



# Quality Account

2017/18



Imperial College Healthcare  
NHS Trust



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## 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 118.

## Alternative formats

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

Este documento encontra-se também disponível noutros idiomas, em tipo de imprensa grande e em formato áudio, a pedido.

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

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

Dokument ten jest na życzenie udostępniany także w innych wersjach językowych, w dużym druku lub w formie audio.

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Este documento también está disponible y puede solicitarse en otros idiomas, en letra grande y formato de audio.

Dipas kërkesës, ky dokument gjithashtu gjendet edhe në gjuhë të tjera, me shkrim të madh dhe në formë dëgjimore.





# Statement from the Chief executive



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

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

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

This all contributed to a very pressurised operational environment,

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

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

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

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

We have the second lowest mortality rates in the UK and with our focus on reduction of avoidable harm for patients

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

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

We are disappointed that when the Care quality commission inspected the Trust during the year we had not made sufficient progress overall to improve our rating which remains at requires improvement. The CQC noted some outstanding practice with medical care at Charing Cross rated as such for effective and caring. We made improvements in a number of areas

with a net improvement across the quality domain and service level ratings. We're clear that we have to increase our pace and get to 'good' and beyond as soon as possible. We have included the trust wide improvements in our priority plans for 2018/19 and we are reviewing our approach to improvement across the core services against the CQC standards with our top 100 senior leaders in May and will launch this in the summer. There are more details on what CQC found and our approach to improvement throughout the report.

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

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

We were pleased to receive a number of statements from our external stakeholders this year which are included at the end of this document. Many of you asked for more information or provided constructive feedback which we will take forward this year. We will also be arranging time to meet with each of you to discuss this in more detail over the coming months.

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

Professor Julian Redhead  
Interim chief executive officer,  
Imperial College Healthcare NHS Trust  
20 June 2018

# About this report

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

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

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

We have sought to take all reasonable steps and exercised appropriate due diligence to ensure the accuracy of the data reported, but we recognise that it is nonetheless subject to the inherent limitations noted above. We are working to improve data quality across the organisation, as described on page 55. Following these steps, to the board's knowledge, the quality account is a true and fair reflection of the Trust's performance.

We have tried to make this document as straightforward and reader-friendly as possible. A glossary of terms used throughout the document can be found on page 118.

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](mailto:imperial.quality.team@nhs.net).

# Statement of directors' responsibilities in respect of the quality account

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

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

- 1 The quality account has been prepared in accordance with Department of Health guidance and National Health Service Regulations 2010 (as amended) and presents a balanced picture of our performance over the period covered.
- 2 The content of the quality account is consistent with internal and external sources of information including:
  - Trust board minutes and papers for the period April 2017 to May 2018
  - papers relating to quality reported to the Trust board over the period April 2017 to May 2018
  - feedback from clinical commissioning groups
  - feedback from local scrutineers, including Healthwatch and local authority overview and scrutiny committees
  - the Head of Internal Audit's Annual Opinion May 2018
  - the national inpatient survey 2017
  - the national staff survey 2017
  - the General Medical Council's National Training Survey 2017

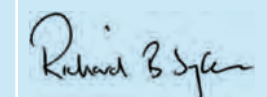
- mortality rates provided by external agencies (NHS Digital and Dr Foster).
- 3 There are proper internal controls over the collection and reporting of the measures of performance included in the quality account, and those controls are subject to review to confirm they are working effectively in practice.
- 4 The data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

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

By order of the Trust board



Julian Redhead  
Chief executive officer



Sir Richard Sykes  
Chairman

20 June 2018





# About our Trust

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

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

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

## Our Trust in numbers

### Our services

**1,125 million**

Patient contacts

**299,000**  
Emergency attendees



**97%**  
Inpatients who would recommend us to their friends and family



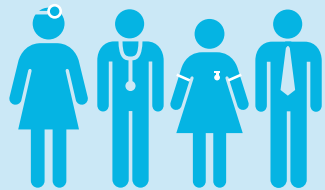
**10,000**  
Babies born



**39,000**  
Operations



### Our staff



**11,800**  
Staff, including:

**2,600**  
Doctors

**130**  
Pharmacists

**4,700**  
Nurses & midwives

**900**  
Medical students

**720**  
Allied health professionals

**470**  
Nurses in education, pre-registration

**1,200**  
Scientists & technicians

### Our finances



**£3m**

Adjusted net surplus



**£1,160m**

Turnover



**£43m**

Cost improvements



**£57m**

Invested in buildings and infrastructure, including IT

### Our vision and objectives

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

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

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

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

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

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

- Developing more person-centred approaches to care.** We will work in partnership with our patients and partner organisations to create sustainable services and organisational models that help our population stay as healthy as possible and ensure access to the most appropriate care when and where it is needed.
- Making our care safer.** We will build a culture where all our staff feel safety is key, are able to 'speak up' and understand their responsibilities; and where patients also feel confident to raise safety concerns and believe they will be addressed.
- Making the Trust a great place to work.** We will create a shared sense of belonging across our organisation, with staff feeling supported, valued and fulfilled, and a compelling 'offer' in terms of reward and recognition, wellbeing and development.
- Building sustainability.** We will continue to build our organisational culture and strategy that enable us to deliver our promise, effectively and sustainably.

