have completed their appraisal has been steadily increasing throughout the year and at 93.76 per cent it is now at its highest since we started measuring it.

We exceeded our target for completion of consultant job plans: Job planning involves regular reviews of consultants' time, including educational and research work as well as clinical practice, to ensure it is used efficiently and effectively. We review our consultants' job plans each year, with the aim of ensuring at least 95 per cent of our consultants have a completed, approved job plan in place. 99.5 per cent had a job plan in place at the end of the job planning round in July 2018. We are building on this success for the next job planning round, continuing to run drop-in support sessions and providing regular reports for clinical managers on progress.

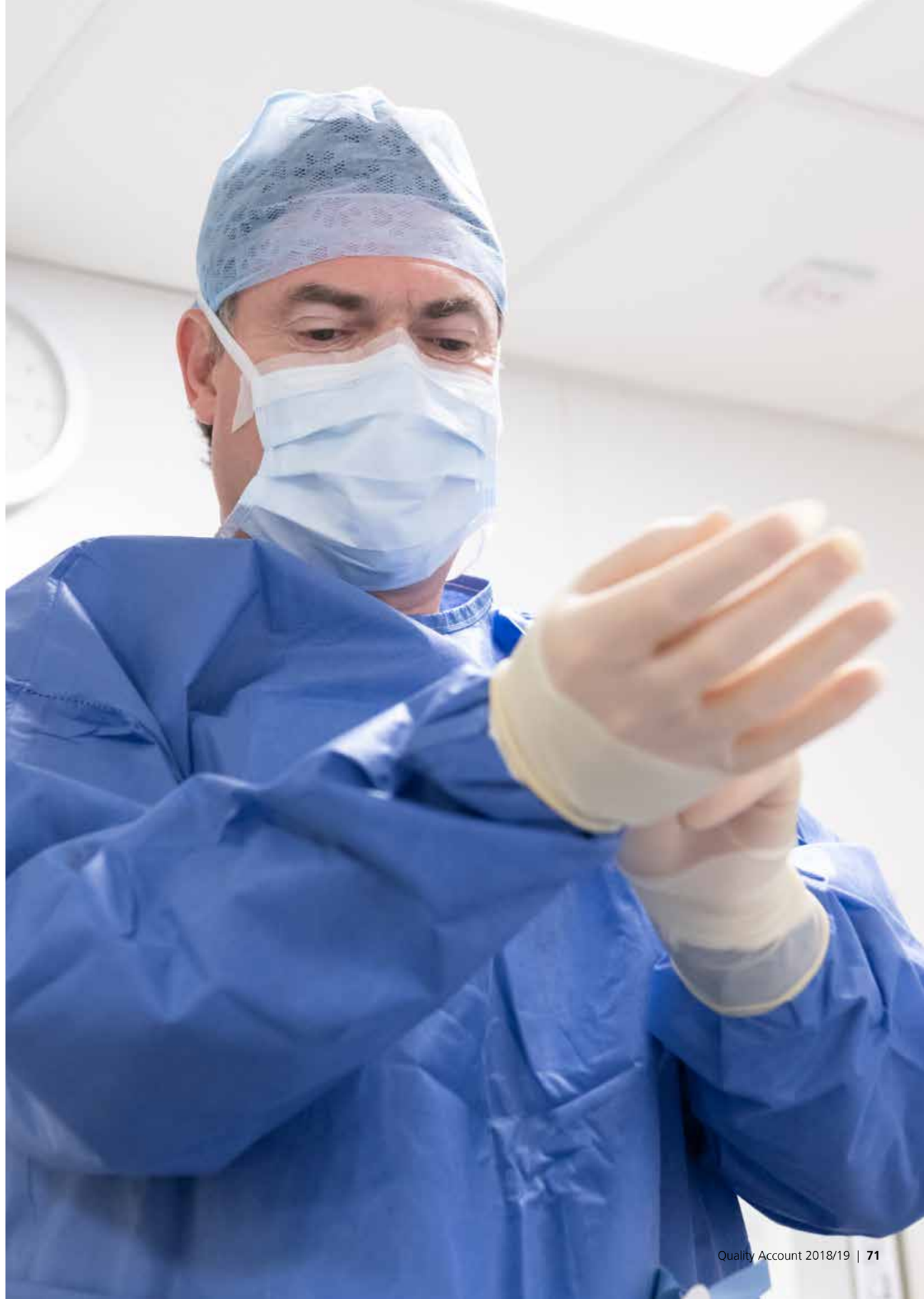
We have improved the percentage of staff who have had a performance development review (PDR): Our appraisal scheme 'Performance Development and Review (PDR)' for staff, excluding doctors, is aimed at driving a new performance culture across the Trust. Although we are below target we have improved compared to last year. In total 8,100 staff members (89.6 per cent of our staff) had a PDR completed.

The National Staff Survey results for 2018 show that out of our staff members who completed the survey, 90.6 per cent had been appraised within the last year which is above the national average. Respondents also stated that the quality of appraisals was above the national average. We continue to run a one day essential training course for all managers undertaking PDRs and 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.

Next year, we will also ensure our consultants have PDRs, in addition to their annual appraisals. This will mean that they engage in the same values based conversations as all other staff.

We are in segment three of four in the NHS Improvement (NHSI) provider segmentation: Under the Single Oversight Framework, which is designed to help NHS providers attain, and maintain, CQC ratings of 'good' or 'outstanding', NHSI segment providers based on the level of support they need across the five themes of quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability.

We are currently in segment three of four, which is 'providers receiving mandated support for significant concerns'. This is because we are rated as 'requires improvement' by the CQC and because NHSI have sought formal undertakings from us related to our financial position, A&E performance and Referral to Treatment (RTT) performance. There are action plans in place in response which are being delivered, with regular reporting to the Board.



99.5%

of consultants have an agreed job plan in place

Use resources sustainably

For 2018/19, we have included one more standard, 'Use resources sustainably', which was defined by the National Quality Board (NQB) and which is monitored by NHS Improvement and included in CQC inspection reports. We have included this to ensure that we are delivering value for money for our patients, communities and taxpayers.

Clinical services

In the context of continued year on year commissioned growth, we have worked hard to improve pathways and performance against national access standards, whilst remaining one of the safest hospitals in the country. This is despite the challenges presented by having one of the poorest estates, and an estimated beds deficit of more than 100.

This year we have improved efficiency in key areas, which have also seen real benefits for patients, including a reduction in non-patient elective cancelations, an increase in theatre efficiency and investment in 50 additional beds, whilst delivering another 35 through efficiencies in A&E and patient flow.

We still have work to do to reduce the number of pre-procedure bed days and our DNA rates, although both are improving. This will continue to be a focus into 2019/20.

We have delivered significant growth in imaging services, despite substantial challenges with the estate and aged asset base. We are leading the collaboration of imaging services through the North West London Imaging Network. This network has agreed a shared vision and aims, and are procuring a joint image share and reporting solution, as well as developing joint plans for asset growth and workforce training.

We are pioneering new services to deliver efficiency and improved patient outcomes, including:

- Thrombectomy service for Major Stroke, leading to significant reductions in length of stay and improved patient outcomes.
- Brain focused ultrasound (FUS) – cutting edge non-invasive care for patients, replacing the current treatment of Deep Brain Stimulation (DBS). This is expected to be significantly cheaper, with fewer potential complications.

Imperial Private Healthcare continues to grow, delivering a 3.8 per cent increase in income compared to last year.

People

We are a central London teaching hospital, facing the people challenges of a highly mobile workforce, adjacent local career opportunities and high cost of living. This year we've delivered an increase in consultant job plans, consistently high appraisal levels, low sickness absence and a recruitment and retention programme for nursing and midwifery staff.

We have also been improving how we use management information to optimise how workforce productivity and how we use technology to improve operational productivity and patient safety.

Estates and facilities

We continue to work to improve our estate, which is a major driver of our deficit. There are many reasons for this, including that we are a multi-site organisation, and the under-utilisation and inefficient configuration of the floor space of our aged estate. We have an 8 year £130m backlog investment programme to address critical infrastructure and fire safety.

The table below sets out our performance with the Use of Resources metrics in the IQPR during 2018/19.

Goal/Target	Performance in 17/18	Outcome in 18/19
Monthly finance score	3	2
In month position £m	N/A	1.48
YTD position £m	N/A	-0.10
Annual forecast variance to plan £m	£1.1m favourable (£2.6m favourable excluding STF)	-0.10
Agency staffing	£28.4m	£25.2m (4.37%)
CIP (cumulative financial YTD)	£43.1m	£44.1m (73.90%)

Use of resources quality highlights and challenges

We have met our financial plan: We met our financial plan for 2018/19, delivering a deficit of £22m. Meeting our financial plan – as well as our expected improvement in A&E performance – has given us access to additional central funding of just over £48m, meaning we posted a surplus of £28 million. Our savings also enabled us to reduce our underlying financial deficit by £2m, less than planned but still an important contribution to our longer term sustainability.

We have reduced annual agency spend by 40 per cent (£20.89m) since 15/16: this has been facilitated through robust control, recruitment and expanded bank provision. In 2018, fewer agency cap breaches have also been seen.

We have a good recent track record of delivering CIP above national targets: 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. We delivered £43m in 17/18 and £44m in 18/19. Our medical director and director of nursing review all proposed CIPs for their impact on quality of care using a quality impact assessment process.

For more detailed information about our financial situation, please see the annual report which will be published on our website in August 2019.

£

Reduction in annual agency spend

by 40% since 15/16

The NHS Outcomes framework indicators 2018/19

The NHS Outcomes Framework 2018/19 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 2018/19. 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.

N.B. As of 1st October 2017 NHS England discontinued mandatory varicose veins surgery and groin hernia surgery PROMs collection.

