Imperial College Healthcare NHS
NHS Trust

Quality Strategy

Creating a culture of continuous improvement
to increase and sustain the quality of our services
for our patients, people and stakeholders

Contents

Foreword from the medical director

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In 2013, we launched our first Quality Strategy, which outlined our aim to put quality at the forefront of everything we do. In this, the second Quality Strategy for the Trust, we build on the progress made so far in our journey and bring our plans in line with the Care Quality Commission (CQC) framework, as well as working to ensure sustainable and continuous improvement across our services.

Through this strategy, we want to achieve a rating of 'good' in our next CQC inspection, while striving for 'outstanding' where we can be across our sites and services by the end of 2017/18.

These are undeniably challenging times for healthcare, with NHS services under increased pressure due to our ageing population. However, with these challenges, we have an exciting opportunity when it comes to improving healthcare quality. We hope our commitment to improvement and our determination to get things right for our patients, people and stakeholders is clear in this strategy.

Events at Mid-Staffordshire have helped to generate a sector-wide commitment to quality, with quality improvement now seen as everybody's business. As we gain more understanding of the different ways we can improve, we are in a better position than ever before to look critically at what we can do better, and test and apply improvements. We are working to harness these opportunities in order to provide safe, high quality, patient-centred care for all our patients. This is our commitment as an organisation – but we also want it to become a personal commitment for each of our people, from surgeon to receptionist.

To achieve this, we are rolling out a programme of quality improvement training and support to build an organisation-wide culture of continuous improvement. At the same time, patients have a stronger voice than ever before, and we have begun working more closely with the people and communities we serve to make sure that the care they receive is centred on their needs.

Our current position 2015

We have seen some inspiring work across our five hospital sites since we launched our first strategy, particularly in the last year. We have made significant improvements in patient experience and our mortality rates are among the lowest nationally, reflecting the excellent clinical outcomes achieved for many of our patients. We have focused on developing our culture with promising signs of improvement already showing through.

However, in some ways, 2014/15 has been a challenging year for us as a Trust. Like many hospitals, we saw unprecedented demand on our A&E departments over winter, which put increased pressure on all our services. We have challenges around our elective pathways which mean that patients are waiting longer than we would like to receive the care they are expecting. Our Trust was also inspected in September 2014 by the CQC, who gave us an overall rating of 'requires improvement' in their final report. Although a number of services were rated as 'good' the standards observed were not consistent nor of the quality the Trust aspires to deliver. We have a comprehensive action plan in place however we recognise we have much to do to achieve our ambitions.

> **We will use this quality strategy to strengthen confidence and pride in the services we provide.**

A focus on quality

This strategy shows our commitment to a continued focus on quality. We will use it to strengthen confidence and pride in the services we provide. We want patients to be confident that the Trust is among the best in the world – safe, effective, caring, well led, and responsive to our patients' needs. We want people working within and alongside the Trust to know that they are providing the best service they can, and that what they do is important and valued.

This three year strategy is the plan by which we will continue our journey to achieve our ambitions and a positive outcome in subsequent CQC inspections as continuous quality improvement becomes our business as usual.

Introduction to our Quality Strategy 2015/18

This is the second quality strategy for the Trust, bringing our plans in line with the CQC framework 2014. The purpose of the strategy is to set out the goals and targets for ICHT in providing high-quality services over the next three years and, therefore, delivering our vision and objectives.

The Trust's vision

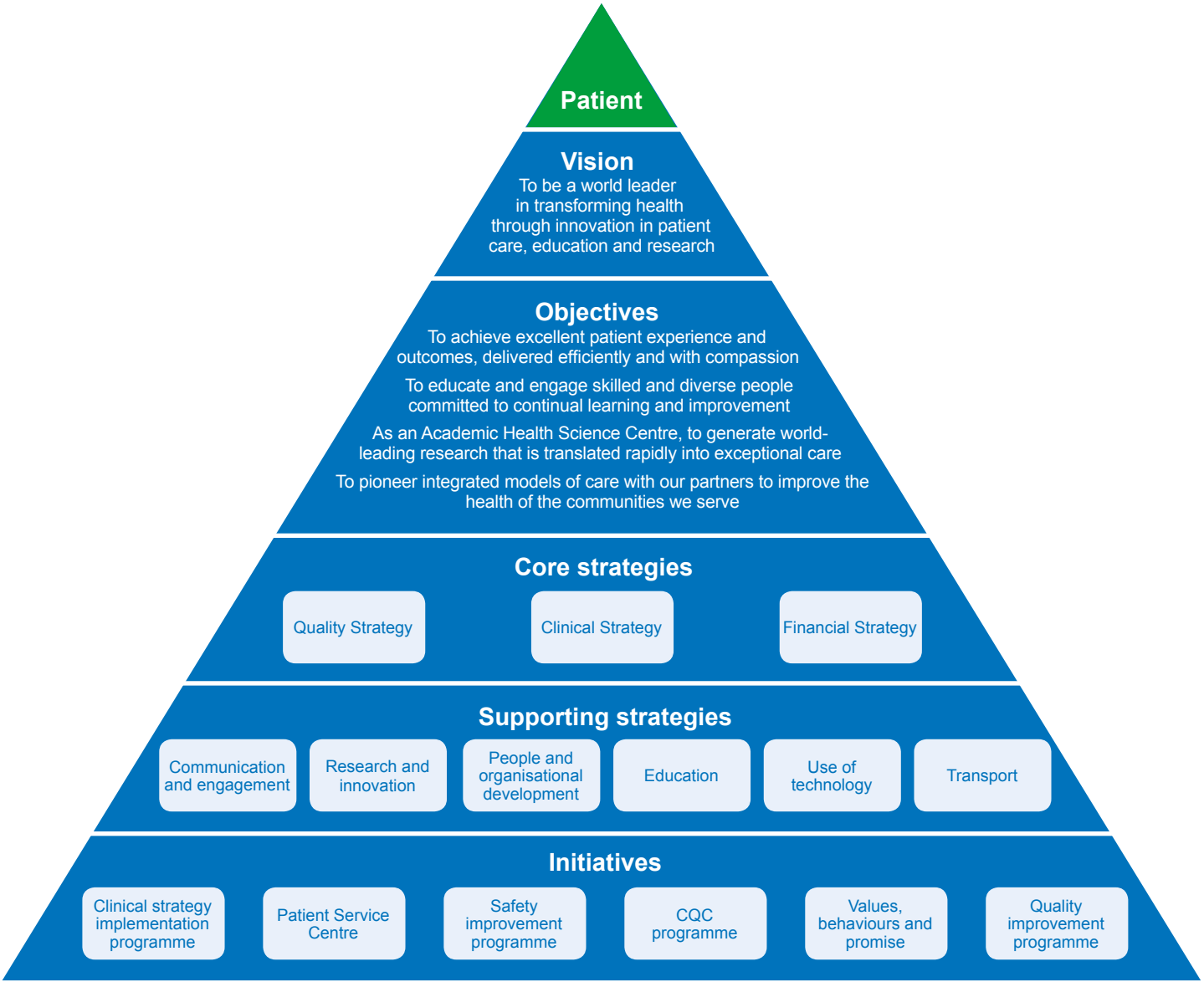
The Trust's vision is to be a world leader in transforming health through innovation in patient care, education and research.