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

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

### Our ethos and values

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

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

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

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

Our values are:

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

# About our Trust

## Our governance framework and structures

### Management structure

An organisational structure was put in place in July 2016 to devolve more authority to clinical staff providing care to patients and to reduce the number of management layers. Services are organised into one of 24 clinical directorates, each with its own 'triumvirate' of lead doctor, nurse and manager, with dedicated support from finance, human resources and information and communications technology. These clinical directorates are organised into three clinical divisions, each led by a practising clinician, they are:

- medicine and integrated care
- surgery, cardiovascular and cancer
- women's, children's and clinical support.

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

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

The clinical divisions are supported by six corporate divisions:

- office of the medical director (including quality, improvement, education and research)
- nursing director's office (including patient experience, estates and quality compliance)

- finance
- people and organisational development
- information and communications technology
- communications (including public and patient involvement).

### Governance framework

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

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

Every month, our executive management team reviews a comprehensive set of performance indicators – our 'scorecard'. A scorecard with a core set of indicators is also reviewed by the Trust board at its bi-monthly public meeting. For each indicator, we look at how we are performing against national standards and/or our own targets that flow from our various strategies. In addition to our 'scorecard' we also prepare a monthly quality report which includes each of the indicators that we set out in our quality account in the previous year. In 2018/19 we will produce an expanded and integrated scorecard for use at all committees, more information is included on page 16.

On our website, we publish an easy-to-understand monthly performance

summary as well as the full scorecard.

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

- quality
- finance and investment
- audit, risk and governance
- remuneration and appointments
- re-development.

Below the board committees is the executive committee which meets on a weekly basis. Sub-groups to a number of our executive committees meet monthly to ensure that there is sufficient time and detailed work being undertaken to deliver improvements. As an example the sub-group to the executive quality committee considers the minutes from the divisional quality committees and is where divisions come together and trust wide themes and issues are considered.

## Our key strategies

### Quality strategy

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

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

the development of the new quality strategy is on page 14.

### Patient and public involvement strategy

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

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

### People and organisational development (P&OD) strategy

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

### Clinical strategy

Our current clinical strategy sets out how we develop, organise and connect our services and specialties. Over the last year we have been progressing our Trust specialty review programme (SRP) to support us with the development of a new five-year clinical strategy that we plan to publish during 2018. Information on the SRP is included on page 78. The strategy will have been built up from our specialties and will for the first time, give us a roadmap for our specialties and hospital sites. This strategy will take us through

our redevelopment programme and beyond, and will be a key tool for continued engagement with our teams.

### Estates strategy and redevelopment programme

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

Our estates strategy for 2016 to 2026 provides an integrated approach to the estate with the aim to ensure that the Trust provides safe, secure, high-quality healthcare buildings capable of supporting current and future service needs. Whilst the strategy is being progressed, the Trust board has prioritised its capital expenditure to support priority backlog maintenance and medical equipment replacement. For further information, please see our annual report.

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

### Digital strategy

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

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

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



# Our quality improvement plan

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

## Our approach to quality improvement

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

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

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

- using the model for improvement – incorporating a clear aim, well defined

measures and space to think about change ideas, followed by rapid tests of change using multiple Plan-Do-Study-Act (PDSA) cycles

- using driver diagrams (see glossary on page 118 for definition) to articulate why certain work / projects / initiatives will logically lead to achieving the aim
- moving to 'measurement for improvement' – time series data with control limits, and annotations showing what changes were tried and when
- using coaching methods to drive improvement & transformation across the Trust
- co-designing change with patients, staff, carers & our wider communities
- putting an emphasis on sharing and spreading learning from improvement work.

### Enabling quality improvement work

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

We have designed, tested and implemented a comprehensive quality improvement capability building programme which has involved over 2,500 participants over the past two years. Our QI capability building programme aims to provide all staff at every level with the tools, skills and confidence to carry out and lead improvement work. This ranges from introductory sessions, to day-long 'Tools for Change' and co-design days, to our award winning Coaching and Leading for Improvement four-day programme, which has run five cohorts and developed over 100 coaches who are now leading improvement work across the organisation. This programme, together with the establishment of a year-long Flow Coaching programme involving nine Imperial clinician-manager pairs, and our Quality Improvement Fellowship are examples of where we have been building the improvement capacity of the organisation.