Indicator	Trust performance 2018/19	National average (median reporting rates)	Where applicable - best performer	Where applicable - worst performer	Trust statement	2017/18	2016/17	2015/16
SHMI value and banding	73.21 (Q3 17/18 – Q2 18/19) Fourth lowest SHMI ratio of all non-specialist providers in England	100 (Q3 17/18 – Q2 18/19)	69.2 (Q3 17/18 – Q2 18/19)	126.8 (Q3 17/18 – Q2 18/19)	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 ratio for the last three years. • We have the fourth 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 pages 32-33 for more information on our implementation of the Learning from Deaths framework.	74.13 Second lowest SHMI ratio of all non-specialist providers in England	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
Percentage of admitted deaths with palliative care coded	57.5% (Q3 17/18 – Q2 18/19)	33.4%	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.	56.7%	54.9%	53.5%
PROMs for hip replacement surgery	* (Low sample size) (provisional data for April - September 2018)	EQ-5D: 0.458 EQ VAS: 13.877 Oxford knee score: 22.210 (April 2017 – March 2018 published Feb 2018)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • Adjusted health gain was unable to be calculated as there were insufficient forms returned. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • implementing our action plan. See pages 59-60 for further information.	EQ-5D: 0.464 EQ VAS: 15.379 Oxford Hip Score: 21.950	* (Low sample size)	EQ-5D: 0.475 EQ VAS: 14.259 Oxford Hip Score: 24.229

Indicator	Trust performance 2018/19	National average (median reporting rates)	Where applicable - best performer	Where applicable - worst performer	Trust statement	2017/18	2016/17	2015/16
PROMs for knee replacement surgery	* (Low sample size) (Provisional data for April - September 2018)	EQ-5D: 0.337 EQ VAS: 8.153 Oxford knee score: 17.102 (April 2017 – March 2018 published Feb 2018)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • Adjusted health gain was unable to be calculated as there were insufficient forms returned. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Implementing our action plan. See pages 59-60 for further information.	EQ-5D: 0.298 EQ VAS: 8.283 Oxford Knee Score: 13.870 (April 2017 – March 2018 published Feb 2018)	* (Low sample size)	EQ-5D: 0.292 EQ VAS: * low sample size Oxford Knee Score: 13.420
28 day readmission rate for patients aged 0-15	4.88% (Dr Foster data – Oct 17 – Sep 18)	9.39% (Dr Foster data – Oct 17 – Sep 18)	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.	4.92% (Oct 16 – Sept 2017)	5.15% (Oct 2015-Sep 2016)	4.81% (Jan-Dec 2015)
28 day readmission rate for patients aged 16 or over	6.75% Dr Foster data – Oct 17 – Sep 18)	8.49% Dr Foster data – Oct 17 – Sep 18)	Not available	Not available	See above.	6.92% (Dr Foster data – Oct 16 – Sept 2017)	6.64 % (Oct 2015-Sep 2016)	7.39% (Jan-Dec 2015)
Percentage of staff who would recommend the provider to friends or family needing care	71.7% [national staff survey – published February 2019]	71.3% [national staff survey – published February 2019]	87.3% [national staff survey – published February 2019]	39.8% [national staff survey – published February 2019]	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 February 2019. • The results are slightly above average for acute trusts. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • See page 67 for information on our improvement plans.	73% [national staff survey – published March 2018]	70%	68%
Percentage of admitted patients risk-assessed for VTE	96% (Q1 18/19) 96.37% (Q2 18/19) 95.23% (Q3 18/19) 93.97% (Q4 19/19)	95.63% (Q1 18/19) 95.49% (Q2 18/19) 95.65% (Q3 18/19)	100% (Q1 18/19) 100% (Q2 18/19) 100% (Q3 18/19)	75.84% (Q1 18/19) 68.67% (Q2 18/19) 54.86% (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. • We have monitored VTE risk assessments on a monthly basis throughout the year. From April 2018, we met the target consistently until December 2018. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • See page 54 for information on our improvement plans.	93.87% (2017/18 full year data) Q1: 92.71% Q2: 91.63% Q3: 95.53% Q4: 95.64%	95.33%	95.87%

Indicator	Trust performance 2018/19	National average (median reporting rates)	Where applicable - best performer	Where applicable - worst performer	Trust statement	2017/18	2016/17	2015/16
Rate of C-Diff per 100,000 bed days	15.1 (total number of cases: 51)	12.3 (2017/18 data)	0.0 (2017/18 data)	91 (2017/18 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. See pages 54-55 for further information.	17.64 (63)	18.03 (63)	20.9 (73)
Responsiveness to inpatients personal needs: National Inpatient survey score	8.2 [overall score] 6.88 [responsiveness score] [no new data has been published since the national inpatient survey published June 2018]	Not available	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 Inpatient Survey which was published in June 2018. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • See pages 61-62 for information on our improvement plans.	8.2 [overall score] 6.88 [respon-siveness score]	8.2 [overall score] 6.72 [respon-siveness score]	7.9 [overall score] 6.74 [respon-siveness score]
Rate of reported patient safety incidents per 1,000 bed days	50.4 (NRLS data: Apr – Sep 18) Internal data Apr 18 – Mar 19: 47.25	42.44 (NRLS data: Apr – Sep 18)	107.4 (NRLS data: Apr – Sep 18)	13.1 (NRLS data: Apr – Sep 18)	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 us for the period April – September 2018: our incident reporting rate for this period was 50.4 against a median peer reporting rate of 40.83 • Our individual incident reporting data is made available by the NRLS every six months • Based on our full year internal data, our reporting rate is below the top quartile at 47.25, although we have significantly increased the numbers of incidents reported since 2016/17 and maintained a similar number compared to 2017/18. This is due to a number of issues with our published bed day data for quarter three which is used to calculate our reporting rate for the last six months of 2018/19. The quarter four bed occupancy data is expected to reduce, bringing our reporting rate up. 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. See pages 36-37 for further information.	Apr-Sep 17: 47.96 Oct 17 – March 18: 51.26 (rate per 1,000 bed days)	Apr – Sep 16: 42.3 Oct 16 – Mar 17; 46.82 (rate per 1,000 bed days)	Apr – Sep 15: 41.38 Oct 15 – Mar 16: 43.18 (rate per 1,000 bed days)

Indicator	Trust performance 2018/19	National average (median reporting rates)	Where applicable - best performer	Where applicable - worst performer	Trust statement	2017/18	2016/17	2015/16
Percentage of patient safety incidents reported that resulted in severe/major harm or extreme harm/death	0.0% severe/major harm (2 incidents) 0.06% extreme harm/ death (5 incidents) (NRLS data: Apr – Sep 18) Internal data Apr 18 – Mar 19: 0.04% severe/major harm (6 incidents) 0.03% severe/major harm (5 incidents)	0.24% severe/major harm 0.10% (extreme harm/death) (NRLS data: Apr – Sep 18)	0.0% severe/major harm 0.0% extreme harm/death (NRLS data: Oct 17 – Mar 18)	1.2% severe/major harm 0.5% extreme harm/ death (NRLS data: Oct 17 – Mar 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 from the NRLS • Between April and September 2018 (most recent national data available), we reported 0.0% severe/major harm incidents (2 incidents) compared to a national average of 0.24%, and 0.06% extreme/death incidents (5 incidents) compared to a national average of 0.10%. • Based on our full year internal data, we have reduced the total number of incidents causing extreme harm/death or severe/major harm in 2018/19 reporting 11 compared to 27 in 2018/19. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • See pages 35-36 for an update on our improvement plans.	Apr – Sep 17: 0.1% severe/ major harm (6 incidents) 0.1% extreme harm/death (6 incidents) Oct 17 – Mar 18: 0.1% severe/ major harm (9 incidents) 0.1% extreme harm/death (6 incidents)	Apr – Sep 16: 0.1% 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)	Apr -Sep 15: 0.1% – 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)
Inpatient Friends & Family Test	97.42% (Apr 18 – Mar 19)	96% (Apr 18 -- Mar 19)	100% (Feb 19)	76% (Feb 19)	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 61-62 for an update on our improvement plans.	97% (2017/18)	97% (2016/17)	96% (2015/16)
A&E Friends & Family Test	94.26 % (Apr 18 – Mar 19)	86.6% (Apr 18 -- Mar 19)	100% (Feb 19)	57% (Feb19)	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 page 62 for an update on our improvement plans.	94% (2017/18)	95% (2016/17)	92% (2015/16)

Statements from stakeholders

Before the final document is published, our external stakeholders are given the opportunity to review and provide statements on our quality account. We would like to thank our stakeholders for submitting their statements, which provide helpful feedback and highlight the areas where we have made improvements as well as where we know we still have work to do and progress to make. We will take the feedback into account in our improvement plans for the following year. We look forward to continuing to work with our stakeholders throughout the year as we strive to achieve our goals.

Response from Hammersmith and Fulham Clinical Commissioning Group

Hammersmith & Fulham CCG (H&F CCG) welcome the opportunity to provide this statement with regards to the Quality Account for Imperial College Healthcare Trust, on behalf of its Associate Commissioners. The Quality Account has been viewed by Associate Commissioners as well as H&F CCG's Quality Committee.

We have reviewed the content and data within the account and to the best of the CCG's knowledge the information contained within the Quality Account is a reflection of the quality performance linked to the provision of the Trust's services.

The 2018 Quality Account describes it's links to the Trust's development of a new Quality Strategy 2019-2023. We are aware of the work to bring together a new Quality Strategy and would welcome the opportunity to be been involved in its conclusion. The Quality Account has a focus on quality and safety for the organisation using the key priorities and makes links to the areas for improvement as requested by the Care Quality Commission (CQC)

The Trust underwent a CQC Inspection in November 2017 and as an organisation was rated 'requires improvement' with some attached Requirement Notices. The Trust has delivered on key areas such as Medicines Management; maintenance of equipment; compliance with Statutory and Mandatory Training etc. leading to these no longer featuring as priority areas in this new Quality Account. In early 2019 the Trust underwent planned inspection of 4 service areas and well led inspection in April 2019 and we await the Inspection report.

Through the latter half of 2018 Commissioners have observed and discussed the development of bi-monthly reporting arrangements to the Trust and the Clinical Quality Group (CQG) meetings. This has reflected the work to embed the divisional management structures and the oversight Quality & Risk Meeting and escalation structures. The new reports are bringing clarity to the concerns and risks arising from Ward/Department to Divisional level and on to Board and CQG. We look forwards to this continued development.

Safe:

We look towards continuing to work in partnership with the Trust to support the further improvement on incident and serious incident management. Safer Surgery – Commissioners have raised concerns at CQG about the number of Never Events in 2018 especially in related to invasive procedures. We look forwards to hearing the impact of the simulation training and coaching as well as a supportive approach to gaining a shared understanding in relation to Human Factors that may be at play in some incidents.

We commend improvement work delivered through the Safety Culture programme and the 9 associated work streams. We have supported the review of priorities contained within the Programme and look forwards to hearing that some incident types which have required continued focus have an improving picture in 2019. Imperial have been shortlisted as finalists in a few categories of the Health Service Journal Patient Safety Award – Well Done!

It is already noted that the Trust is recognised as a leader in its work around mortality and together with 'Learning from Deaths' guidance. We anticipate continued good practice.

We recognise the extensive work that has gone in to improving compliance with hand hygiene. This has included a new methodology and also developing trust in a peer review approach. It will be interesting to see what impact the new communications campaign has. We do note and wish to see continued focus on, ensuring that the Trust manages the interdependencies between estates; maintenance and Infection Prevention and Control robustly to reduce the risk and spread of outbreaks. We are concerned by the performance of the cleanliness audit scores and anticipate improvement over the coming year with respect to a review of the current provision. Good work has been delivered around early intervention in sepsis and results of a mortality reduction from 18% to 14%, hopefully with further roll out this number will continue to decline. It is disappointing that none of the organism targets were achieved for 2018/19 along with cleanliness audit scores and flu vaccinations for staff. There will need to be a continued focus on these areas.

Caring:

Responsive:

We recognised the achievement of the Trust to achieve a RTT wait time's position with a target of zero 52 week waiters. It is disappointing that the cancellation of operations and rebooking target continue to be a challenge. Commissioners are keen to see how this will be improved on within the next year.

We are pleased to see the outcomes of the patient experience work on nutrition and noise at night. We look forwards to hearing more about the 'Eat& drink; Move & Sleep 'project as we recognise the importance and risks to patients of deconditioning. We commend the trust on a pilot and innovative idea of using volunteers in the Patient & Advice Liaison Service to test the impact for patients of having access to support and a listening ear in real time.