This vision will be delivered through the achievement of the Trust's strategic objectives, which are:

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

These objectives have quality embedded in them. This shows the commitment and reality that quality drives all that we do.

Diagram 1 below shows how improvement, and therefore this strategy, supports delivery of our vision and objectives. It sets out a number of the key enablers and examples of the projects required to improve performance to illustrate the breadth of our work programme. We have the patient central to our improvement planning and our priorities are aligned to achievement of our vision through annual goals and targets.



What is the Quality Strategy?

Our Quality Strategy is the plan through which we focus on the quality of clinical care and ensure that we continuously improve our services. It ensures that quality drives the overall direction of our work and that the patient is at the centre of all that we do.

What is the Quality Strategy?

This strategy sets out our definition of quality, and describes our vision and direction, ensuring that quality is our number one priority. It sets out our five quality goals and associated targets and a number of projects which we must focus on to ensure we can evidence that our services are safe, effective, caring, well led and responsive. It also describes the governance arrangements to ensure delivery and sustainability over three years from 2015/16. The strategy also outlines our current position, showing improvements we have made over the lifespan of our original Quality Strategy and what we are building on for the second.

It is ambitious, setting out our commitment to make quality central to all that we do. It also reinforces that wherever possible, our focus will be on embracing new ways of working to improve care for patients and their families and integrating healthcare across community services and social care.

It provides a modern approach to continuous improvement and acknowledges that our people are central to delivering our potential as the hospital in which we would want our loved ones cared for.

We will use the implementation of the Quality Strategy to strengthen confidence and pride in the services we provide. We want patients to be confident that the Trust is among the best in the world.

We want people working in and with the Trust to be confident that they are providing the best service they can, are valued and are important. We recognise the importance of building a culture where quality and its continual improvement is our priority and we are committed to doing so.

We want a shared pride in the Trust and assurance that it is the very best it can be.

How we developed the strategy

The strategy has been informed by the reports and recommendations from Francis, Keogh, Berwick and the CQC framework. We also assessed our progress against priorities in our last strategy and quality account.

Comparison was also undertaken of trends and variation from a range of intelligence including:

- Patient surveys
- Staff surveys
- Governance data, e.g. incidents, complaints, claims and audit

This was then merged with feedback from key stakeholders, including our patients, members of the public, our people and our commissioners, through development workshops held in 2014/2015 to form our goals and targets.

The engagement events highlighted that we should be more transparent with our performance data and make it as simple as possible and easily accessible. We have therefore been careful to develop goals and targets that are measurable whilst trying to encapsulate our commitment to the qualitative elements of our work. This will provide clarity for our patients and external stakeholders, and ensure that our people have tangible, measurable and reportable goals to aim for. These targets will be redefined each year throughout the three years of the strategy. They will be described in our annual quality account, with progress monitored through the Trust's governance system (appendix 1). We believe that if we can meet our targets under each quality domain, we will see significantly improved outcomes for our patients and a better working environment for our people. Our goals and targets have been selected to have the highest impact across the Trust and are purposely challenging.

We recognise in particular that we need to improve many of our processes and systems to ensure better outcomes and experience for our patients. A series of Trust-wide improvement projects, informed by our CQC inspection action plan and a review of the key lines of enquiry that the CQC use, have been established to deliver specific time bound programmes of work.

We therefore believe the strategy is relevant to our people and stakeholders and reflects the areas we should be prioritising.

What is our definition of quality?

We have based our definition of quality on the **CQC's 2014 framework**, which draws on the Francis, Keogh and Berwick reviews and recommendations, and incorporates public consultation.

Our approach aligns Berwick's six improvement principles which were used in our first strategy to the five domains that patients have defined as important during the CQC consultation to construct their new framework. Quality at the Trust is therefore defined by whether services are safe, effective, caring, responsive and well led.

The combination of performance in each of the five domains determines the overall quality of the healthcare we provide. We believe that we can improve services only by supporting continuous improvement in all areas hence our commitment to this driver.

The first year of our three-year strategy is focused on making immediate quality improvements and ensuring that we achieve a rating of 'good' in our next CQC inspection, while striving for 'outstanding'.

The quality domains

The quality domains are outlined below, together with the descriptor of what these mean. The domains match those used by the CQC to ensure we are focused on making improvements which are aligned with our regulatory body's expectations.

Safe

People are protected from abuse and avoidable harm

Effective

People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Caring

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 assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture

Delivering the Strategy

How will the strategy be delivered and progress reported?

Quality goals and targets

The strategy will be delivered through the achievement of our quality goals, which are supported by specific annual targets. These are outlined below under each quality domain and have been chosen to ensure that we focus on making improvements where they are most needed, and on sustaining improvements that have already been achieved. We believe that if we can meet our goals and targets in these priority areas, we will see significantly improved outcomes for our patients and a better working environment for our staff. The goals and targets under each domain will be incorporated into the performance scorecards, ensuring they can be tracked from ward to board. This will provide clarity on the Trust's priorities and will show the impact of the improvements we have made.

Key initiatives

Alongside the quality goals and targets, we have developed measurable and structured improvement projects (appendix 2). These projects have been informed by analysis of a number of measures of our performance including:

- current performance against national and local targets
- our quality account
- areas of known risk
- our CQC inspection action plan
- review of the key lines of enquiry that the CQC publish.

The projects span all quality domains and have an executive lead responsible for their delivery. Each project has been assessed for their potential to positively impact on the goals and targets we have set. This analysis is included in appendix 3 and we are confident that we have the necessary work in progress to deliver the required improvements.

Progress with these improvement projects will be reported on a quarterly basis though the Trust's governance structure (appendix 1). This will allow us to measure and monitor the milestones, outcomes and timeframes of the projects, with clear lines of accountability and responsibility to the project owners.

Executive oversight of quality of care in the Trust is through the Executive Quality Committee, which will report quarterly progress and exception to the Quality Committee.

Trust board reporting will occur on a bi-annual basis. Our annual Quality Account will report on progress against the three-year strategy and confirm the targets for the following year.

Quality improvement – building capability to deliver the strategy

We recognise that our people are key to delivering the strategy. We therefore must make sure that we are training and supporting our people to make improvements continuously as well as carrying out their roles. We want to implement new ways of working to improve our processes, systems and services with transparent measurement to track progress.

We have therefore decided to adopt a standardised approach to quality improvement to make this possible. This is designed to encourage and support our people by providing them with the tools they need to make sustained improvements. We believe this will be one of the long term drivers to delivery of the strategy. We want this to stimulate energy for learning and development in improvement methodology and ensure that change becomes the way of doing things at the Trust.