Through these coaches, and the input of the improvement team, we are actively supporting a wide range of local teams in undertaking quality improvement projects. The improvement team have also actively supported the design, delivery and evaluation of 39 Trust-wide improvement initiatives this year. Many of these projects and initiatives have already led to significant improvements. Examples include reductions in length of stay (diabetic foot big room),





# Our quality improvement plan

improvements in care pathways (virtual fracture clinic), improvements in patient safety (sepsis big room) and improvements in uptake (for example a near 300 per cent increase in staff flu vaccines in 2017-18). Other improvement work is included throughout the quality account, with more information on big rooms on page 79.

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

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

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

## Developing our 2018–2023 quality strategy

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

To strengthen our approach to developing the new strategy we commenced a listening campaign in December 2017 as well as an evidence scan to ensure it is designed to meet a range of national, system-wide and community needs and priorities. The campaign focused on what quality means to different stakeholders with a key principle of inclusiveness: connecting with those who we find hardest to reach, taking steps to overcome barriers to participation and encouraging everyone to have their say. Through this we have listened to over 700 people face to face and their perspectives are being used to shape our priorities. A measure of success of

the new strategy will be whether patients, staff and community groups can recognise their priorities in ours and in how we strengthen their involvement in our improvement journey.

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

The strategy will be published in the autumn of 2018.

## Monitoring quality

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

The clinical quality group is our monthly forum attended by all of our commissioners, and is a key part of our governance structure as set out below.

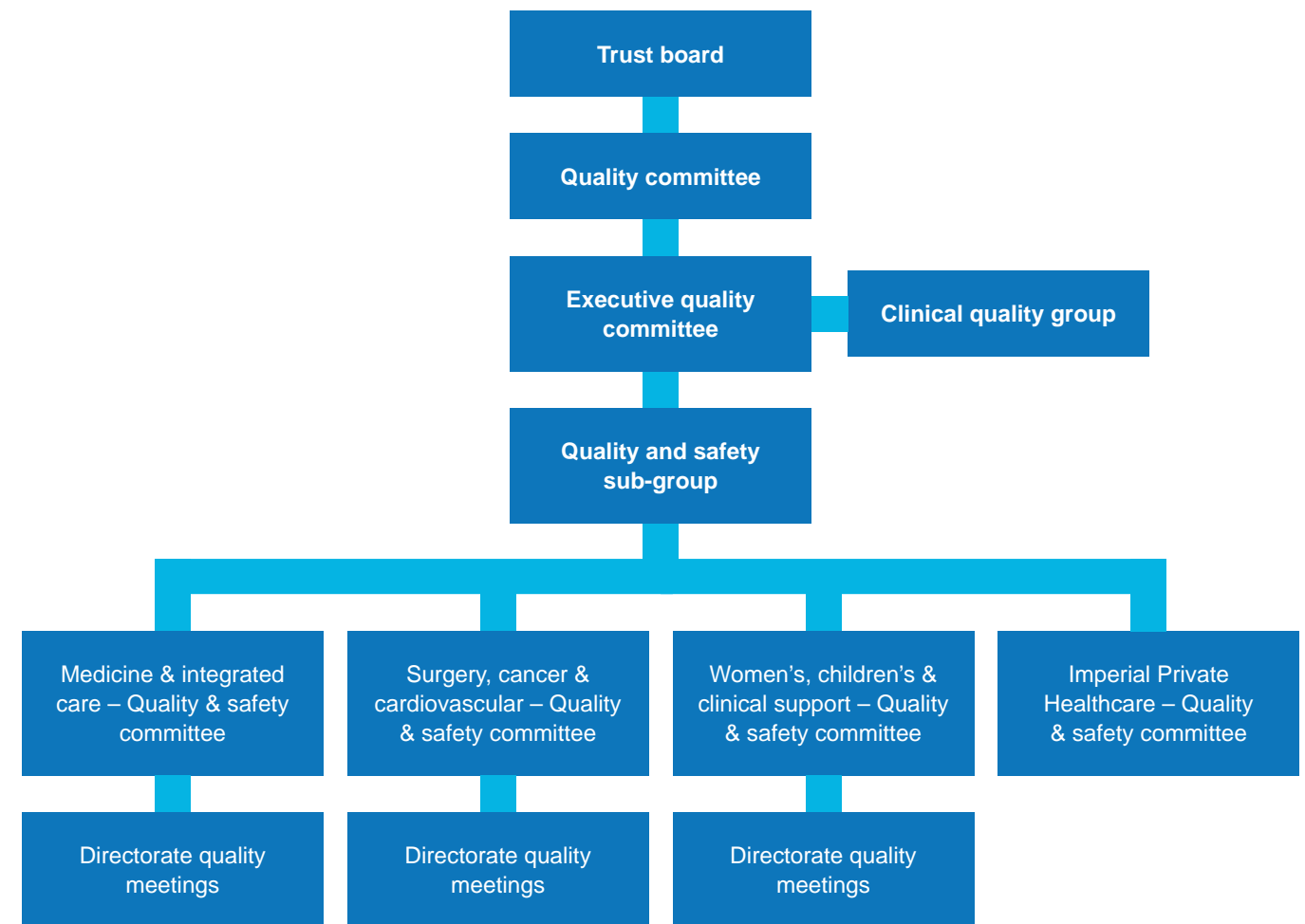
The governance arrangements for quality in the Trust are led by the medical director who has executive responsibility, and are summarised below. Progress with our quality goals, targets and priorities are reported through this framework, to enable monitoring from ward to board.