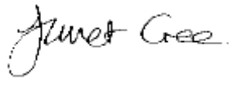
Well Led:

The Trust has regularly reported its actions to develop and retain its staff, together with the suite of leadership programmes. We are encouraged by the link the Trust has made to the importance of exploring what immediate support and arrangements can be put in place for staff involved in a serious incident that both offer psychological support to staff and reduce sickness rates.

We are pleased to see the steps that the Trust are taking to improve the Organisation's culture, to improve the employee's experience in the workplace, recognising the direct impact this has on good patient care. We particularly are pleased to see the efforts to promote the 'Freedom to Speak Up' Strategy and the work to recognise the appreciation by management and patients of the work of staff and in turn staff of each other. We anticipate that the importance of the trust's value and behaviours runs as a 'golden thread' through your leadership programmes as well as at Induction.

With the continued importance of securing a consistent workforce, Commissioners are pleased to see the improvement in the experiences of Junior Doctor experiences and the consideration of the well-being of Junior Doctors is good. The improved position (surveillance) from a Health Education England view is welcomed.

We look forwards to seeing the evolution of reporting on the effective 'Use of Resources' at CQG.



Janet Cree
Managing Director
Clinical Commissioning Groups Group

Diane Jones
Chief Nurse and Director of Quality
Hammersmith & Fulham North West London
Clinical Commissioning

Response from the Westminster Family and People Services Policy and Scrutiny Committee

Introduction

The Westminster Family and People Services Policy and Scrutiny Committee welcomes the opportunity to comment on the Imperial College Healthcare NHS Trust Quality Account 2018/19.

Quality progress 2018/19

We are pleased the progress in reducing avoidable harm to patients, in particular that there has been:

- to see a reduction in the number of incidents causing the most harm to patients
- fewer avoidable deaths
- some of the lowest mortality rates in the country
- a reduction in mortality for patients diagnosed with sepsis
- a reduction in falls with harm

We are however concerned that there has been seven never events, although note that one has since been reclassified as a serious incident.

The work to improve the safety culture across the Trust is welcomed, especially the increased number of incidents reports while maintaining low levels of harm and increased confidence of staff in being able to raise concerns.

We are disappointed that the trust has not met its 4 hour A&E target but note that in March 2019 performance was significantly better (5.2 per cent) compared to March 2018, despite having 4.3 per cent more attendances.

We are pleased that there has been a reduction in delayed beds, an increase in patients discharged before noon, an increase in the use of our discharge units (from 10 per cent in 2017/17 to 14 per cent in 2018/19). Average discharge time has been brought forward by 46 minutes.

We look forward to seeing the findings of the A&E targets trial.

It is disappointing that the trust did not meet the standard of 92 per cent of patients treated within 18 weeks of referral in 2018/19. We do note that there has been an improvement since last year.

We are pleased to see that the trust has significantly reduced the number of patients waiting over 52 weeks for surgery.

The Trust's estate and maintenance backlog have been features of all our regular meetings. We are pleased that targets are being consistently met for maintenance of medium risk and low risk equipment and there has been a significant improvement for

high risk equipment. However, we note that repairs and maintenance issues are having an effect on treatments that are available as shown by the upcoming closure of the hydrotherapy pool.

We are pleased to see that a number of the improvement priorities involving staff have seen progress. These improvements include a significant increase in the number of staff who have completed all the core skills modules which has been above the 90 per cent target since November 2018. We also note that the workforce race equality standard has improved since the previous year. We are concerned that the Trust has not achieved its target of 13 per cent nurse vacancy levels, although note you have reached planned safe levels.

We are pleased to see a significant improvement in hand hygiene in compliance on wards with focused improvement support, we hope to see improvement in other wards. We would challenge imperial to set a tougher target than 70% given the importance of hand hygiene compliance.

We would like to congratulate the Trust on being shortlisted for a HSJ award in the category of 'Changing Culture' and on the success of the Trust's Flow Coaching Academy.

Priorities for 2019/20

We are pleased to see that the Trust's approach to quality improvement includes co-designing work/projects/initiatives with staff, patients and wider communities. We hope that this work sees further improvements in 2019/20.

Conclusion

Overall, the progress that the Trust has made over the last year is welcomed. I have appreciated the Trust's collaborative approach towards engaging on service changes over the past 12 months. I have also appreciated the regular meetings with the Chief Executive to keep abreast of issues that are affecting the Trust. I look forward to continuing to work closely with the Trust in 2019/20.

Councillor Jonathan Glanz
Chairman Family and People Services Policy and Scrutiny Committee.

Response from the Hammersmith & Fulham Chair, Health, Inclusion and Social Care

Thank you for your recent attendance at the Health, Inclusion and Social Care Policy and Accountability Committee. Members of the Committee welcomed the opportunity to engage with you and health colleagues regarding the Trusts Draft Quality Accounts 2018/19.

The Committee understood that there remains in place a period of severe, restrictions on both NHS revenue and capital budgets, and this is particularly affecting the hospitals in North West London, and indeed is reflected in the Trust's performance on many measures provided in the quality report. While we might not expect the report to reflect deeply on these matters, we do feel it should acknowledge them.

Members of the Committee valued the opportunity to consider and comment the Draft Quality Accounts and endeavoured to fit them into our schedule of works at an appropriate time. However, we were disappointed that residents could not attend the discussion. While it is accepted that the timetable and conditions that determine the production of the submission are often factors outside of the Trusts control, it would be helpful to have consider this within the public domain in future. Our residents expect that the PAC meetings are open to the public it would be useful it this could be facilitated with the Board for next year.

We recognise that the Trust's quality report is intended to set out the organisation's improvement priorities and metrics for the following year, and to describe progress in delivering the priorities outlined in the previous year's document.

In many ways it is a 'tick box exercise' but nevertheless it provides an opportunity to hold the Trust to account for poor performance and to ask how this will be dealt with in future. We have identified a number of areas of challenge, based on our review of the report, and were possible have linked this to areas of scrutiny considered by the Committee in the past year.

i) CQC quality domains

The Trust refers to its 5 quality priorities using CQC domains (pp13-27):

1. Safe
2. Effective
3. Responsive
4. Caring
5. Well-led.

The Trust has added a sixth domain – to use resources sustainably which it defines as using resources responsibly and efficiently, providing fair access to all, according to need, and promoting an open and fair culture. This was defined by the National Quality Board (NQB) and is monitored by NHSI and included in CQC inspection reports, with the intention of ensuring the Trust delivers value for money for patients, communities and taxpayers.

ii) Trust's improvement metrics

At this point the Trust includes no metrics but just a description of the nature of what is being measured. However, these metrics are included later in the report (pp62-98).

Below we have constructed a simple table based on the Trust's presentation of metrics relating to these domains.

	Number of targets	Achieved	Failure rate
Safe	29	16	45%
Effective	10	7	30%
Responsive	24	7	71%
Caring	9	4	56%
Well-led	6	3	50%
Total	**78**	**37**	**53%**

It is clear from this that the Trust is not performing well on almost half of the metrics reported. It is particularly bad on the 'Responsive' set, which relates most clearly to the delivery of services to its patients, and on which it fails almost all tests. Failures include waiting time targets, cancer treatment targets, cancelled operations, critical care and A&E targets. All of these impact on how residents experience health care delivered by the Trust.

There are also several issues with the Trust's performance on the 'Safe' domain, failing on almost half of targets set. In particular, the Trust performs badly on infection control issues.

The Trust also reports 6 targets for the resources domain but no target appears to have actually been set and, as reported in the draft report, these are of little use. This may have been addressed in later iterations of the report.

The presentation in the report would benefit from better quantification, and a better explanation for lack of progress, with a more open and honest style. It would have been helpful to have provided with an analysis identifying potential factors for poor progress and responsiveness to complaints.

iii) National Outcomes Framework indicators

These are national data that the Trust is required to publish in this report. Many of the targets have already been reported on in the Trust's own quality outcomes as discussed above (see pp100-104), and so there is little to be added.

iv) Estates Strategy and redevelopment programme

The Committee noted that the Trust had the largest backlog of maintenance, attributed to the age of the estate and the deterioration of buildings such as St Mary's. You explained that you had put aside funds to address the backlog of the most urgent repairs in order to keep buildings safe and that you were in on-going dialogue with government about this.

In light of the recent changes regarding the future of Charing Cross hospital and the recent announcement withdrawing Shaping a Healthier Future, the Committee would have welcomed more details about how the Trust would now tackle this. Charing Cross urgently requires investment in estates and members were keen to know how this could be achieved and what they Council could do to further this agenda. Your response was that you would continue with your strategy to continue to invest in the site, regardless of future plans or policies.

v) Patient Safety

Worryingly, there were 7 never events reported in the period to January 2019 compared with just one in 2017/18, and a target of 0. These include:

1. wrong route medication in May 2018 (emergency medicine at Charing Cross Hospital);
2. retained swab in July 2018 (maternity at Queen Charlotte's and Chelsea Hospital);
3. retained foreign object in September 2018 (cardiac surgery at Hammersmith Hospital);
4. wrong site surgery in October 2018 (urology at Charing Cross Hospital)
5. wrong site block in November 2018 (plastic surgery at Charing Cross Hospital);
6. wrong site block in January 2019 (CT radiology at St Mary's Hospital); and
7. retained swab in January 2019 (maternity at Queen Charlotte's and Chelsea Hospital).

The Trust states that (p64):

Six of the seven were related to invasive procedures and thankfully none caused harm to the patients involved. All of the incidents have been investigated and have action plans in place.

However, while the Committee accepts that action plans were implemented, it was difficult to understand how in the case of any of these incidents, no harm was done to patients. In your response clarifying the meaning of "no harm to patients" you explained that a culture of safety programme was implemented and that you were also concerned about the spike in never events. You accepted this and agreed that it would need to change, going forward. Senior leadership had reviewed this and the Committee were informed that you chaired a committee on patient safety. The focus on education had strengthened a number of areas, for examples, doctors learning about invasive procedures and how to implement these safely.

The committee welcomed the simulation coaching programme, consisting of different stages of learning which included informal discussion, following by simulation of the never event and concluding in a peer review. The Committee felt assured by this comprehensive and innovative approach which placed the patient's story at the heart of the clinicians learning experience.

vi) Workforce Recruitment and Retention (Improvement Priority 3, to improve permanent nurse staffing levels)

In September 2018 the Committee received a report on the issue of workforce recruitment and retention. Staff turnover is a national challenge and vacancy rates were above target, with voluntary turnover rates at 9%. Additional challenges also included how the Trust dealt with poor behaviour and performance. You reported that a premium for recruitment had been introduced, for example, for care of the elderly wards and acute, and that the Trust recruited internationally where necessary. It was understood that recruiting well was key to achieving deliverables and to move forward from the Requires Improvement rating for CQC (Care Quality Commission).

Focusing on people and culture, the Committee acknowledged that the Trust was rightly proud of the commitment and calibre of staff and that the Trust continued to provide safe levels of staffing deploying bank and agency staff. The Committee noted that despite the March 2018 strategy to improve nursing retention and recruitment, the Trust had not managed to achieve its 13% target vacancy rate.