Recognising the importance of organisational culture on the successful implementation of the quality improvement (QI) programmes, the Trust's QI programme will be grown out of the 'values and behaviours' project established at the beginning of 2015. This project has to date engaged with approximately 1,500 staff from across the organisation. Throughout the process, all staff groups have been clear that for the values and behaviours project needs to be grounded in action which will be realised via the QI programme. Key to this is the development of a culture of sharing ideas and learning, celebrating success and the developing new perspectives.

The approach is made up of two elements: a values-based quality improvement

training programme, which will provide blended training for our people, and a new team called the 'Imperial Quality Improvement (iQI) Hub' to support improvement delivery and potential.

The new team will offer a wide range of skills, including leadership, stakeholder and staff engagement, clinical and nursing, training, research, education, clinical audit, project management, data analytical and administrative support. They will specifically be responsible for providing training and education in QI methodology and tools, supporting and guiding teams undertaking QI projects and monitoring and reporting QI activities. The hub will involve patients, carers and members of the public as well as our people.

The values based QI programme will provide staff with the necessary skills and tools to enable and empower them to lead QI projects in their own work areas via a comprehensive education and training programme. The focus is to build capacity in people who can act as QI enablers across our workforce. There are

Our people are key to delivering the strategy. We must support our people to make continuous improvements.

three arms to the training and education delivered by the QI programme:

- 'Reaching out' – the QI programme is being launched jointly with the new Trust values and behaviours, and all of our staff will receive an introduction to both. This will be achieved through a variety of methods and 60 per cent of people will be trained by 31 December 2015 and 100 per cent by 31 March 2016.
- Targeted training will be delivered to teams responsible for priority workstreams and teams who nominate a QI project. This will be delivered over two days and will include training in QI tools using a 'live' project to support learning.
- An ongoing development programme offering a range of QI training will be accessible to all staff.

We have identified a series of priority workstreams from the new Quality Strategy, the Clinical Strategy Implementation Programme (CSIP) and the CQC action plan.

As well as these defined workstreams, we will identify individual QI projects through in-depth reviews of clinical services, theme reviews, self-referral by staff and executive referrals.

All quality initiatives or projects will demonstrate how they will support delivery of the strategy before being initiated. This will increase our improvement potential by having a co-ordinated approach to delivery of our goals and targets.

Our goals and targets

Our goals are set out below under each of the five quality domains. The targets which support delivery of these goals have been developed for year one of the strategy. Each year, we will review our progress and redefine our targets to ensure we are focused on the areas where improvement is most needed. These targets will be defined in our annual quality account.

Quality domain 1

Safe

People are protected from abuse and avoidable harm

Goal: To eliminate avoidable harm to patients in our care as shown through a reduction in number of incidents causing severe and extreme harm. We believe harm is preventable not inevitable.

Research conducted by NHS England suggests that around 10 per cent of patients will experience an adverse event while in hospital, half of which are considered avoidable. We want to ensure our patients are as safe as possible while under our care and that they are protected from avoidable harm. Our goal will be to be below the national average for the number of incidents causing severe and extreme harm in year one and continue to reduce the number throughout the three years of the strategy. Throughout year one of our Quality Strategy, we will be focusing on achieving sustainable improvements in the target areas outlined below; these targets aim to reduce avoidable harm in specific priority areas and set the trajectory to ensure that we can achieve our goal of eliminating avoidable harm by the end of year three.

Target 1

We will have sufficient staff in place to deliver safe care to all our patients, as shown through the vacancy rate for staff groups and the percentage of shifts meeting planned safe staffing levels.

We believe our staff, patients and the public need to feel assured that our wards and outpatient areas are adequately staffed to provide the safest possible care. This includes clinical, administrative, management and nursing staff. Our aim is to have a vacancy rate of less than five per cent for band 2-6 ward roles and less than 10 per cent generally, and to maintain the percentage of shifts meeting planned safe staffing levels at 90 per cent for registered nurses and 85 per cent for care staff.

This was one of the key themes from our engagement events for both staff and patients. It is also one of the **Berwick recommendations**.

By ensuring we have enough staff in place, we will be able to better protect our patients from avoidable harm and abuse.

5%

The maximum vacancy rate we are aiming for in band 2-6 ward roles.

Target 2

We will demonstrate the development of a safety reporting culture by increasing our incident reporting numbers and therefore remaining within the top quartile of trusts

We chose this target to enable us to demonstrate that we are willing to report adverse events, learn from them and deliver improved care as a result. A high reporting rate with below average levels of harm will show that staff feel supported to report incidents and that we take action to prevent future harm for patients. Our overall goal to eliminate avoidable harm shows our commitment to improving patient outcomes.

Target 3

We will have zero 'never events'.

'Never events' are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Target 4

We will ensure we have no avoidable infections

'Avoidable infections' measures the number of Trust-attributable MRSA blood stream infections and cases of clostridium difficile attributed to lapse of care. We chose this target as we want to ensure that our patients are safe from infection in our hospitals. At present, we are not meeting all our infection control targets, so we have chosen this as a 'stretch' target, to make sure we are doing everything we can to reduce the risk of patients picking up an infection during their stay with us.

0

The number of avoidable infections – zero – we are aiming for in the first year of our strategy.

Target 5

We will ensure we maintain a compliance rate of 90 per cent for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams.

Anti-infectives (drugs that are capable of acting against infection) include antibacterials, antifungals and antivirals. These agents are often referred to collectively as antibiotics. They are extremely important and are potentially life-saving therapies. However, if they are used inappropriately and excessively, drug-resistant organisms can emerge, putting patients at an increased risk of developing a more resistant strain of an infection. We will aim to maintain a compliance rate of 90 per cent for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams in 2015/16.

Target 6

We will reduce avoidable category Trust-acquired pressure ulcers by at least 10 per cent in year one.

We have made some achievements in reducing the number of pressure ulcers over the last year, however with 33 graded 3 or 4 during 2014/15 we have more we would like to do. For 2015/16, we have chosen to focus on reducing category 3 or 4 pressure ulcers by 10 per cent.

Target 7

We will assess at least 95 per cent of all patients for risk of venous thromboembolism (VTE) and prevent avoidable death as a consequence of VTE.

Venous thromboembolism incorporates both deep-vein thrombosis and its possible consequence: pulmonary embolism. A deep-vein thrombosis is a blood clot that develops in the deep veins of the leg. If the blood clot becomes mobile in the blood stream, it can travel to the lungs and cause a blockage (pulmonary embolism) that could lead to death. This target is important because the risk of hospital-acquired venous thromboembolism can be greatly reduced by risk-assessing patients and prescribing them appropriate measures that prevent it from occurring.

Target 8

We will promote safer surgery by ensuring 100 per cent compliance with the elements of the World Health Organisation checklist in of all relevant areas.