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

To strengthen oversight between our divisions and our executives we are planning to introduce bi-monthly

divisional oversight reviews during 2018/19. This will mirror the reviews already in place within the divisions and their directorates with the aim of better supporting trust wide performance improvement.

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





# Our quality priorities for 2018/19

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

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

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

improvement activity. The scorecard metrics and targets are provided in each quality domain in this account.

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

In March 2018, CQC announced that they would be including 'use of resources' as a sixth quality domain. We will therefore include metrics within this domain in the 2018/19 scorecard. They are not included in the quality account as they are still being developed. Performance against them will be included in next year's account with our improvement plans.

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

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

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

Improvement priority 1	To reduce avoidable harm to patients
<b>Rationale for inclusion</b>	Reducing avoidable harm is implicit in our strategic objective to achieve excellent outcomes for patients and is central to our operational objective to make care safer. Although our incident reporting rates and harm profile are good we take avoidable harm seriously and strive to continuously minimise it.  In 2017/18 we reported 27 incidents that caused severe/major harm or extreme harm/death, 13 deaths that were avoidable as well as an increasing number of SIs in recurrent categories. We also recognise that the management of patients with sepsis could be improved with a focus on the time between diagnosis and administration of antibiotics being key.
<b>What will we do?</b>	We will: <ul style="list-style-type: none"> <li>• support each safety stream with a focus on reducing recurrence of incidents</li> <li>• test our approach to implementation of policies across the streams to better understand the behavioural insights work needed to support staff to comply</li> <li>• scope and implement the improvement plan for the new stream</li> <li>• roll out the sepsis electronic alert across the Trust with targets set for improvement of time to antibiotic</li> <li>• launch the Trust sepsis policy</li> <li>• evaluate the impact of the safety streams that are continuing in 2018/19 in Q3</li> <li>• map the actions from all SIs to the improvement plans for each stream to ensure they continue to address the root causes of our incidents.</li> </ul>
<b>Measureable target for 2018/19</b>	We will reduce recurrence of the most commonly occurring SI's which have caused or have the potential to cause patient harm: <ul style="list-style-type: none"> <li>• recognition of the deteriorating patient (including sepsis)</li> <li>• safe mobility and prevention of falls with harm</li> <li>• fetal monitoring</li> <li>• safer surgery</li> <li>• abnormal results</li> <li>• positive patient confirmation</li> <li>• reducing treatment delays for mental health patients in the emergency departments.</li> </ul> <p>In addition, once our electronic alert has been rolled out we will ensure that 50 per cent of patients receive antibiotics within one hour of diagnosis. We will then set trajectories for further improvement.</p> <p>When combined this work will support us to reduce the number of incidents with the highest harm and those that are avoidable.</p>
<b>Executive lead</b>	Medical director

Improvement priority 2	To improve the safety culture across the Trust
<b>Rationale for inclusion</b>	Safety culture is embedded in our operational objective to make our care safer. We tested our culture during 2016 by inviting staff feedback through the safety attitudes questionnaire. A programme was then set up based on intelligence from research and experience from organisations at national and international level; incident themes; safety culture workshops; staff surveys and qualitative feedback including from work conducted in theatres. This resulted in a list of change ideas which have been prioritised as follows: <ul style="list-style-type: none"> <li>• improving our investigations</li> <li>• knowing what's reportable, being encouraged and supported to report and making reporting more straightforward</li> <li>• learning better from serious incidents</li> <li>• sharing information about safety better.</li> </ul> <p>In the staff survey we saw an improvement in people feeling able to report incidents, however an increase in the percentage of our staff who said that they had witnessed potentially harmful errors, near misses or incidents in the last month (from 30 per cent in 2016, to 37 per cent in 2017). This is above the national average.</p> <p>Culture is not something that changes quickly so it is important that we continue our focus on this programme.</p>