The Committee would have liked to have seen more detail around the measures and new human resources protocols put in place for disciplinary investigations. The Trust has tried to effect significant culture change with regards to engagement with BAME staff and the Committee welcomed the Trusts commitment to engaging with the workforce, for example, through identifying career progression opportunities for BAME staff.

Low levels of staff satisfaction remained cause for concern, particularly around poor behaviour and senior leadership. As a Trust, you had outlined a set of expected behaviours and values which you expected all staff to adhere to. These had been set out in a leaflet and provided to staff. You accepted that it would be helpful to include a metric in the report regarding staff satisfaction (undertaken annually), which the Committee found helpful. The Committee acknowledged that the Trust endeavoured to identify the kind of values that there both collaborative and aspirational and that they had recognised that there was significant work that remained to understand the kind of behaviour that allowed staff to enjoy their work and what might prevent this. The Committee recognised the challenges of this, dependent of the competence of managers and leaders to challenge staff appropriately which took time. Historically, the NHS had focused on clinical expertise rather than administrative and that the Trust was engaged in a long-term programme to address this through coaching and leadership training.

vii) Proposed Changes to Physiotherapy Services – consultation and engagement

The Committee considered proposals that the Trust is currently in the process of consulting upon regarding potential changes to physiotherapy services and how these are delivered. The Committee has responded separately with their views regarding the changes and what this might mean for residents, indicating reservations as to the possible loss of hydrotherapy services.

The Committee expressed concern regarding the way in which the Trust has consulted on the changes and the depth of the research undertaken. The Committee questioned whether there has been sufficient research to establish clinical based evidence as to the benefits of hydrotherapy.

The Committee always values the opportunity to engage with the Trust, particularly where substantive changes to services are being considered, however, it would be helpful to develop a protocol by which the local authority could work more closely and much earlier with the Trust, in those instances where it hopes to engage with residents and stakeholders about the way in which hospital services are provided within our community.

viii) General Comments

The following additional points were highlighted

- The NHS Long-Term plan placed a renewed focus on autism and the treatment of the learning disabled, how poor care could impact on life expectancy. Ensuring that appropriate provision is made for the most vulnerable would ensure greater equity and parity across all groups.
- Management of A&E patients with mental health issues. The proper triage of patients expressing the need to self-harm was paramount in ensuring that those presenting were managed effectively to avoid further deterioration and escalation of their condition. It was not acceptable that mental health patients experienced a different standard of care. The Committee welcomed the fact that the Trust continued to report on this metric.
- Sepsis treatment - The Committee welcomed the Trusts plans to achieve its target of ensuring that 50% of patients received anti-biotics within one hour of and how this could be increased.

ix) Concluding Comments

The Trust is in a difficult position, having been committed to the closure of Charing Cross hospital and pursuing an unrealistic plan for the rebuilding of St Mary's hospital. H&F hope to continue to engage with the leadership of the Trust to establish what the Trust is doing to support the creation of a more acceptable plan for the future of local acute services, and how the Council might contribute to this. The Committee welcomes a closer working relationship that might help alleviate the presentation of unacceptable options.

The Committee understands that seeking massive additional capital resources to rebuild acute hospitals would impose a burden that is not recognised within NHS funding flows and capital funding systems. Too often in these circumstances these costs are met from the local population by restrictions to capacity and access to services provided. In these circumstances, the Committee is clear that it will not support reductions to local capacity and access to services in return for newer buildings, which would be principally at Paddington.

Councillor Lucy Richardson
Chair – Health, Inclusion and Social Care Policy and Accountability Committee Member for Sands End

Response from London Borough of Hounslow Health and Adult's Care Scrutiny Panel

On behalf of the London Borough of Hounslow's Health and Adult Care Scrutiny Panel, I would like to thank you for providing us with your Quality Account 2018/19 for comment. Please find below our response statement for inclusion in the Imperial College Healthcare NHS Trust Quality Account 2018/19 final report.

LONDON BOROUGH OF HOUNSLOW HEALTH AND ADULTS CARE SCRUTINY PANEL RESPONSE

The London Borough of Hounslow Health and Adults Care Scrutiny Panel ('Scrutiny Panel') welcomes the opportunity to provide a response to the Imperial College Healthcare NHS Trust ('the Trust') Quality Account 2018/19 which seeks to report on progress and identify future priorities.

Overall, the Scrutiny Panel welcomes and supports the priorities for 2019/20. These accord with the London Borough of Hounslow Corporate Plan 2019-24. Our Corporate Plan aims towards ensuring 'residents that are healthy, active and socially connected'. This means people enjoy good health, have a sense of belonging, and play a role in their local community.

To make Quality Accounts more meaningful to service users at a local level, it is suggested that large multi-site organisations like Imperial College Healthcare NHS Trust, provide site-specific information on the quality of their healthcare services. Furthermore, it would be helpful if performance data and outcomes are split by the local authority of residence of the patient.

The report is also very detailed. A shorter summary of performance progress would make it more accessible to the public and might enable more feedback. Democratically-elected councils have much to contribute when it comes to the success of the local health economy, a simplified version alongside the detailed report will allow councillors and members of the public to engage more actively with giving feedback on this report.

Detailed comments

Reducing avoidable harm

Any incidents or avoidable deaths are concerning; however, the Panel is pleased to see that the Trust reported fewer numbers of severe and extreme harm incidents and fewer avoidable deaths. It is reassuring to see that the Trust continues to have some of the lowest mortality rates in the country. The reduction in mortality for patients diagnosed with sepsis from 18% to 14%, and the 22% reduction in falls with harm are to be commended.

The Panel is concerned to see that the Trust reported seven 'never' events this year, compared to just one last year. However, it is good that these events are being reported and the Panel is reassured that the Trust has developed actions to reduce the likelihood of similar incidents.

Infection prevention and control

The Panel is pleased to note that the inpatient areas along with some other high-risk areas were re-audited in November 2018, and overall compliance for hand hygiene was 61%. We also commend the Trust on the decrease in the number of infection control SIs, with nine reported this year compared to 16 last year.

It is disappointing to see that the Trust did not meet its targets around infection prevention and control around MRSA BSI, C Difficil, E Coli and CPE. The 60.2% flu vaccination rate for frontline healthcare workers (against a target of 70%) is also worrying.

Emergency flow through the hospital

The Panel is aware that in early 2017 the Trust launched a programme to improve operational performance across the whole urgent care patient pathway to meet the four-hour A&E wait standard. Although, we note the significant work, the four-hour target has not been met in the last three years. The small but incremental improvement are noted, alongside improvements in the reduction in delayed beds and an increase in patients discharged before noon.

The Panel notes the improvements in emergency and referral to treatment (RTT) performance but note with concern that both are below target and off trajectory.

Patients waiting for elective surgery

The Panel was disappointed to see that the Trust did not meet the standard of 92% of patients treated within 18 weeks of referral, although it is encouraging to see a slight improvement since last year (84% compared to 83%).

With regards to cancelled operations, the Panel notes with concern that 18% of patients whose elective operations were not rebooked within 28 days of being cancelled. The target for this was 8%.

It is noted that there are agreed improvement trajectories and several workstreams to drive improvement. It is pleasing to see that you have

significantly reduced the number of patients waiting over 52 weeks for surgery, with 573 reported in 2018/19 compared to 1,854 in 2017/18, and none in March 2019. Additionally, we were pleased to see that there were no cases of confirmed clinical harm for patients waiting over 52 weeks in 2018/19.

Critical care

It is worrying that the Trust has not met the national standard of admissions of critically unwell patients. The standard is that 100% should be admitted within 4 hours. The Trust reached 93%. Delays in admission can be harmful to critically ill patients.

Falls

The Panel is pleased to see that overall, the Trust has seen a 22% reduction in falls with harm (moderate and above) since April 2016.

Estates and facilities improvement

Although the Trust met most of the targets it set itself for estates and facilities improvements, clearly the Trust has one of the poorest estates in the country with a £1.3 billion backlog maintenance liability. The Panel is pleased to learn of the Trust's active work on the estate strategy, but the backlog is a continuing concern.

Safety culture

The Trust's safety culture programme was launched in 2016. The Panel noted that the staff survey showed a small improvement in the percentage of staff feeling able to raise concerns (77% compared to 75% in 2017). We welcome the shift in priorities from promoting a safety culture to improving the behaviours across the Trust related to safety

Staffing levels and training

Although, it is disappointing to read that the Trust did not achieve the target of a 13% general vacancy rate nor the 12% rate for nursing and midwifery, the Panel is aware of the broader issues and is pleased to see that the Trust ensures staffing levels meet planned safety levels.

The Panel is pleased to note that the percentage of staff who have completed all the core skills modules has increased this year and has been above the 90% target since November 2018. The 'HOTT' (Helping Our Teams Transform) programme, involving simulation training, in situ coaching, conversation cafés, and human factors training to improve safety, sounds like an exciting innovation. We look forward to learning about the effectiveness of this programme.

Staff engagement programme

The Panel is pleased to note that 95% of staff responded that they are 'clear about the values and behaviours expected at work' and 92% responded that they 'go the extra mile'. However, as was the case in the last two years, there is concern around staff reporting they do not have enough time to complete all their work and higher response rates on poor behaviour not being addressed effectively. Hence, the Panel welcomes the newly launched 'vision, values and behaviours programme' aimed at developing a better consensus of what the Trust is trying to achieve as an organisation.

Patient experience and responsiveness

The Panel is pleased to learn of the efforts to respond to patient feedback and welcomes the introduction of patient support volunteers as well as the programme of work to improve noise at night and food quality. The reported improvements in the percentage of patients (outpatients, A&E and those who use patient transport) who would recommend the Trust is noteworthy. The Panel also commends the Trust in exceeding its target to respond to complaints within 40 days.

NHS Long Term Plan and Integrated Care

We expect that the NHS Long Term Plan will have an impact on the Trust and we encourage the Trust to participate in the engagement process in North West London. The Scrutiny Panel recommends, in future reports, that there is a clear articulation of approaches the Trust intends to use in addressing challenges and opportunities arising from the Plan.

On behalf of the Scrutiny Panel, I thank the Trust for sharing the Quality Account 2018/19. We hope to continue this positive engagement going forward.

Yours sincerely
Councillor John Chatt

Response from Healthwatch Central West London

We welcome the opportunity to comment on Imperial College Healthcare NHS Trust's (the Trust) 2018-2019 Quality Account (QA) and on the quality of the services delivered locally to meet the health needs of residents.

We appreciate our continued working relationship with the Trust and we give our full support to its efforts to involve patients and Healthwatch representatives in its work.

Strategy and quality improvement plan

We are pleased to see the inclusion of the Trust's key strategies. We suggest that the Trust adds a link with more information on each strategy.

We welcome the development of a new Improving Quality Strategy for 2019-2023 and we suggest that it should also be based on the Patient and Public Involvement Strategy.

We acknowledge the key risk of Estates Maintenance backlog for the Trust. We congratulate the Trust on its active involvement and leadership on many significant research activities.