The World Health Organization Surgical Safety Checklist was introduced in 2008 to increase the safety of patients undergoing surgery. As part of our drive to promote safer surgery, we will be auditing the use of the checklist in all relevant areas in the Trust to ensure that our surgical teams are using the checklist correctly and that the 'five steps to safer surgery' are embedded in practice. The five steps are:

1. **Team brief:** At start of theatre session
2. **Sign in:** Before anaesthesia
3. **Time out:** Before skin incision
4. **Sign out:** Before patient leaves theatre
5. **Team debrief:** At the end of the theatre session.

The use of the checklist was highlighted as an area of concern in the CQC report, and this was another reason that we chose this target.

Target 9

We will stop non-clinical transfers of patients out-of-hours.

Transferring patients at night when it is not clinically necessary can cause unnecessary distress and, in some cases, harm to patients – particularly among older people. Patients attending our engagement events raised this as one of their concerns. As part of our drive to eradicate avoidable harm we will set up a process to enable us to monitor and report out-of-hours transfers, which will give us the tools to analyse the cause, review cases for clinical harm and put a stop to all transfers at night which are not deemed clinically necessary.

Quality domain 2

Effective

People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Goal: To be in the top quartile for all national clinical audit outcomes.

Clinical audit is a key improvement tool through which we continually monitor and improve the quality of care that we provide. By fully taking part in national clinical audit programmes, we are able to benchmark our performance against our peers, ensure the care we provide is evidence-based and measure improvements on a year-by-year basis.

We aim to be in the top quartile for outcomes for all those national clinical audits in which we are eligible to participate and where data is analysed this way. This enables us to have evidence that each of our services is effective and promotes a good quality of life for our patients. Further assurance of this will be provided by the chosen indicators below, which will demonstrate low morality rates, improved outcomes for patients in key areas (cardiac arrest, surgical procedures) and an improved and safer discharge process.

Target 1

We will improve our mortality rates, as measured by the Standard Hospital Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR), to be the lowest-risk NHS organisation and improve our position annually in comparison to the Dr Foster Global Comparators data set to be in the top third.

HSMR and SHMI are two indicators that enable us to compare our mortality rates with our peers. We currently have the second lowest SHMI and HSMR for non-specialist acute providers in the country according to the latest available data. However, we aspire to have the lowest rates during this strategy. We will also monitor the percentage of admitted deaths with palliative care coded, with the aim of being below the national average.

Dr Foster's Global Comparators Programme compares the HSMR of 39 hospitals from Australia, Belgium, Denmark, England, Finland, Holland, Norway and the USA. We have not previously measured our performance against our international peers; this year, we will start to compare ourselves to the members of the Global Comparators Programme with the target of being within the top third.

Target 2

We will reduce the number of out-of-ICU/ED cardiac arrests calls.

Although our mortality rates are excellent, incidences of cardiac arrest calls to patients outside of our intensive care units or emergency departments are higher than we would want them to be, with 286 occurring last year. We want to work to reduce this number and introduce a root cause analysis process to support this improvement programme.

Target 3

We will increase Patient Reported Outcome Measures (PROMs) participation rates to 80 per cent and have reported health gains that are better than the national average.

PROMs measure quality from the patient perspective and seek to calculate the health gain experienced by patients following one of these four clinical procedures: groin hernia surgery, varicose vein surgery, hip replacement surgery and knee replacement surgery. We have not met the national targets for these measures and have much to do to improve our performance.

Target 4

We will ensure mortality reviews are carried out using a standardised format whenever a patient dies in our care. We will also ensure that the review outcome is presented at a multidisciplinary team meeting.

Reviewing every death that occurs in our hospitals will enable us to learn from any errors and pick up quickly on potential issues which could result in harm to other patients. Currently, this does not happen uniformly across the Trust, and the results are not reported in a standardised format.

In year one, we will focus on implementing the processes to ensure that all cases are reviewed at multidisciplinary team meetings, and results are reported through our governance process. In year three, we will aim to demonstrate 100 per cent compliance across the organisation.

Target 5

We will discharge at least 35 per cent of patients on relevant pathways before noon.

We have chosen this target to enable us to provide more effective care for our patients, by optimising capacity in our hospitals. By discharging patients earlier where clinically appropriate, we are in a better position to place elective and emergency patients appropriately in the right ward, in the right bed and at the right time.

This target also improves clinical outcomes for elective surgery patients, as they do not have an extended stay in theatre recovery or on a ward while waiting for a bed to become available.

Timely discharge is important for good patient experience and discharge has been a key theme from our engagement events, and has been identified as a priority by members of the public and our staff.

35%

Minimum target for percentage of patients on relevant pathways discharged before noon.

Target 6

We will consistently meet the national target for recruiting the first patient into clinical trials within 70 days and sustain year on year improvements.

As the UK's first Academic Health Science Centre (AHSC), we are committed to encouraging innovation in everything that we do. Part of this involves carrying out pioneering research into novel diagnostic methods and treatments across a broad spectrum of specialities and for some of the most complex illnesses, with benefits for patients everywhere.

Since 2012, the National Institute of Health Research (NIHR) has published outcomes against public benchmarks, including a target of 70 days or less from the time a provider of NHS services receives a valid research application to the time when that provider recruits the first patient for that study.

As part of our focus to provide safe, effective and innovative care for our patients, we have chosen to focus on delivery of the NIHR's key 70 day metric. This will allow us to measure our performance against our peers and provide assurance that we are giving as many of our patients as possible the opportunity to participate in potentially ground-breaking and life-saving research.

Throughout 2014-15, we have improved our performance from 57.1 per cent in Q1 to 83.3 per cent in Q4. However, we want to see this improvement sustained, with year-on-year improvements. To facilitate this, we will set up a centralised monitoring process for research and agree Trust-wide targets.

Quality domain 3

Caring

Staff involve and treat people with compassion, kindness, dignity and respect

Goal: To provide our patients with the best possible experience by increasing the percentage of inpatients who would recommend our Trust to friends and family if the needed similar care or treatment to 95 per cent, and the percentage of A&E patients to 85 per cent.

We know that treating our patients with compassion, kindness, dignity and respect has a positive effect on recovery and clinical outcomes. To improve their experience in our hospitals, we need to listen to our patients, their families and carers, and respond to their feedback. The Friends and Family Test (FFT) is one key indicator of patient satisfaction. This test asks patients whether they would be happy to recommend our Trust to friends and family if they needed similar treatment.

We will aim to improve our position, with our goal being that 95 per cent of our inpatients and 85 per cent of our A&E patients would recommend our Trust. This will help to assure us that the services we provide are caring, putting the individual at the centre of their own care, and treating them as we would like our own friends and family to be treated. The indicators outlined below will support this goal and help us determine whether our services are caring and patient centred in all aspects.

Target 1

We will improve our score in the national inpatient survey relating to responsiveness to patients' personal needs (amalgamation of five questions from national survey).

Responsiveness to inpatients' personal needs is a composite score taken from five questions in the national inpatient survey. The score is a driver to ensure that people have a positive experience of care by focusing on hospitals' ability to meet the personal needs of their patients. We have chosen this target because we believe it is a helpful way to measure how we are improving the experience of our inpatients, while allowing us to compare our performance with that of our peers.