# Our quality priorities for 2018/19

<b>What will we do?</b>	<p>We will:</p> <ul style="list-style-type: none"> <li>• use our live driver diagram to target improvement work</li> <li>• explore our approach to “just culture” through an externally supported workshop in the summer</li> <li>• complete data analysis of staff survey results by staff group, age profile and gender to understand where to focus support and improvement energy</li> <li>• review our approach to supporting staff involved in incidents with a focus on addressing concerns raised following national high profile cases in 2017</li> <li>• include an additional question in our internal staff survey to assess whether staff know how to report incidents</li> <li>• continue to co-design improvements with staff and patients</li> <li>• internal communications of the culture work will be given additional focus including taking forward plans to create an Imperial safety campaign and video.</li> </ul>
<b>Measureable target for 2018/19</b>	<p>We will aim to improve our incident reporting rates overall.</p> <p>We will expand our work to support specific staff groups with low reporting rates. Improvement targets will be set when appropriate.</p> <p>We will improve staff survey results in questions related to staff reporting incidents and their perceptions of the fairness of processes</p> <p>Evaluation of all improvement interventions will be undertaken and reported during the year.</p>
<b>Executive lead</b>	Medical director

<b>Improvement priority 3</b>	<b>To improve permanent nurse staffing levels</b>
<b>Rationale for inclusion</b>	<p>Feedback from the listening campaign has unanimously reported the importance of having the right number of staff to enable care to be provided, with a specific focus on nursing.</p> <p>Vacancy rates at the Trust are above target with variance across departments. Safe staffing is routinely maintained through the use of temporary staff and cover provided by senior nurses however it is accepted that substantive staffing should be maximised.</p> <p>One of the operational objectives is to make the Trust a great place to work with staff feeling supported, valued and fulfilled. Increasing our permanent workforce and retaining them will be key to this.</p>
<b>What will we do?</b>	<p>A strategy was approved in March 2018 to improve the supply of nurses, this requires significant investment and will be implemented during 2018/19.</p> <p>We will:</p> <ul style="list-style-type: none"> <li>• commence overseas recruitment</li> <li>• introduce initiatives to improve retention of the existing nursing workforce</li> <li>• implement recruitment and retention premiums in the most hard to recruit areas</li> <li>• develop our nurse degree and associate apprenticeship programmes to grow our own nurses and associates for the future.</li> </ul>
<b>Measureable target for 2018/19</b>	Improve our vacancy rates to target.
<b>Executive lead</b>	Divisional directors

<b>Improvement priority 4</b>	<b>To ensure our staff are up to date with the mandatory skills to do their jobs</b>
<b>Rationale for inclusion</b>	Core skills and core clinical training rates have been below target despite many interventions. This has been identified as one of the priorities for the Trust as we have not managed to reach our target and this has been repeated cited by CQC as an area of concern at their inspections. This is central to our operational objective to making our care safer.
<b>What will we do?</b>	<p>The electronic system for management and monitoring of training is not fit for purpose and not linked to our HR systems. To support improvement by making sure our data is accurate and to ensure the right staff undertake the appropriate training a new learning management system will be procured and introduced in late 2018. We will also review all mandatory training modules, agree the correct portfolio for each staff group and manage staff within this once the new system is in place.</p> <p>Until the new system is in place the current recording system will be used to track compliance with a focus on our medical staff compliance where performance has been most difficult to influence. This will be done by focusing on:</p> <ul style="list-style-type: none"> <li>• induction transfer of training for doctors in training</li> <li>• linking training to appraisal, excellence awards and study leave/funding</li> <li>• line management oversight and follow up.</li> </ul>
<b>Measureable target for 2018/19</b>	The target for training compliance will be monitored with trajectories for improvement to reach 85 per cent in the first instance increasing to 90 per cent once the new system is embedded.
<b>Executive lead</b>	Director of people and organisational development