Quality Priorities 2019/20120

We support the Trust's commitment to continue focusing and further developing the priorities set in 2018/2019. We congratulate the Trust on many excellent quality initiatives and are pleased to see that overall the Trust has made improvements.

We welcome the inclusion of an explanation of how the monitoring of quality works.

Improvement Priority 1: To reduce avoidable harm to patients

We are pleased to see the reduction in mortality from sepsis.

Improvement Priority 2: To improve the safety culture across the Trust

We welcome that the patients receive both a verbal and written apology and explanation for all appropriate incidents in over 90 per cent of the cases.

Improvement Priority 3: To improve nurse staffing levels

We support the Trust's continuous efforts to improve nursing retention and recruitment. We welcome the addition of staff numbers at the "about our Trust" section that enables the reader to understand improvement in nursing numbers.

Improvement Priority 9: Emergency Flow through the Hospital

We are pleased to see that the delivery of the "keeping care flowing collaborative programme has been effective and we support its continuation.

Improvement Priority 11: To Improve access for patients waiting for elective surgery

The Trust should make a commitment to keep in touch with patients who wait a long time for elective surgery (hip or knee replacement) to inform them how long they will have to for their operations, so

they know that they have not been forgotten or fallen off the list.

Quality Domains

We welcome the Trust's approach to link the quality domains with the improvement priorities. We think that the new layout with the metrics as an appendix works well.

We also welcome the emphasis on patients at both the caring and effective domains.

Quality Domain: Caring

We are pleased to see that the Trust has taken initiatives based on patient feedback that had positive results, such as tackling noise at night on the pilot ward at Charing Cross Hospital.

We are positive about the BMJ award initiate on ensuring that qualitative patient feedback is being listened to. We would like reassurance that the overall process is looked by a human being and not just a computer, and that patients can access the dashboard of comments.

Transportation has been identified as a major issue for our members. We welcome the inclusion of the non-emergency patient transport scheme that will commence in June 2019 and we look forward to receiving more information.

Quality Domain: Responsive

We are impressed by the Community Information Exchange which gives patients rapid access to their records. We hope that following the new contract that it will be more widely used, especially by GPs and be more user friendly.

We note that there are still improvements to be made for the implementation of the "Paper Switch Off Project", as we heard from patients that although they liked the idea of booking their own appointments they found it confusing due to the long and complicated passwords required.

We welcome the PLACE results that show an improved position in five of six areas reviewed.

We are supportive of partnership initiatives to make better use of resources and expertise such as the

Prostate RAPID diagnostic pathway in joint working with Royal Marsden Partners.

Quality Domain: Well-laid

We welcome the Trust's efforts to effectively engage with staff and its active participation at the Freedom to Speak up initiative. As part of the Patient and Public Involvement Initiatives, we welcome the Make a Difference award in memory of Michael Morton.

Conclusion

Overall our members welcome the Trust's quality improvement measures. We look forward to

continuing to work with Imperial College Healthcare NHS Trust in improving the care and support of patients and service users.

Healthwatch Central West London
info@healthwatchcentralwestlondon.org
Date: 3rd June 2019

Response from Harrow Council's Health and Social Care Scrutiny Sub-Committee meeting held on 12 June 2019

I confirm that the draft report on the Imperial College Healthcare NHS Trust – Quality Account 2018/19 was circulated to Members of Harrow Council's Health and Social Care Scrutiny Sub-Committee; it was reviewed by Members of the Sub-Committee at the meeting held on 12 June 2019 to their satisfaction.

A representative from the Trust attended the Sub-Committee meeting to present the final draft Quality Account. Members of the Sub-Committee asked questions of the representative which were responded to. The Sub-Committee noted the report.

Response from Brent community and Wellbeing Scrutiny Committee

The scrutiny committee welcomes the opportunity to respond to the Trust's Quality Account for 2018/19 and highlight any particular issues it considers to be relevant. We would like to thank all the staff at Imperial College Healthcare Trust for the care they have provided to many people in the London Borough of Brent, but in particular to those at St Mary's Hospital, which is used by residents living in the south of Brent. Overall, we can understand from the Quality Account where the Trust is doing well and where improvements in service quality have been achieved and what are required for next year as well as what the priorities are for quality standards next year.

Improvement Priorities

The Quality Account states that there has been a reduction in the number of incidents causing the most harm to patients, and there were fewer avoidable deaths. However, there were seven 'never events', compared with one last year. It is welcome that as part of the priorities for improvement an action plan was put in place around never events and that the appropriate learning is developed, and that it will continue to be a priority with nine safety streams.

The Quality Account is clear that culture is key to improving patient safety. It is welcome that there is an acknowledgement that an organisation's safety culture can be understood by its willingness to report incidents affecting patient safety, and to learn from them in order to improve care. And furthermore that a high reporting rate reflects a positive reporting culture. It can be assumed that the increase in the numbers of incidents reported in 2018/19 to 16,913 is in part because there is a positive culture and that staff are ready to be open and transparent when things go wrong as well as reflect and learn from what happened.

Workforce is an issue across the NHS and it is right that the importance of safe levels of staffing and improving on the number of nurses on permanent contracts are priorities. However, the Quality Account notes that the Trust has not achieved a target of 13 per cent, reporting an average vacancy rate for nursing and midwifery staff of 15.56 per cent in 2018/19. It is concerning that there are shifts which are not being filled although the difficulties with retaining and recruiting permanent nurses is a problem across the NHS. At the same time, it is good that there is a focus on staff skills and training and that there is a commitment to have at least 90 per cent of staff with the core skills.

The Quality Account has a detailed discussion around hand hygiene as an improvement priority. It acknowledges that independent audits and feedback from inspections have raised concerns about consistency of compliance with hand hygiene measures. It is welcome that there is a campaign across the Trust to improve hand hygiene and a small number of wards have been identified for focused improvement, and that an event to coincide with World hand Hygiene Day has been planned.

Residents' Priorities

Nonetheless it will remain a priority for residents and the public that while staying in hospital the environment is safe and hygienic. We think that PLACE (Patient Led Assessments of the Care Environment) are an important insight into patients' experiences and an important way of involving service users in improvements to services. However, in the 2018/2019 Quality Account there is insufficient detail about the most recent scores other than that they were above or below average. Furthermore, there is no breakdown of the PLACE score by the five hospital sites which are part of the Trust. While we acknowledge that action plans have been put in place to help lead to improvements, more details about the PLACE scores would have helped the committee to better understand what patients' experiences were like from their time in a hospital.

Infections while in hospital are a matter of concern for many people and patients. It would be good to see in following year's Quality Account what changes have been effected by the measures discussed in the 2018/19 Quality Account around sepsis, such as new sepsis nurses and a roll out of sepsis monitoring, and how it is being identified and treated quickly.

Finance

While finance falls outside the scope of a Quality Account, it is generally understood that there are significant financial pressures on many NHS acute Trusts. The Quality Account notes that there is a significant backlog of maintenance (£1.3billion) at the Trust. However, perhaps it should be considered in more detail about the implications for building and estate work on safety or clinical effectiveness of poor buildings as well as the implications for patients' experiences of using services at the Trust.

Winter pressures

Winter pressures are a major test of safety and clinical effectiveness in hospitals and remain a wider concern for patients, and are an important healthcare issue, which again may fall outside the scope of a Quality Account, but should be noted. The committee is grateful that earlier this year, Dr Frances Bowen and Clare Hook from the Trust attended a scrutiny committee meeting along with other local NHS acute Trusts to update us about winter pressures. It is noted that the Quality Account acknowledges that the flu vaccination rate in 2018/19 for front-line staff hardly improved, and did not meet the national target rate of 70 per cent. It would be helpful to understand how the Trust intends to reach that target next year.

Care Quality Commission

Finally, there was a CQC inspection in February 2019, for Critical care at St Mary's and Charing Cross and Hammersmith hospitals, and services for children and young people at St Mary's and Hammersmith. As the full reports will not be published until the summer of 2019, we look forward to seeing the outcome of the report discussed in next year's Quality Account.

Cllr Ketan Sheth, Chair
Brent Community and Wellbeing Scrutiny Committee

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF IMPERIAL COLLEGE HEALTHCARE NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the NHS Improvement to perform an independent assurance engagement in respect of Imperial College Healthcare NHS Trust's Quality Account for the year ended 31 March 2019 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

This report, including the conclusion, is made solely to the Board of Directors of Imperial College Healthcare NHS Trust in accordance with the relevant legislation. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Imperial College Healthcare NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following indicators:

- Percentage of admitted patients risk assessed for VTE (venous thromboembolism); and
- Percentage of patient safety incidents resulting in severe harm or death.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account 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 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- 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; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014/15 ("the Guidance") issued by the Department of Health; and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Trust board minutes and papers for the period April 2018 to May 2019;
- Papers relating to Quality reported to the Trust board over the period April 2018 to May 2019;
- 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 2019;
- The annual governance statement;
- The national inpatient survey 2018;
- The national staff survey 2018;
- The General Medical Council's National Training Survey 2018;
- Mortality rates provided by external agencies (NHS Digital and Dr Foster).

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively "the documents"). Our responsibilities do not extend to any other information.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

The indicators tested represent "point-in-time" measurements, and therefore may be subject to validation changes following completion of our limited assurance procedures.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Deloitte LLP
St Albans, UK
27 June 2019