Target 2

We will achieve and maintain a FFT response rate of 40 per cent for inpatients and 20 per cent for outpatients.

In order to attain a more complete picture of our inpatient and A&E experience, and make improvements in response where necessary, we will focus on increasing the response rate to the FFT question in our inpatient and A&E departments to 40 per cent and 20 per cent respectively.

40%

Response rate target for the Friends and Family Test in our inpatient departments.

Target 3

We will improve our national cancer survey scores year on year.

We will continue to make improvements to the care that our cancer patients receive, and will use the survey scores to show how our developments are affecting patient experience. We will aim to increase our scores year on year.

Target 4

We will increase our responsiveness to complaints and reduce their overall number.

Complaints were high on the national agenda in 2014/15, with the Ombudsman, Healthwatch and the Patients Association all highlighting the value of each complaint as an opportunity to learn and support continuous improvement.

We have been reviewing the way we work to look at how we can create a more responsive and caring complaints service for our patients and identify learning for our staff.

During 2014/15, we investigated 1242 complaints, 63.8 per cent of which were responded to within the timescale agreed by the patient (nominally 25 working days). With the improvements we are making as part of the quality strategy in all aspects of our services, we hope to reduce the overall number of complaints we receive, as this will be an important demonstration of quality improvement, while responding to 100 per cent within the timeframe agreed by the patient.

Target 5

We will develop a dataset that enables monitoring of protected characteristics against patient experience measures.

We are in the process of changing our systems for collecting patient experience feedback. The new system will enable us to capture feedback from a more diverse patient population through the introduction of new surveys that can be completed by more of our patients.
We will have surveys available in:

- the top ten languages used by our patients
- makaton symbols
- yellow and black for patients with visual impairment
- age-appropriate graphics for children and young people.

We have reviewed the demographic data that we will collect to ensure it matches the information we collect for all our patients. This will enable the Trust to directly compare how different groups respond and to identify any specific concerns that may impact on one group more than another.

Quality domain 4

Responsive

Services are organised so that they meet people's needs

Goal: To consistently meet all relevant national access standards through responsive patient pathways in year one, and exceed them by year three.

Having responsive services that are organised to meet people's needs is a key factor in improving patient experience and in preventing delays to treatment, which can cause harm to our patients. Our engagement events have shown that our patients agree. They would like to see improvements in our performance against national access targets, as we do not consistently meet them. The feedback was particularly focused on our outpatients offering.

Our ultimate aim is to exceed the national targets by 2017, when our Quality Strategy will be updated. To do this, we will continue to review our processes to ensure they are as efficient as possible, while keeping the needs of our patients central.

As well as the national targets above, we will focus on the following targets to improve our responsiveness as a Trust.

Target 1

We will reduce the unplanned readmission rate for both under and over 15s and be below the national average.

We are carrying this target over to monitor the work we are doing to reduce readmissions, particularly for over 15s as we are currently above the average. This is a good measure of the effectiveness of care we provide; as if a patient is discharged appropriately he or she should not require unplanned readmission.

Target 2

We will have no inpatients waiting over 52 weeks for elective surgery and ensure a clinical validation process is in place for each patient who waits for over 18 weeks.

We have chosen this target to ensure that effective processes are in place when we do not meet our 18-week referral to treatment targets for all our patients. This is an issue highlighted in the CQC report, as we had a backlog of patients still awaiting surgery. We are working to improve surgical pathways and will consistently monitor the clinical impact of any future delays.

0

Target number of inpatients – zero – awaiting elective surgery for more than 52 weeks.

Target 3

We will reduce the number of hospital-initiated cancellation of outpatient appointments.

Improving our processes and the experience of our outpatients was a key theme both of the CQC inspection and at our engagement events. We will develop a process to improve our performance and set targets to ensure that our patients are not inconvenienced or harmed by cancelled appointments.

Target 4

We will improve outpatient letter turnaround time.

As above, throughout 2015/16 we will be focusing on improving our processes in outpatients, and therefore the experience and outcomes of our patients. We will aim to improve the turnaround time for outpatient letters.

Target 5

We will reduce the proportion of clinics that are delayed due to late arrival of doctors.

We have chosen this target in response to the CQC inspection; on the day of the inspection, the team found that several clinics they observed did not have all doctors present before the planned clinic start time. We want to prevent this happening in future.

Target 6

We will improve the number of outpatient consultations that occur with the original set of medical records available.

Following Cerner implementation, we have had an ongoing issue with original medical records being available at outpatient consultations. We have been auditing this during the year with temporary notes and clinic letters being used where required. It is important that full clinical records are available in outpatient areas and our focus will be on ensuring this.

Target 7

We will improve our National Patient Led Assessment of the Care Environment (PLACE) to be in the top 25 per cent nationally where possible.

PLACE was introduced in 2013 as an annual patient-led initiative that monitors and scores the patient environment under the following headings:

- Cleanliness
- Privacy, Dignity and Well Being
- Food and Hydration
- Condition Appearance and Maintenance

All patients should be cared for with compassion and dignity in a clean, safe environment. PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced. The Trust's environment was a key issue raised by patients during our engagement process, and was also picked up by the CQC as an area of concern during their inspection.

We will focus on improving our PLACE scores annually, with the goal of being in the top 25 per cent nationally for the first three PLACE headings. The condition, appearance and maintenance of our estates are dictated by the age of our buildings and the future plans which are in place to redevelop all our sites. Whilst we go through the planning stages of our redevelopment, we will continue to face challenges in this area. Our goal for heading four is therefore to maintain our current performance.

Quality domain 5

Well Led

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

Goal: To increase the percentage of our people who would recommend this Trust to friends and family as a place to work or a place for treatment on a year-by-year basis.

Evidence shows that people who are engaged and happy in their jobs, respected and given opportunities to learn provide better care for their patients. Our goal is to increase the percentage of people who would recommend our Trust as a place of work or a place to come for treatment to friends and family by two per cent in year one. This will enable us to have evidence that by supporting our people to develop, we are improving the culture and ethos of the Trust – both as a place to work, and as a place to be a patient. This goal will be supported by the targets outlined below.

Target 1

We will launch our ward accreditation programme with evidence documented of rapid improvements where issues arise.

Following the CQC inspection, we have decided to launch our own internal programme of ward inspection so that we can carry out regular checks and instigate immediate improvement where necessary. This target has been chosen to ensure this is implemented effectively throughout the Trust as we believe it will be a valuable tool in ensuring consistent levels of care across our wards.

Target 2

We will achieve a voluntary turnover rate of 10 per cent or less.

We have chosen to focus on reducing voluntary turnover as retention of staff is a key aspect of building a strong, consistent workforce able to sustain the quality improvements we need to achieve over the next three years. Our turnover rate is currently 11.74 per cent; we want to reduce this to at least 10 per cent in year one.