<b>Improvement priority 5</b>	<b>To ensure our equipment has planned maintenance in line with targets</b>
<b>Rationale for inclusion</b>	<p>The Trust recognises that the safe and appropriate use of medical devices (see glossary on page 119 for definition) is critical to the delivery of high quality patient care. Equipment maintenance oversight and management have been problematic in the past most recently in assuring it is completed within manufacturing recommendations.</p> <p>At the last CQC inspection this was raised as a safety issue and although work was underway our staff were not clear on actions to take when equipment was due for routine maintenance.</p>
<b>What will we do?</b>	<p>We will ensure that our medical equipment has planned maintenance at a frequency determined by the manufacturers instructions or on a risk based strategy by clinical technical services.</p> <p>Medical devices continually move around which can result in devices not being located for maintenance, therefore affecting the scheduled maintenance plan. To address this we are introducing radio-frequency identification (RFID) technology which will replace all of our asset labels on medical devices and enable their locations to be tracked. This will also comply with Globally Recognised Barcodes (GS1) standards (which improve management of assets within the NHS making services safer and more efficient) and assist with the Scan4Safety programme. Labels to indicate high, medium and low risk are also being fixed to all medical devices.</p> <p>An e-Learning package is also being developed to inform staff of essential safety aspects prior to using a medical device and this will be rolled out during 2018.</p>
<b>Measureable target for 2018/19</b>	<p>Targets for planned maintenance will be monitored monthly and are:</p> <ul style="list-style-type: none"> <li>• high risk = 98 per cent</li> <li>• medium risk = 75 per cent</li> <li>• low risk = 50 per cent</li> </ul> <p>The percentages for medical device maintenance compliance are based on standard figures from other hospitals and what we consider achievable from current performance.</p>
<b>Executive lead</b>	Director of nursing



# Our quality priorities for 2018/19

Improvement priority 6	To improve the management of medicines
<b>Rationale for inclusion</b>	<p>Management of medicines has been raised at each of our CQC inspections since 2014. In November 2017 the CQC reported that medicines were not consistently prescribed, given, recorded and stored well and outlined the following additional actions:</p> <ul style="list-style-type: none"> <li>the Trust must ensure that control drugs cupboard key is kept securely and access is appropriately restricted</li> <li>the Trust must ensure that there are effective checking systems for airway trolleys and emergency medicines stored in the resuscitation bays</li> <li>the Trust must ensure that IV fluids are stored appropriately.</li> </ul> <p>The CQC report of 2018 identified similar concerns. A new approach is clearly needed to support improvement.</p>
<b>What will we do?</b>	<p>Improvement methodology has been used to identify the aim and drivers for this programme. The resultant plan has three key themes with ideas for change which will be tested and evaluated in 2018/19;</p> <ul style="list-style-type: none"> <li>storage</li> <li>temperature</li> <li>disposal.</li> </ul> <p>A new medicines improvement group has been formed to oversee the programme.</p> <p>All training programmes will also be reviewed to ensure they support the improvement priorities and fully equip our staff to manage medicines safely.</p>
<b>Measureable target for 2018/19</b>	<ul style="list-style-type: none"> <li>Monthly Fridge Temperature monitoring</li> <li>Six monthly safe storage audit</li> <li>Six monthly CD audit</li> </ul> <p>Improvement targets will be set once the baseline is agreed.</p>
<b>Executive lead</b>	Director of nursing

Improvement priority 7	To ensure hand hygiene compliance is measured accurately with focused improvement to support staff where risk exists.
<b>Rationale for inclusion</b>	<p>Monthly hand hygiene audits have been completed by front line nurses for the last 10 years. Results consistently show excellent performance however independent audits do not always give the same results. This and feedback from inspections has raised concerns about consistency of compliance. When research is considered compliance would be expected to be lower than that seen in our point prevalence results.</p>
<b>What will we do?</b>	<p>A new approach to hand hygiene compliance at the Trust was approved in March 2018. A trust wide improvement programme is being implemented, commencing in May 2018 with the launch of a new audit system. This will see us moving from monthly audit to an annual programme for all in-patient areas carried out in partnership with our infection prevention and control team and divisional senior staff. Improvement plans will be implemented for areas of increased risk following these audits.</p> <p>Communication, education and engagement will be key focus points of the improvement plan.</p>

<b>Measureable target for 2018/19</b>	Audit results of hand hygiene compliance will be measured however a target will not be set until the Trust baseline audit has been completed. Research results will be used to set targets going forward.
<b>Executive lead</b>	Medical director