Appendix A: Participation in National Clinical Audit

National Clinical Audit and Clinical Outcome Review	Host Organization	Eligible	Participated	% submitted
Adult Cardiac Surgery	National Institute for Cardiovascular Outcomes Research	✓	✓	Ongoing collection
Adult Community Acquired Pneumonia	British Thoracic Society	✓	✓	Ongoing collection
BAUS Urology Audit – Cystectomy	British Association of Urological Surgeons	✓	✗	Did not participate
BAUS Urology Audit – Female Stress Incontinence (SUI)	British Association of Urological Surgeons	✓	✗	Did not participate
BAUS Urology Audit – Nephrectomy	British Association of Urological Surgeons	✓	✗	Did not participate
BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL)	British Association of Urological Surgeons	✓	✗	Did not participate
BAUS Urology Audit – Radical Prostatectomy	British Association of Urological Surgeons	✓	✗	Did not participate
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research	✓	✓	N/A
Case Mix Programme	Intensive Care National Audit and Research Centre	✓	✓	Ongoing collection
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	✓	✓	100%
Elective Surgery (National PROMs Programme)	NHS Digital	✓	✓	100%
Falls and Fragility Fractures Audit Programme (FFFAP) – Fracture Liaison Service Database	Royal College of Physicians London	✓	✓	Ongoing collection
Feverish Children (care in emergency departments)	Royal College of Emergency Medicine	✓	✓	N/A
Inflammatory Bowel Disease Programme / IBD Registry	Inflammatory Bowel Disease Registry	✓	✗	Did not participate
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol's Norah Fry Centre for Disability Studies	✓	✓	N/A
Major Trauma Audit	The Trauma Audit and Research Network	✓	✓	96.9%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Public Health England	✓	✓	Ongoing collection
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRACE-UK, National Perinatal Epidemiology Unit, University of Oxford	✓	✓	N/A
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	✓	✓	N/A
Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Homicide be People with Mental Illness	✗	N/A	N/A
Myocardial Ischaemia National Audit Project (MIN/AP)	National Institute for Cardiovascular Outcomes Research	✓	✓	Ongoing collection
National Asthma and COPD Audit Programme	TBC	✓	✓	N/A
National Audit of Anxiety and Depression	Royal College of Psychiatrists	✗	N/A	N/A
National Audit of Breast Cancer in Older People	Royal College of Surgeons	✓	✓	N/A
National Audit of Cardiac Rehabilitation	University of York	✓	✓	589 patients
National Audit of Care at the End of Life (N/ACEL)	NHS Benchmarking Network	✓	✓	Ongoing collection
National Audit of Dementia	Royal College of Psychiatrists	✓	✓	100%
National Audit of Intermediate Care	NHS Benchmarking Network	✗	N/A	N/A
National Audit of Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research	✓	✓	Ongoing collection
National Audit of Pulmonary Hypertension	NHS Digital	✓	✓	Ongoing collection
National Audit of Seizures and Epilepsies in Children and Young People	Royal College of Paediatrics and Child Health	✓	✓	N/A
National Bariatric Surgery (NBSR)	British Obesity and Metabolic Surgery Society	✓	✓	N/A
National Bowel Cancer Audit (NBOCA)	NHS Digital	✓	✓	95%
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre	✓	✓	100%
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	British Society for Rheumatology	✓	✓	100%
National Clinical Audit of Psychosis	Royal College of Psychiatrists	✗	N/A	N/A
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	King's College London/London North West Healthcare NHS Trust	✓	✓	N/A
National Comparative Audit of Blood Transfusion programme	NHS Blood and Transplant	✓	✓	100%
National Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research	✗	N/A	N/A
National Diabetes Audits – Adults	NHS Digital	✓	✓	Ongoing collection
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	✓	✓	91.6% CXH 100% SMH
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research	✓	✓	Ongoing collection
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership	✓	✓	Ongoing collection
National Lung Cancer Audit (NLCA)	Royal College of Physicians	✓	✓	Ongoing collection
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists	✓	✓	100%
National Mortality Case Record Review Programme	Royal College of Physicians	✓	✓	100%

National Clinical Audit and Clinical Outcome Review	Host Organization	Eligible	Participated	% submitted
National Neonatal Audit Programme (NN/AP)	Royal College of Paediatrics and Child Health	✓	✓	Ongoing collection
National Oesophago-gastric Cancer (N/AOGC)	NHS Digital	✓	✓	100%
National Ophthalmology Audit	Royal College of Ophthalmologists	✓	✓	98.1%
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	✓	✓	Ongoing collection
National Prostate Cancer Audit	Royal College of Surgeons of England	✓	✓	N/A
National Vascular Registry	Royal College of Surgeons of England	✓	✓	100%
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	✓	✓	Ongoing collection
Non-Invasive Ventilation - Adults	British Thoracic Society	✓	✓	Ongoing collection
Paediatric Intensive Care (PICANet)	University of Leeds	✓	✓	100%
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists's Centre for Quality Improvement	✗	N/A	N/A
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Public Health England	✓	✓	Ongoing collection
Sentinel Stroke National Audit Programme (SSN/AP)	Royal College of Physicians	✓	✓	98.6%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Serious Hazards of Transfusion	✓	✓	N/A
Seven Day Hospital Services	NHS England	✓	✓	N/A
Surgical Site Infection Surveillance Service	Public Health England	✓	✓	N/A
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	✗	N/A	N/A
Vital Signs in Adults (Care in emergency departments)	Royal College of Emergency Medicine	✓	✓	N/A
VTE risk in lower limb immobilization (care in emergency departments)	Royal College of Emergency Medicine	✓	✓	N/A

Appendix B: Actions in response to national clinical audits

As described on page 30, we fully reviewed the reports of twenty six national clinical audits and confidential enquires in 2018/19. 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 Diabetes Insulin Pump Audit (NDIPA)

This audit collects data on the number and characteristics of people with diabetes using an insulin pump, the reason for going on an insulin pump and the outcomes achieved since starting the pump. It has been a challenge to identify the total number of people with Type I diabetes at the Trust, but work is underway to better capture this data from the electronic patient record. An insulin pump MDT and training for patients has been established and Trust clinicians participate in the pan-London network.

National Audit of Dementia (NAD)

The Trust performs better than the national average for delirium screening on admission, clinical assessment of delirium and the symptoms of delirium being summarised in patient the record. The Trust aims to further improve, through the use of 4AT rapid clinical test for dementia for all patients aged over 65 (or those with known dementia) within 24 hours of admission and introduce education for all staff on the early features; the implementation of both will be monitored through local audit processes prior to the next national audit.

Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme

The Trust has reasonable assurance that transfusion training is in place. How to fully implement electronic blood management systems and the transfusion-associated circulatory overload (TACO) checklist into the electronic patient record is currently being scoped by the transfusion leads in collaboration with the Trust informatics team.

Critical Care Case Mix Programme

Across all units, standardised mortality rates were good. Highlights on the St Mary's site included low rates of unit acquired infection on the Charing Cross site non-clinical transfers and on the Hammersmith site low rates of unit acquired infection and blood stream infection, delayed discharge, out-of-hours discharge and readmission.

On the St Mary's and Charing Cross sites, areas for improvement mainly reflect capacity issues (delayed discharge and length of stay) which are being addressed through improvement work directed at improving flow on both sites. On the Hammersmith site, areas for improvement related to the number of high risk admissions and cardiac arrest pre-admission, which may reflect the specialisms and case mix on the Hammersmith site.

These will continue to be monitored through quarterly data submission to the Intensive Care National Audit and Research Centre.

National Emergency Laparotomy Audit (NELA)

The National Emergency Laparotomy Audit aims to look at measures for the quality of care received by patients undergoing emergency laparotomy. The Trust assessed itself against the ten key findings; with substantial assurance against five key findings, reasonable assurance in two (consultant surgeon in theatre where risk of death ≥ 5 per cent and admitted to critical care post-operatively where risk of death is > 10 per cent). Specific issues for the Trust where there is limited assurance relate to prospective data collection, reporting of CT scans and documentation of mortality risk pre-operatively and specialist review of elderly patients; improvement action plans have been agreed and will be monitored through local audit processes prior to the next national audit.

MBRRACE–UK Perinatal Confidential Enquiry

The MBRRACE-UK study showed that our perinatal mortality rate for 2016 births was 10 per cent higher than the average. The department reviewed each case and none were deemed to be avoidable. The Trust has implemented the 'stillbirth bundle' which is a national toolkit aimed at reducing still birth in the UK. Our patient demographic was felt to more complex although the study says that the figures are 'risk adjusted'.

National Paediatric Diabetes Audit

This audit assesses compliance with important areas of diabetes services in childhood. The Trust performed better than the national average in terms of overall health check completion rate, treatment regimen, offering structured education and diabetes related hospital admission. In terms of outcomes of care the Trust is in the top 5 per cent local and the top 15 per cent nationally.

Elective Surgery National PROMs Programme

Adjusted for average health gain for the Oxford hip score is above the national average, whilst the knee score has been identified as below the national average. This has been reviewed by the service, with a move towards an improved knee clinic model where patients with high preoperative scores are offered options that do not involve surgery where there is low expected gain from operative treatment. This will be monitored through further quarterly audits.

Appendix C: 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 audit group and to Executive Quality Committee 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 quality improvement involvement. These audits include:

- Patient falls
- Medicines safety and medicines management
- Safer surgery and the WHO safer surgery checklist
- The deteriorating patient: (NEWS and MEWS scoring)
- Hand hygiene
- Positive patient identification
- Never events

Some of the findings from these audits include:

- Improved compliance year-on-year with the WHO safer surgery checklists.
- An increase in hand hygiene compliance in wards receiving focused improvement support.
- A reduction in the number of falls with harm in wards receiving focused improvement support.
- A mean hospital wide reduction of patient identification errors to 25 per month in 2017 and 2018 compared to 30 per month in 2015 and 2016, and a 50 per cent year-on-year reduction in 'wrong blood in tube incidents' (at the time of auditing).

Local Clinical Audits

Over 2018/19 there were 313 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.

A selection of these audits where specific learning or improvement has been identified can be found in the table below.

Audit Description	Findings	Actions identified
The trauma and orthopaedic team looked at the incidence of post-operative hyponatraemia in surgical patients undergoing elective knee or hip replacements. They investigated whether delays in discharge were incurred as a result	The study concluded that local practice is good and ensures patient safety, and that patients are not discharged with excessively sub-physiological serum sodium levels whilst also protecting patients from extended hospital admission. It was found that delayed discharges as a direct result of post-operative hyponatraemia were virtually zero.	Improvements identified. No action required.
The general surgery team audited compliance of emergency operational notes against RCS guidelines to ensure better information keeping, information sharing and better clinical practice and patient care.	This audit showed good compliance in most areas audited with the exception of blood loss and deep vein thrombosis (DVT) prophylaxis.	The team are currently developing a template on our electronic patient record with mandatory fields to ensure records contain accurate information.
The general surgical team carried out a re-audit, evaluating adherence to NICE guidelines for the use of venous thromboembolism (VTE) prophylaxis	The study found that there was good adherence to best practice guidelines.	A VTE prophylaxis poster was developed and circulated to new medical members of staff to ensure continued compliance, and that clear decision making is continued when prescribing/withholding VTE prophylaxis
A re-audit was completed by the trauma and orthopaedic team for clinical coding for spine injections.	This audit demonstrated that there has been a six-fold improvement in comorbidity documentation from 10 per cent in the previous audit to 63 per cent with resultant best practice tariff recovery.	Improvements identified. No action required.
The cardiology team audited providing fitness to drive advice following acute coronary syndrome. It looked at the adequacy of advice provided on the electronic discharge summary including whether the patient was informed of whether they could drive after leaving hospital, whether there was medico-legal proof documented and whether this information was communicated to the patient's GP.	It was found that there was low risk/satisfactory assurance for this documentation but the recommended 100 per cent was not achieved.	In response a local quality improvement project has been set up to increase compliance to 100 per cent, making junior doctors/advanced nurse practitioners aware of the documentation requirements.
The gynaecology and reproductive medicine team carried out a retrospective evaluation of pre-operative Computed Tomography (CT) findings with surgical and histological tumour dissemination patterns at cytoreduction for primary advanced and relapsed epithelial ovarian cancer.	The study showed that the pre-operative CT imaging, while being highly specific had a low sensitivity in detecting tumour involvement at key sites in ovarian cancer surgery	As a result of this study there is now a well-designed multicentre prospective trial currently underway to further evaluate different imaging modalities in the prediction and assessment of disease extent in patients with ovarian cancer.