Target 3

We will reduce our sickness absence rate to 3.40 per cent in year one.

Low sickness absence is an indicator of effective leadership and good people management. As such, we have chosen this target as a measure of staff satisfaction and wellbeing. We believe that our new health and wellbeing programme will play a significant part in improving our people's physical and mental health. We aim to reduce the rate of sickness absence from its current position of 3.46 per cent to 3.40 per cent or less in year one.

3.4%

Maximum sickness absence rate for the first year of our strategy – down from 3.46 per cent.

Target 4

We will achieve a performance development review rate of 95 per cent and a non-training grade doctor appraisal rate of 95 per cent.

In 2014-15, we rolled out a new appraisal scheme performance development and review (PDR) for all staff, excluding doctors, aimed at driving a new performance culture across the Trust.

We required all our managers to undergo re-training in the skills of having effective performance conversations, training 1600 during 2014. The new PDR process involves ratings for staff and for the first time makes a link between performance and obtaining increments, and also a clear link to our values and behaviours.

As a result of this programme, our national staff survey results show that the number of staff believing they had a well-structured appraisal was in our top five scoring questions and in the top 20 per cent of Acute Trusts. We also conducted our own evaluation which showed us that "80 per cent of direct reports felt that their PDR had been an improvement on previous experience" and also "90 per cent of managers felt that the PDR process will improve the engagement of their team and will improve the performance of the team".

The current rate for PDR at the end of 2014/15 is 93.65 per cent, a big improvement on the appraisal compliance results from previous years; however our target is to make sure the improvements made this year are sustained by ensuring at least 95 per cent of our non-clinical staff have had their performance development review on an annual basis.

Non-training grade doctors have an appraisal on a yearly basis as part of the General Medical Council's Revalidation process, during which the doctor has a formal structured opportunity to reflect on his or her work and to consider how their effectiveness might be improved, with the focus on enhancing quality and improvements in patient care. Currently, we are behind our target of ensuring at least 95 per cent of our non-training grade doctors have had their appraisal on an annual basis, with a rate of 88.9 per cent at the end of March 2015. We have chosen this target to bring doctors' appraisals in line with non-clinical PDRs and to ensure that they receive the same opportunities to develop.

Target 5

We will achieve consistent compliance of 95 per cent with statutory and mandatory training.

Our statutory and mandatory training programme ensures the safety and wellbeing of all our staff and patients. During 2014-15 we moved the majority of our training to online elearning and also implemented a new reporting tool (WIRED 2) to improve our ability to monitor and report on compliance. We have chosen a target of 95 per cent compliance to demonstrate that our staff comply with statutory and mandatory requirements which have a direct impact on patient safety.

Target 6

We will reduce the number of programmes with red flags in the General Medical Council's national trainee survey by five per cent and increase the overall number of green flags.

As one of London's largest teaching hospitals, we want to provide the best training for our junior doctors, as we believe this is a key element of us being a well-led organisation. The General Medical Council's annual national survey is an important measure of trainee satisfaction, which can highlight not only problems with teaching in organisations, but also patient safety issues and problems with bullying and undermining.

Although we have seen improved survey results in recent years, in the 2014/15 survey, 39 per cent of our programmes currently have a red flag (where we are shown to be a significant national outlier). We have chosen this target to drive improvements across education in order to reduce the number of programmes with red flags by five per cent, while increasing our number of green flags.

Target 7

We will obtain a minimum score of 0.5 for placement satisfaction for all medical student placements as measured by Student Online Evaluation (SOLE) feedback.

As well as junior doctors, we also run placements for medical students at the Trust and are keen to focus on how we can improve their experience. The feedback we receive through the national SOLE system is usually mixed. We will focus on how we can improve their experience throughout the year in a consistent manner, with the aim of obtaining a minimum score of 0.5 (which corresponds to a 'mostly agree' score) for satisfaction for all student placements.

Target 8

We will have trained departmental safety co-ordinators in all specialties.

Departmental Safety Co-ordinators (DSCs) are appointed by departmental managers to assist them in meeting their health, safety and wellbeing responsibilities, as an additional part of their existing role. In year one, we want to ensure that 90 per cent of our specialties have a fully trained DSC, with all departments having one in year three. Currently, we have around 300 trained DSCs in post, with a view to increasing this number to 400 by the end of the year. Ensuring that our specialties are fully compliant with health and safety will ensure a safer environment for our staff and consequently for our patients.

Summary of our quality performance 2013-15

The targets and goals we have set for 2015/16 are designed to sustain and improve on achievements made through the implementation of our first Quality Strategy. We also recognise that we have some way to go before we can meet all our goals. Some examples of our achievements over the two years of our first Strategy, and continued work to improve the quality of healthcare in our Trust are outlined here, under the headings of our new quality domains.

Incident reporting

In April 2014, we upgraded Datix, our incident reporting system to provide improved systems and processes for monitoring, reporting and learning from adverse events. Since then, we have seen an increase in our reporting rate to its current level within the top quartile when compared to our peers. We believe this is also due to a culture of increasing openness and transparency, which is reflected by the improved responses to the safety questions in our staff survey. We have exceeded our targets for reporting, while maintaining a low level of harm and continuing to have one of the lowest mortality rates in the country.

Harm-free care

We consistently deliver over 95 per cent harm free care for our patients as measured by the safety thermometer. This includes reporting a low level of harm when compared with the national average for pressure ulcers, falls, VTE and urinary catheter infections.

Reporting and monitoring safety and effectiveness

In 2014, we appointed an associate medical director to be the Trust lead for safety and effectiveness, and have set out to improve the ways in which we monitor how safe and effective our services are. We have undertaken the following actions:

- Weekly incident review meetings for all divisions held with the associate medical director for safety and effectiveness. This ensures that issues are highlighted and action taken in real time;
- Monthly Safety and Effectiveness reports for each clinical division - these include information regarding mortality rates split by specialty, themes from serious incidents, including lessons learnt and actions to be taken, divisional incident reporting rates and participation in local and national audit. These allow divisions to monitor their performance at specialty level and make improvements were necessary;
- Monthly Quality Reports report the same information at Trust level to our Executive Quality Committee.

Mortality rates

We have maintained consistently low mortality rates. Our SHMI and HSMR scores are excellent when compared nationally, with the rate for each being the second lowest for non-specialist acute providers across the available data for this last year.

Clinical audit

In 2014, a business case was approved to develop a clinical effectiveness team in the medical director's office. This team will mean we can run a more comprehensive programme of local audit, focusing quality improvement on those areas where it will be most helpful, to improve outcomes for patients. We anticipate that the team will be in place in autumn 2015.

Specialist services

We are proud of our high performing specialist services at Imperial, including our hyper acute stroke service at Charing Cross, our heart attack and arrhythmia centre at Hammersmith and our Major Trauma Centre at St Mary's, which has some of the best outcomes in the country.