Improvement priority 8	To continue to define, develop, implement and evaluate an organisational approach to reducing unwarranted variation
<b>Rationale for inclusion</b>	<p>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.</p> <p>One of our approaches to reduce variation is the use of 'flow coaching' within a clinical pathway. Three pilot pathways (sepsis, diabetic foot and children's asthma and wheeze) were used to test the flow coaching approach in 2017/18 (details in Responsive section) and in March 2018 we launched Flow Coaching Academy (FCA) Imperial to support a further nine pathways.</p> <p>The reduction of unwarranted variation across patient pathways is a key part of how we will improve sustainability and experience for our patients.</p>
<b>What will we do?</b>	<p>In 2018/19 we will define and implement our organisational approach to reducing unwarranted variation including:</p> <ul style="list-style-type: none"> <li>how we systematically identify where unwarranted variation exists, linking with existing programmes across the Trust including the 'specialty review programme' (see page 78), clinical audit (see page 68) and GIRFT (see page 69)</li> <li>developing skills and capabilities for staff across the organisation for tackling unwarranted variation</li> <li>with our finance and business intelligence colleagues, start to meaningfully measure outcomes from reducing unwarranted variation linked to the sustainability programme</li> <li>continue to deliver and further develop FCA Imperial: <ul style="list-style-type: none"> <li>continue to support the three pilot pathways, measuring their impact and learning from their experience</li> <li>support the nine new pathways and 18 coaches selected from across the divisions</li> <li>provide dedicated space for the weekly "big rooms" (see page for more information see page 79) on each site.</li> </ul> </li> </ul> <p>The nine FCA (Imperial) pathways are children with acute abdominal pain, perioperative vascular surgery, lower urinary tract symptoms, enhanced recovery, mental health crisis, acute respiratory care, acute kidney injury, adolescence and young people and the maternity pathway.</p>
<b>Measureable target for 2018/19</b>	<p>Each of the 12 pathways has measureable improvement targets for example:</p> <ul style="list-style-type: none"> <li>reduction in length of stay in diabetic foot patients</li> <li>improved time to antibiotics in sepsis</li> <li>improved outcomes for children and young people with asthma or wheeze through increasing use of asthma action plans, education and checking of inhaler technique.</li> </ul> <p>Progress will be reviewed through our governance structures throughout the year.</p>
<b>Executive lead</b>	Medical director



# Our quality priorities for 2018/19

Improvement priority 9	Emergency flow through the hospital
<b>Rationale for inclusion</b>	<p>The 'improving patient flow programme' was launched in early 2017 to improve operational performance across the whole urgent care patient pathway at the Trust and to enable us to meet the trajectory for performance against the four hour A&amp;E wait standard. Significant work was completed against the programme milestones and improvements have been realised in a number of areas, however we have not met our performance target.</p> <p>Achievement of the four hour wait standard is a national priority with new targets set for 2018/19 to meet 90 per cent from September and 95 per cent in March 2019.</p>
<b>What will we do?</b>	<p>Our work will be structured around six priorities:</p> <p><b>1) Effective emergency department (ED) operations</b></p> <p>This work stream will be divided into three sub groups;</p> <ul style="list-style-type: none"> <li>point of care testing (POCT) in the emergency departments</li> <li>redevelopment of the emergency department at Charing Cross hospital, creation of additional capacity and reviewing the urgent care centre (UCC) and emergency department pathways. The non-admitted pathway in ED will also be reviewed to reduce breaches</li> <li>at St Mary's hospital, utilizing improvement methodology to drive efficiency including an emphasis on mental health pathways.</li> </ul> <p><b>2) Specialist pathways</b></p> <p>A number of discreet projects including the outpatient parenteral antibiotic therapy (OPAT) service, Surgical pathways, and trauma.</p> <p>Following a visit to Addenbrookes Hospital, we will carry out a feasibility study of implementing single medical assessment between ED and acute services.</p> <p><b>3) Real time bed management</b></p> <p>Given our limited capacity, an effective real time bed management solution is vital. This work will be overseen by a bespoke task and finish group.</p> <p><b>4) Improving ward flow</b></p> <p>This work stream will oversee improvements in discharge processes and use of discharge facilities as well as the rollout of the SAFER bundle across the Trust.</p> <p><b>5) External partners</b></p> <p>The work stream will focus on the aspects of inpatient flow that require joint working with external partners for improvement.</p> <p><b>6) Infrastructure</b></p> <p>This work stream will focus on vital support services that either directly impact on or have effect on both the EDs and ward flow.</p> <p>A helpful review was undertaken by NHSI which will report in April 2018, the recommendations of this will be incorporated into the programme.</p>
<b>Measureable target for 2018/19</b>	<p>The overall target is improvement in four hour performance.</p> <p>The existing scorecard will be refreshed to reflect the priorities for 2018/19 with work stream KPIs and improvement targets.</p>
<b>Executive lead</b>	Divisional director of medicine and integrated care

Improvement priority 10	To improve access to services across the Trust through a focus on increasing capacity
<b>Rationale for inclusion</b>	<p>Emergency and RTT performance has been challenged during 2017/18 with deterioration over the winter period. Although elective activity was reduced this was not sufficient to ensure patients were admitted in line with standards. Bed modelling has historically shown that demand does not meet capacity.</p> <p>To achieve these important access targets, additional capacity will be required as well as efficiency improvements.</p>
<b>What will we do?</b>	<p>Bi-weekly capacity management meetings are in place with the CEO and executive team. A full review of demand and capacity will be completed with an options appraisal of bed space opportunities considered internally and externally with commissioners.</p> <p>Bed stock will be reviewed to consider best use of additional space including escalation space by the divisions.</p> <p>We will then review our escalation and full capacity protocols.</p>
<b>Measureable target for 2018/19</b>	<p>If capacity is increased we will measure improvement in:</p> <ul style="list-style-type: none"> <li>number of days where black escalation is in place</li> <li>number of cancelled elective patients</li> <li>occupancy levels.</li> </ul>
<b>Executive lead</b>	Chief executive officer