Appendix D: CQUIN performance 2018/19

NHSE 2018-19 CQUIN schemes	Description of scheme	Full year plan value	Achieved % (Q1-Q3)
BI1 HCV Improving Treatment Pathways through ODNs	The Trust is an HCV ODN lead provider and as such this was a mandatory CQUIN. It recognises the Trust as a system leader in Hepatitis C and supports the governance and partnership-working across the North West London providers. The CQUIN requires prioritisation of patients with highest clinical need and supports the sustainability of treatment. The outcomes anticipated are: • Improvement in the engagement of patients • The planned roll-out, aligned to NICE guidance, of new clinical and cost effective treatments • Improved participation in clinical trials • Enhanced data collection to demonstrate the effectiveness and equity of this way of working and the availability of new treatments	£4.29M	Q1 – 100% Q2 – 100% Q3 – 100%
GE3 Hospital Medicines Optimisation	This CQUIN has been designed to support Trusts and commissioners to realise agreed targets and metrics to unify hospital pharmacy transformation programme (HPTP) plans and commissioning intentions to determine national best practice. It 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 • Significantly improved drugs data quality • The consistent application of lowest cost dispensing channels • Compliance with policy/ consensus guidelines to reduce variation and waste.	£1.07M	Q1 – 100% Q2 – 100% Q3 – 100%
IM4 Complex Device Optimisation	Clinical decision making around device selection varies between implanting units and may impact on clinical outcomes as well as inflating the overall cost. This scheme seeks to ensure that device selection for patients remains consistent with the commissioning policy, service specification, and relevant NICE guidance and that contractual requirement are in place for providers while new national procurement and supply chain arrangements are embedded. The outcomes anticipated are: • Enhancement and maintenance of local governance systems to ensure compliance with national policies and specifications; • Development of sub-regional network policies to encourage best practice when determining device choice including minimum standards for patient consent to ensure optimal device selection. • To improve timely access to all patients who need referral for consideration of complex device implantation. • To ensure that referral pathways and robust MDT decision making processes are developed for complex and clinically unusual cases, revisions and lead extractions.	£230,000	Q1 – 83% Q2 – 100% Q3 – 100%
CA2 Nationally Standardised does Banding Adult Intravenous SACT	This CQUIN is to incentivise the standardisation of doses of SACT in all chemotherapy units providing intravenous treatments across the country. The outcomes anticipated are: • Have the principles of dose banding accepted by their local oncology and haematology teams. • Have the drugs and doses approved by their 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	£210,000	Q1 – 100% Q2 – 100% Q3 – 100%
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. Options to be considered include: • Issuing all parents with accurate scales / feeding charts for "hospital at home" • Daily Skype / face time support • online educational and other materials to support • Weekly drop in clinics for parents • The option to develop wider packages of support e.g. psychology, dietetics etc. to be bolted on to the drop in sessions.	£290,000	Q1 – 100% Q2 – 100% Q3 – 100%
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. The output from this will be used to inform future plans for beds and models of care. The outcomes anticipated are: • work with local acute hospitals to collate data over a six month period August to December 2017 • provide a summary report by February 2018 • oversee the review of each of their referring acute hospitals in their usual catchment against the Paediatric Intensive Care (PICS) standards	£210,000	Q1 – 100% Q2 – 100% Q3 – 100%
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 within hub and satellite units • To support the management of renal patients across the whole renal pathway by supporting primary care and providing rapid assessment and diagnosis so that patients with CKD can be managed effectively in the community. • To increase home dialysis uptake • Increase rate of haemodialysis with AV Fistulas in line with patient choice • To improve rates of pre-emptive transplantation as a therapy of choice for those suitable with chronic kidney failure	£780,00	Q1 – 95% Q2 – 95% Q3 – 85%

NHSE 2018-19 CQUIN schemes	Description of scheme	Full year plan value	Achieved % (Q1-Q3)
Heamoglobinopathies Network	The prevalence of haemoglobinopathies across England varies widely, with the majority of patients concentrated around urban areas, as does the expertise to manage these conditions. The diseases mainly affect black and minority ethnic populations which often have poorer health outcomes. Despite this, there is not yet a comprehensive, approved network linking lead / specialist haemoglobinopathy centres with non-specialist centres to provide a clear pathway for appropriate referral and care. This CQUIN incentivises removal of the remaining barriers to achieving an appropriate network of care by enabling lead / specialist centres to provide MDT led annual review of all patients and the associated communications, clinical support, staff training and data entry to demonstrate the clinical outcome benefits of such a model.	£210,000	Q1 – 100% Q2 – 100% Q3 – 100%

CCG 2018-19 CQUIN Schemes	Description of scheme	Full year plan value	Achieved % (Q1-Q3)
Improving staff health and wellbeing	This CQUIN scheme aims to encourage the improvement of health and wellbeing of NHS staff with a focus on reducing workplace stress, providing healthier food options for NHS staff, visitors and patients and to improve the uptake of flu vaccinations for frontline clinical staff. In 2017/18, we were the most improved trust for vaccination take-up rates, with 60.5 per cent of our frontline healthcare workers vaccinated against flu. In 2018/19, our vaccination rate was similar to last year's. By the end of 2018 we had removed price promotions and advertising of all sugary drinks and food high in fat, salt and sugar, as well as removing them from checkouts. For more information on the work we are doing to promote staff health and wellbeing see page 69.	£1.01M	Q1 – 100% Q2 – 100% Q3 – 100%
Improving services for people with mental health needs who present to A&E	This CQUIN scheme aims to reduce the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable. The frequent attender service runs at CXH. The team consists of an A&E doctor, a specialty trainee psychiatry doctor, an A&E consultant, and a liaison psychiatry consultant. A social prescriber joined the team in December 2017. The team has developed a person-centred approach to holistically address the complex needs of those who are disproportionately accessing A&E. The service has reported marked success in reducing the A&E attendances of their initial 13 patients selected to participate, supporting them to access the services they need for long-term support. A write-up of the service was included on the BMA website in January 2019.	£1.01M	Q1 – 100% Q2 – 100% Q3 – 100%
Reducing the impact of serious infections (antimicrobial resistance and sepsis)	This CQUIN scheme aims to reduce the impact of serious infections by focussing on the timely identification of sepsis in A&E and acute inpatient settings, the treatment of sepsis in A&E and acute inpatient settings, the assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours, and the reduction in antibiotic consumption per 1,000 admissions. For information on the progress we have made, please see page 55.	£1.01M	Q1 – 100% Q2 – 100% Q3 – 100%

CCG 2018-19 CQUIN Schemes	Description of scheme	Full year plan value	Achieved % (Q1-Q3)
Advice and guidance	This CQUIN scheme aims to standardise and streamline the advice and guidance we provide for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. 21 departments within our Trust currently offer an advice and guidance service. The current process is that the doctor on call will respond to as many queries as they are able to on their shift. We are performing regular audits as we start working towards a 48 hour response target.	£1.01M	Q1 – 100% Q2 – 100% Q3 – 100%
Preventing risky behaviours	This CQUIN scheme aims to incentivise non-specialist interventions for which there is sound evidence of effectiveness in reducing ill health and thereby the burden on health services, when delivered at scale. The interventions are brief, and include components such as: short screening questions, brief or very brief advice on the benefits of drinking less or stopping smoking, and where appropriate referral to specialist services. Specialists from local service providers at Change, Grow Live and Kick-it have presented short talks on a range of topics relevant to smoking and alcohol addiction and risky behaviour including: • Supporting people with alcohol dependency • Introduction to Smoking Cessation course in accordance with the NCSCT guidance We have trained 10 staff to deliver a 'very basic assessment' (VBA) for patients who have been flagged as being a smoker or consumes alcohol and will be scheduling regular VBA clinics for inpatients.	£1.01M	Q1 – 100% Q2 – 100% Q3 – 100%

Appendix E: Safe metrics

Area	Description	National Target / National Average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved?
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	0.25% (Oct 17 – Mar 18)	0.08% (14 incidents)	Below national average	0.04% (6 incidents)	Yes
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	0.10% (Oct 17 – Mar 18)	0.08% (13 incidents)	Below national average	0.03% (5 incidents)	Yes
Patient safety – incidents and reporting	We will maintain our incident reporting numbers and be within the top quartile of trusts	42.44 (Apr – Sep 18)	48.97 (Apr 17 – Mar 18)	Over 48.98 (Apr – Sep 18)	50.4 (Apr 18 – Sep 18 – NRLS published data) 47.25 (Apr 18 – March 19 internal data)	No
Patient safety – incidents and reporting	We will have zero never events	0 never events	1 never event	0 never events	7 never events	No
Patient safety – incidents and reporting	We will ensure that we comply with duty of candour and being open requirements for every incident graded moderate and above	N/A	SIs: 98% Level 1: 89% Moderate: 79% (Apr 17-Feb18)	100%	SIs: 90.9% Level 1: 93.7% Moderate: 97.5% (Mar 18 – Feb 19)	No
Infection prevention and control	We will ensure we have no avoidable MRSA BSIs and cases of C. difficile attributed to lapse in care	N/A	10 (3 MRSA BSI, 7 *C.difficile* lapses in care)	0 avoidable infections	14 (3 MRSA BSI, 11 *C. difficile* lapses in care)	No
Infection prevention and control	We will achieve a 10% reduction in healthcare-associated BSIs caused by E. coli	N/A	74	10% reduction (65)	83	No
Infection prevention and control	We will have no healthcare-associated BSIs caused by CPE	N/A	6	0	7	No
Infection prevention and control	We will ensure our cleanliness audit scores meet or exceed the required standards	N/A	Not reported	98% (very high risk patient areas) 95% (high risk patient areas)	86.8% (very high risk patient areas) 91.6% (high risk patient areas)	No
Infection prevention and control	We will meet flu vaccination targets for frontline healthcare workers as part of the national seasonal flu campaign	N/A	60.5%	70%	60.2%	No
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	over 95%	Q1: 92.71% Q2: 91.63% Q3: 95.53% Q4: 95.64% 93.87% (full year data) 0 avoidable deaths	over 95%	Q1: 96% Q2: 96.37% Q3: 95.23% Q4: 93.97% 95.42% (Apr 18 – Mar 19)	No
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	N/A	Not reported	50%	70.64%	Yes
Maternity standards	We will maintain the ratio of births to midwifery staff at 1 to 30	1:30	1:30	1:30	1:27	Yes
Maternity standards	We will maintain postpartum infections (puerperal sepsis) to within 1.5 per cent or less of all maternities	1.5%	0.42%	1.5%	0.64%	Yes
Workforce and people	We will have a general vacancy rate of 10 per cent or less	N/A	12.12%	10% or less	13.5%	No
Workforce and people	We will have a vacancy rate for all nursing and midwifery staff of 12 per cent or less	N/A	14.7%	12% or less	15.56%	No
Safe staffing	We will maintain the percentage of shifts meeting planned safe staffing levels at 90% for registered nurses	90%	97.02%	90%	96.67%	Yes
Safe staffing	We will maintain the percentage of shifts meeting planned safe staffing levels at 85% for care staff	85%	97.70%	85%	95.66%	Yes
Estates and facilities	We will improve medical devices maintenance compliance according to risk categorisation	N/A	76% high risk; 70% medium risk; 64% low risk	98% high risk; 75% medium risk; 50% low risk	96% high risk; 82% medium risk; 82% low risk	Partly
Estates and facilities	We will ensure lifts are kept in service to minimise disruption and inconvenience	N/A	Not reported	90% availability	97.11%	Yes
Estates and facilities	We will improve the number of reactive maintenance tasks completed within the allocated timeframe	N/A	Not reported	70%	37.38%	No
Estates and facilities	We will ensure that planned maintenance tasks are completed within the allocated timeframe	N/A	Not reported	70%	78.68%	Yes
Estates and facilities	We will ensure compliance with statutory and mandatory estates requirements	N/A	Not reported	85%	99.9%	Yes