Caring

Improvements in patient experience

We have seen improvements in our results in the national inpatient, cancer and A&E patient surveys over the last year, and have fully implemented the 'Friends and Family Test' question in all outpatient areas. A number of key programmes of work have contributed to our improved scores, including:

- the introduction of carers' passports which enables carers of patients who have dementia or are vulnerable to visit outside hospital visiting hours;
- the introduction of SMILE to improve the experience of patients with cancer in response to the 2013 survey results;
- a research study to improve dignity for older people in hospital.

Patient stories

This year we have changed the way patient stories are presented to the board. Patients now attend in person and share their experience directly with the board. The patient story opens the meeting to remind everyone of why we are here and to ensure our patients are at the forefront of everyone's mind as they discuss board matters. The board have the opportunity to ask the patient questions and have used this to really understand what matters to our patients.

We will continue to have our patients share their experiences and hope to extend this further using video technology to reach more patient groups.

Responsive

We have not consistently met all national access targets this year. We have been focusing on improving and streamlining our operational processes and are seeing some gradual improvements in our performance. Some of the initiatives have included:

- Enhanced the cancer administrative team, recruiting more tracking staff to support the delivery of cancer targets;
- Network-wide pathway mapping work with other providers in the north-west London to reduce the number of cancer delays related to inter-trust referrals;
- Breaking the cycle week to focus on and address the operational difficulties we were experiencing in A&E, developments include facilitating early discharge, early escalation of potential breaches and improving out-of-hours operations.

Well Led

We have seen significant improvements in our staff engagement throughout 2014/15, with the following key programmes of work contributing to our improved scores:

- We run local engagement surveys every quarter. Each manager receives local results at specialist and ward level and then develops quarterly action plans to address the issues raised;
- We have produced a new Health and Wellbeing strategy for staff. This includes activities such as yoga, weight management, health and wellbeing days on all sites, and walking challenges;
- We have developed a suite of leadership development programmes, for clinicians and non-medical managers;
- We have rolled out a new Performance Management Review process throughout the Trust. This has involved training for 1,600 managers in effective performance conversations;
- We introduced Make a Difference awards as our way of recognising the hard work, dedication and achievements of our staff. The scheme has been very popular with high take-up rates throughout the year with an estimated 1500 instant recognition award and 250 nominations for the other awards.

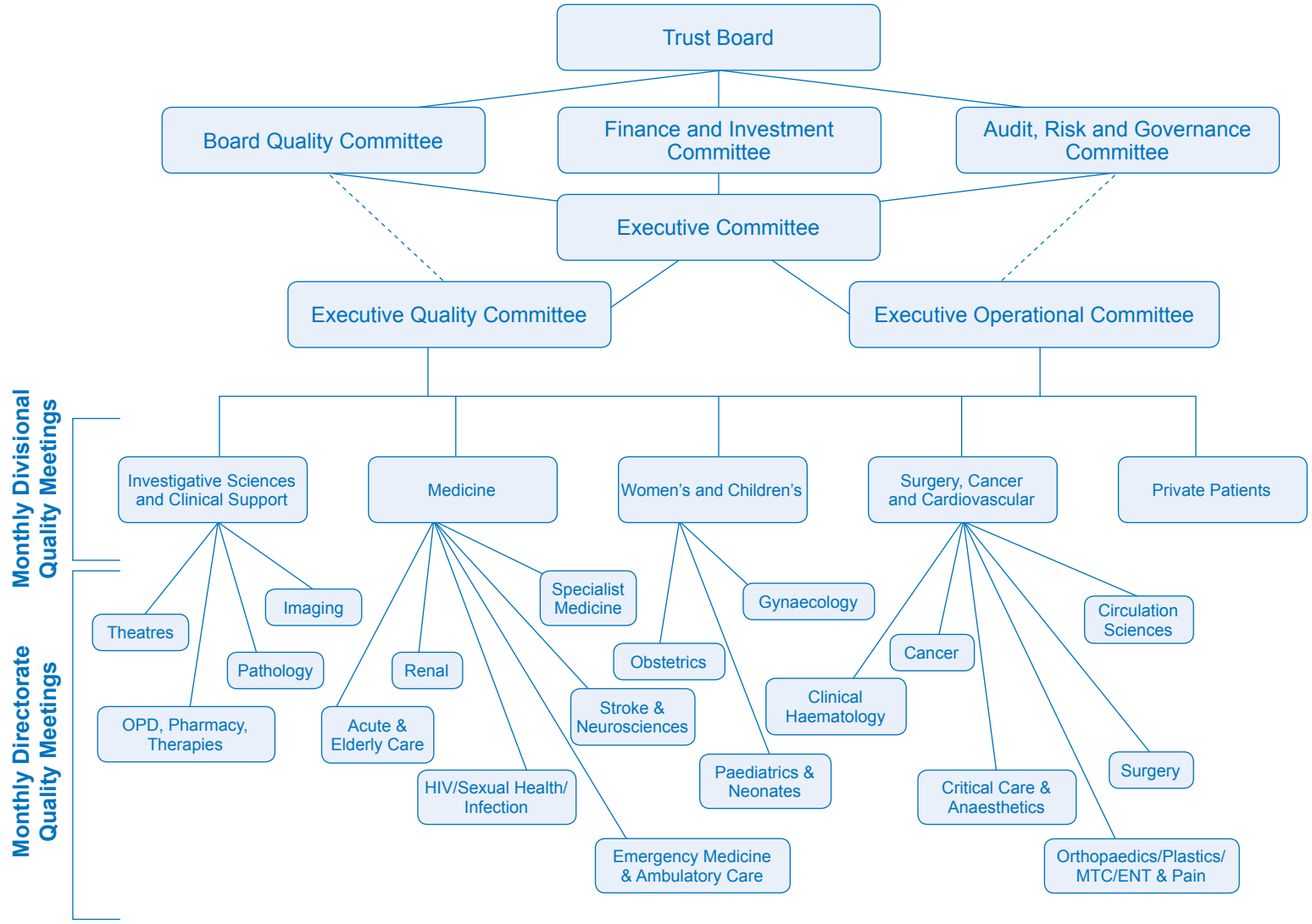
Conclusion

We believe implementation of this strategy will ensure our services are safe, effective, caring, responsive and well led, leading to better outcomes and experience for our patients, improved engagement for our people and a strengthened confidence in our Trust as an organisation committed to continuously improving.

We have an exciting opportunity to use our values based quality improvement programme to make Imperial the best it can be, with all our people sharing in leading and delivering improvements, whether big or small, ensuring that the needs of the individual patient are central to all that we do.

We look forward to working with our patients, our people, our commissioners and other external stakeholders over the next three years as we work to deliver the ambitious goals and targets set out in this strategy.

Appendix 1: Reporting structure



Appendix 2: Key initiatives

Safe	Effective	Caring	Responsive	Well Led
Critical care development programme **Chief operating officer**	Clinical guideline assurance programme **Medical director**	Equality programme **Director of nursing**	Surgery backlog reduction programme **Chief operating officer**	OD strategy implementation **Director of people and organisational development**
Safety improvement programme **Medical director**	Clinical audit programme **Medical director**	End of life improvement programme **Director of nursing**	Cancer standard management (sustained delivery of targets) **Chief operating officer**	Quality improvement programme **Medical director**
Paediatric Intensive Care Unit (PICU) redevelopment programme **Chief operating officer**	CAS alerts/medical devices/new interventions **Medical director**	Volunteer development programme **Director of nursing**	A&E performance improvement programme **Chief operating officer**	Education improvement programme **Medical director**
Isolation facilities improvement programme (usage and increasing provision) **Chief operating officer**	Discharge process improvement programme **Chief operating officer**	Ward leader development **Director of nursing**	Operational target strategy/improvement programme **Chief operating officer**	Values, behaviour and promise project **Director of communications**
Quality Impact Assessment process for cost improvement programmes **Director of nursing**	Nursing and Midwifery Revalidation **Director of nursing**	Time to care programme **Director of nursing**	Complaint improvement programme **Director of nursing**	Board development programme **Director of people and organisational development**
Safety thermometer – reduction in harm **Medical director**			Outpatient improvement programme **Chief operating officer**	Ward accreditation programme **Director of nursing**
Safe-guarding programme **Director of nursing**			Site capacity improvement plan **Chief operating officer**	Communication improvement programme **Director of communications**
			Integrated care service **Chief operating officer**	Divisional structure – Mid-term review of effectiveness **Chief operating officer**
				Clinical strategy implementation programme **Medical director**

Appendix 3: Project analysis

KEY	
	*** major contributor to target
	** contribution to target but not essential
	* Small contribution but not critical to target
	x No relationship or contribution to target

Domain: Safe		GOALS & TARGETS										
		Reduction in incidents causing severe and extreme harm	Sufficient staffing — vacancy rate	To achieve agreed fill rates for nursing staff	Safety culture – high reporting, low harm	Zero 'never events'	No avoidable infections	Compliance with anti-infective policy	Eradicate avoidable category 3/4 Trust-acquired pressure ulcers	Venous	WHO checklist auditing	Reduce out-of-hours transfers
PROJECTS	Critical care development programme – COO	***	***	***	***	***	***	**	**	x	x	***
	Safety improvement programme – MD	***	x	x	***	***	***	**	***	***	***	x
	PICU re-development project – COO	***	**	**	***	x	***	x	x	x	x	***
	Isolation facility improvement programme (usage and increasing provision) – COO	***	x	x	x	x	***	**	x	x	x	***
	QIA process for CIP – DON	**	***	*	**	*	**	*	x	x	x	x
	Safety thermometer – reduction in harm – MD	***	x	x	***	***	***	***	***	***	x	x

Appendix 3: Project analysis

Domain: Effective		GOALS & TARGETS						
		National clinical audit outcomes – top quartile	SHMI and HSMR Ratios	Reduction in out-of-ICU / ED cardiac arrests	PROMS reporting performance and health gain	Mortality reviews in all specialties	35 per cent increase in discharges before noon	70-day research target
PROJECTS	Clinical guideline assurance programme – MD	*	*	*	x	x	*	*
	Clinical audit programme – MD	***	**	**	*	***	x	x
	CAS alerts/medical devices/new interventions – MD	*	*	*	x	x	x	**
	Discharge process improvement programme – COO	**	**	x	*	x	***	x
	Nursing and Midwifery Revalidation – DON	*	x	x	x	x	x	x
	Safety thermometer – reduction in harm – MD	***	x	x	***	***	***	***

Appendix 3: Project analysis

Domain: Caring		GOALS & TARGETS					
		Increasing percentage of our patients would be happy to recommend the Trust to friends and family if they needed similar care or treatment	Improve our score in the national inpatient survey relating to responsiveness to patients' personal needs	Achieve and maintain a FFT response rate of 40 per cent in inpatients and 20 per cent in A&E	Improve our national cancer survey scores	Increase our responsiveness to complaints and reduce overall number	Develop a dataset that enables monitoring of protected characteristics against patient experience measures
PROJECTS	Safe-guarding programme – DON	**	x	x	x	x	**
	Equality programme – DON	***	**	**	**	x	**
	End of life improvement programme – DON	**	***	*	***	x	x
	Volunteer development programme – DON	**	**	*	**	x	x
	Ward leader development – DON	***	***	***	***	x	x
	Time to care programme – DON	***	***	***	***	x	x

Appendix 3: Project analysis

Domain: Responsive		GOALS & TARGETS							
		Meet all national access standards	Reduce the unplanned emergency readmission rate	Reduce the backlog of patients waiting 52 weeks for elective surgery and ensure clinical validation in place for 18-week waits	Hospital initiated cancellation of outpatient appointments	Outpatient letter turnaround time	Reduction in number of delayed clinics due to late arrival of doctors	Improve number of outpatient consultations where original medical records are available	PLACE target improvement to be in the top 25 per cent nationally
PROJECTS	Surgery backlog reduction programme – COO	***	**	***	**	**	**	**	x
	Cancer standard management (sustained delivery of targets) – COO	***	**	**	**	**	**	**	x
	A&E performance improvement programme – COO	***	***	*	*	*	*	*	*
	Operational target strategy/ improvement programme – COO	***	***	***	***	***	***	***	*
	Complaint improvement programme – DON	*	*	***	***	***	***	***	**
	Outpatient improvement programme – COO	*	**	**	***	***	***	***	*
	Site capacity plan – COO	***	***	***	**	**	**	**	**
	Integrated care service – COO	**	**	*	**	**	**	**	*

Appendix 3: Project analysis

Domain: Well Led		GOALS & TARGETS									
		Increase percentage of staff who would recommend the Trust as a place for treatment or a place to work	Ward accreditation programme launch	Voluntary turnover rate of 9.5 per cent or less	Sickness absence rate to 3.40 per cent or less	Performance development review rate of 95 per cent	Doctors appraisal rate of 95 per cent	95 per cent statutory and mandatory training	Reduction in number of programmes with GMC NTS red flags by five per cent and increase in green flags	Minimum score of 0.5 for Student Online Evaluation (SOLE) feedback	Safety co-ordinators in 90 per cent of departments
PROJECTS	OD strategy – DOPOD	***	**	***	***	***	**	***	**	**	***
	Quality improvement programme – MD	***	**	**	***	***	***	**	***	***	x
	Education improvement programme – MD	***	***	***	***	***	***	**	***	***	x
	Values, behaviour and promise – DOC	***	**	**	**	**	**	*	***	***	x
	Board development programme – DOPOD	***	x	x	x	x	x	x	x	x	x
	Ward accreditation programme – DON	***	***	**	**	**	**	***	**	*	x
	Communication programme – DOC	***	***	**	**	**	**	**	x	x	x
	Divisional structure – Mid-term review of effectiveness – COO	**	x	x	x	x	*	x	*	x	x
	Clinical Strategy Implementation programme – MD	***	*	**	**	*	**	*	**	**	x