Area	Description	National Target / National Average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved?
Staff training	We will achieve compliance of 85% with core skills training	N/A	87.44%	85%	92.1%	Yes
Staff training	We will achieve compliance of 85% with core clinical skills training	N/A	74.80%	85%	87.8%	Yes
Staff training	We will ensure that 90% of eligible staff are compliant with level 3 safeguarding children training	N/A	Not reported	90%	91.12%	Yes
Health and safety	We will ensure we have no reportable serious accidents, occupational diseases and specified dangerous occurrences	0	51	0	55	No
Health and safety	We will have a departmental safety coordinator in 75% of clinical wards, clinical departments and corporate departments	N/A	49%	75%	82%	Yes
Health and safety	We will ensure at least 10% of our staff are trained as fire wardens	N/A	9%	10%	13%	Yes

Appendix F: Effective metrics

Area	Description	National Target / National Average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved?
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	100	67.37 (Jan – Dec 17) 2nd lowest risk	Top five lowest-risk acute trusts	64.0 (Jan – Dec 18) Lowest risk acute trust	Yes
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	100	74.29 (Q2 16/17 – Q1 17/18) 2nd lowest risk	Top five lowest-risk acute trusts	73.21 (Q3 17/18 to Q2 2018/19) 4th lowest risk	Yes
Mortality indicators	We will ensure that palliative care is accurately coded	N/A	100% (for all reviewed deaths)	100%	100% (for all reviewed deaths)	Yes
Mortality indicators	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.	N/A	91%	100% of relevant cases	90%	No
Readmissions	We will reduce the unplanned readmission rates for patients aged 0-15 and be below the national average	9.39% (Oct 17 – Sep 18)	4.92% (Oct 16 – Sep 17)	Better than national average for 2018/19	4.88% (Oct 17 – Sep 18)	Yes
Readmissions	We will reduce the unplanned readmission rates for patients aged 16 and over and be below the national average	8.49% (Oct 17 – Sep 18)	6.92% (Oct 16 – Sep 17)	Better than national average for 2018/19	6.75% (Oct 17 – Sep 18)	Yes
Clinical trials	We will ensure that 90% of clinical trials recruit their first patient within 70 days		55.7% (Q1 – Q4 17/18)	90%	85.1% (Q1 18/19) 95.7% (Q2 18/19) 93.9% (Q3 18/19) 91.6% (Q1-Q3 18/19)	Yes
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	N/A	Not reported	100%	84% (participation in relevant national clinical audits 2 high risk/significant risk audits Review process completed within 90 days for 19/27 audits	No
Patient reported outcomes	We will increase PROMs participation rates to 80%	Not available	Hip replacement: 87.6% Knee replacement: 90.5% (April 2017 – March 2018)	80%	Hip replacement: 67% Knee replacement: 80% (April 2018 – September 2018)	Partially
Patient reported outcomes	We will improve PROMs reported health gain to be better than national average	Not available	Hip replacement – better than national average for 3/3 indexes Knee replacement – better than national average for 1/3 indexes, similar to national average for 1/3 indexes and below national average for 1/3 indexes	Better than national average	Health gain not able to be calculated (April 2018 – September 2018)	No

Appendix G: Caring metrics

Area	Description	National Target / National Average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved?
Friends and family test	To maintain the percentage of inpatients who would recommend our trust to friends and family to 94 per cent	96%	97.20%	94%	97.42%	Yes
Friends and family test	To maintain the percentage of A&E patients who would recommend our trust to friends and family to 94 per cent	86.8%	94.39%	94%	94.26%	Yes
Friends and family test	We will achieve and maintain a FFT response rate of 20 per cent in A&E	12.36%	14.19%	20%	13.63%	No
Friends and family test	To maintain the percentage of maternity patients who would recommend our trust to friends and family to 94% or above	N/A	93.83%	94%	93.81%	No
Friends and family test	To increase the percentage of outpatients who would recommend our trust to friends and family to 94 per cent	93.9%	91.06%	94%	92.98%	No
Friends and family test	To maintain the percentage of patients using our patient transport service who would recommend our trust to friends and family	92.18%	82%	90%	91.20%	Yes
Mixed sex accommodation	We will have zero mixed-sex accommodation (EMSA) breaches	0	295	0	554	No
National cancer survey	We will improve our national cancer survey scores year-on-year	8.8/10	8.5/10 (annual result from 2016 survey)	Above 8.5	8.7 (annual result from 2017 survey)	Yes
National inpatient survey	We will improve our score in the national inpatient survey relating to responsiveness to patients' needs	Not available	6.72 (annual result from 2016 survey)	Above 6.72	6.88 (annual result from 2017 survey) Overall rating of care: 8.2/10	Yes

Appendix H: Responsive metrics

Area	Description	National Target / National Average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved?
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%	83.34%	92%	84.12%	No
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	1,854	0	573 (0 in March 2019)	No
Cancer	We will maintain the percentage of cancer patients who are treated within 62 days from urgent GP referral at 85% or more	85%	86.07%	85%	83.51%	No
Theatre management	We will increase theatre touchtime utilisation to 95% in line with trajectories	95%	N/A	95%	79.43%	No
Cancelled operations	We will reduce cancelled operations as a percentage of total elective activity	1%	1%	0.9%	0.89%	Yes
Cancelled operations	We will ensure patients whose elective operations are cancelled are rebooked to within 28 days of their cancelled operation	8%	12.77%	Less than 8% not rebooked within 28 days	18.46% not rebooked within 28 days	No
Critical care admissions	We will ensure 100% of critical care patients are admitted within 4 hours	100%	Not reported	100%	92.74%	No
Accident and Emergency	We will admit, transfer or discharge patients attending A&E within 4 hours of their arrival in line with trajectories	95%	87.11%	95%	88.13%	No
Accident and Emergency	We will reduce the number of A&E patients spending >12 hours from decision to admit to admission to zero	0	60	0	68	No
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		7+ days: 37.45% 21+ days: 10.74%	A reduction of 50% from baseline (for 21 days)	7+ days: 57.33% 21+ days: 25.23%	No
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	3.05%	Not reported	3.5% of beds	2.70%	Yes
Bed management	We will discharge at least 33% of our patients on relevant pathways before noon	N/A	10.22%	33%	14.32%	No
Diagnostics	We will maintain performance of less than 1% of patients waiting over 6 weeks for a diagnostic test	1%	3.66%	1%	0.80%	Yes
Outpatient management	We will maintain the average waiting times for first outpatient appointment at 8 weeks or below	8 weeks	8 weeks	8 weeks or below	7 weeks	Yes

Area	Description	National Target / National Average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved?
Outpatient management	We will reduce the proportion of patients who do not attend outpatient appointments to 10%	10%	11.68%	10%	10.69%	No
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	N/A	8.01%	7.50%	7.93%	No
Outpatient management	We will ensure 95% of outpatient appointments are made within 5 working days of receipt of referral	95%	84.12%	95%	94.87%	Yes
Complaints management	We will maintain numbers of PALS concerns at less than 250 per month	N/A	226	Less than 250 per month	241	Yes
Complaints management	We will maintain the numbers of formal complaints at less than 90 per month	N/A	81	Less than 90 per month	85	Yes
Complaints management	We will ensure that we respond to complaints within an average of 40 days	N/A	Not reported	40 days	30	Yes
Patient transport	We will improve pick up times for patients using our non-emergency patient transport service	N/A	Collection within 60 minutes: 92.11% Collection within 150 minutes: 99.11%	Collection within 60 minutes: 97% Collection within 150 minutes: 100%	Collection within 60 minutes: 93.51% Collection within 150 minutes: 99.29%	No
Patient transport	We will improve drop off times for patients using our non-emergency patient transport service	N/A	0-5 miles: 92.28% 5-10 miles: 77.15%	No longer than 60 minutes 0-5 miles: 95% 5-10 miles: 85%	0-5 miles: 92.25% 5-10 miles: 76.47%	No
Data quality	We will improve data quality by reducing diagnostic and surgical orders waiting to be processed on our system in line with trajectories	N/A	1,498 (Dec-March only)	286	1,271	No
Data quality	We will improve data quality by reducing outpatient appointments not checked-in or out on our system in line with trajectories	N/A	Not checked in: 1,716 Not checked out: 1,208	Not checked in: 769 Not checked out: 707	Not checked in: 2,361 Not checked out: 2,524	No

Appendix I: Well-led metrics

Area	Description	National Target / National Average	Performance in 17/18	Target for 18/19	Outcome in 18/19	Target achieved?
Workforce and people	We will have a voluntary staff turnover rate of 12% or less	N/A	9.82%	12%	11.51%	Yes
Workforce and people	We will have a general staff retention rate of 80% or more	N/A	Not reported	80%	85.46%	Yes
Workforce and people	We will maintain our sickness absence rate at below 3%	N/A	2.90%	3%	3.07%	No
Workforce and people	We will achieve a performance development review rate of 95%	N/A	88.54%	95%	89.57%	No
Workforce and people	We will achieve a non-training grade doctor appraisal rate of 95%	N/A	84.53%	95%	93.76%	No
Workforce and people	We will have a consultant job planning completion rate of 95% or more	N/A	Not reported	95%	99.5%	Yes
NHSI segmentation	We will maintain or improve NHSI provider segmentation	N/A	Not reported	N/A	3	N/A

Glossary

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

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.

Cost improvement programme (CIP) – programmes designed to reduce costs while improving patient care, patient satisfaction and safety.

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 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.

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.

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.

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.

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.

NEWS2 – the latest version of the National Early Warning Score which following an assessment enables staff to calculate a standardised score enabling them to more effectively respond to acute illness.

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 and 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.

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.

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.

Quality schedule – 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. These are set out in the Quality Schedule. Our commissioners (local and NHS England) monitor our performance with these indicators throughout the year through the Clinical Quality Group.

Referral to treatment (RTT) – consultant-led Referral To Treatment (RTT) waiting times, which monitor the length of time from referral through to elective treatment.

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.

RIDDOR – this stands for the Reporting of Injuries, Diseases and Dangerous Occurences Regulations 2013. Under RIDDOR, employers, self-employed people and anyone who's in control of a business' premises are legally required to report specified workplace incidents. There are seven different categories of RIDDOR, and these are: deaths, specified injuries, over seven day injuries, injuries to people not at work, some wok-related diseases, dangerous occurrences and gas incidents.

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.

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.

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.

Summary hospital-level 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.

Standard operating procedure (SOP) – a set of written step-by-step instructions compiled by an organisation that describe how to perform a routine activity.

Stakeholder – a person, group, organisation, member or system who affects or can be affected by an organisation's actions.

Statistical process control (SPC) – a method of quality control which employs statistical methods to monitor and control a process.

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.

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.

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