Improvement priority 11	To improve access for patients waiting for elective surgery
<b>Rationale for inclusion</b>	<p>Over a sustained period of time, the Trust has encountered a number of data quality and operational performance challenges to delivering a balanced position on elective care. Many of these challenges have been overcome through focused internal interventions and support from external agencies. Despite this the trust has not achieved the RTT standards since 2015 and we are struggling to meet improvement trajectories set for the 92 per cent incompletes target and for the number of patients who are waiting over 52 weeks for treatment.</p> <p>An external review has been commissioned by the CEO to furnish the Trust with a detailed scope of work to support in reviewing those factors that continue to affect compliance with access standards, and evaluate the initiatives in place that will sustain and improve the delivery of RTT 18 weeks. This will report in May 2018 and its recommendations will be taken forward during 2018/19.</p> <p>Performance in March 2018 shows that 83.29 per cent of patients were treated within target and that 267 patients waited over 52 weeks for treatment which is one of the highest reported numbers in the UK. A monthly clinical harm review process is in place with three patients identified as coming to moderate harm however we do not make any excuse for the distress and anxiety that these long waits have on our patients.</p> <p>This is an integral part of our operational objective to improve the way we run our hospitals and is a measure of whether the trust is responsive and well led. We know we need to improve our performance and are committed to continue to do so.</p>
<b>What will we do?</b>	<p>We will fully implement the Trust elective care operating framework (ECOF) which is the change programme redesigning the way we manage elective care. The overall aim of ECOF is that our patients have timely access to elective services which will be delivered through the primary drivers of:</p> <ul style="list-style-type: none"> <li>patient pathways are proactively managed against clear standards</li> <li>capacity is planned to meet demand at each stage of a patient's pathway</li> <li>operational processes are clearly defined and well understood by all staff where SOPs affect their roles</li> <li>staff have tools that enable them to effectively manage pathways</li> <li>data integrity and quality are proactively managed to provide clarity for all the audiences and staff involved in managing pathways</li> <li>a comprehensive performance management framework ensures that staff are supported and held to account for their role in managing pathways</li> <li>all aspects of elective care management are regularly reviewed and updated to meet demands of them and reflect best practice</li> </ul>



# Our quality priorities for 2018/19

	<ul style="list-style-type: none"> <li>potential clinical harm to patients waiting longer than tolerance levels is proactively managed</li> <li>there is visible senior leadership focus on managing elective care performance.</li> </ul> <p>Plans are in place for each driver which is overseen through the governance framework.</p> <p>A key focus for 2018/19 is the implementation of training for staff as well as improvements to the data tracking solutions in place. These should support staff to get pathways recorded accurately first time.</p>
<b>Measureable target for 2018/19</b>	<p>Delivery of RTT performance standards as agreed with commissioners:</p> <ul style="list-style-type: none"> <li>ensure at least 92 per cent patients wait for no longer than 18 weeks for non-urgent consultant led treatments at Imperial College Healthcare Trust by March 2020 (TBC)</li> <li>no patients wait more than 52 weeks for consultant led treatment by July 2018</li> </ul>
<b>Executive lead</b>	Divisional director of surgery, cardiovascular and cancer

Improvement priority 12	To improve compliance with equality and diversity standards
<b>Rationale for inclusion</b>	<p>The equality and diversity system 2 is a tool to help NHS organisations improve the services they provide to local communities and provide better working environments, free from discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. Trusts are expected to self-assess their compliance against four objectives across 18 outcomes for each of the 9 protected characteristics.</p> <p>Although work has been undertaken in this area progress has not been overseen or co-ordinated in a systematic way. A review was undertaken in 2017 and an equality and diversity steering group has been established within the Trust.</p> <p>These standards are central to the operational objective to make the Trust a great place to work. This is also a key element of the CQC well led framework.</p>
<b>What will we do?</b>	<p>The Trust EDS2 compliance assessment will be used as the framework for identifying good practice and areas of improvement. This will be used to inform the trust action plan.</p> <p>Progress with the action plan will be overseen at the trust equality and diversity committee with regular reporting to trust board.</p> <p>A review of the gender pay gap will be undertaken with a focus on the medical consultant workforce in particular the clinical excellence awards. The results of which will also feed into the action plan.</p> <p>Governance and reporting will be agreed with the all divisions across the Trust to ensure engagement in this important agenda.</p>
<b>Measureable target for 2018/19</b>	To implement systematic assessment of the EDS two goals throughout the organisation with an action plan developed to make improvements where necessary.
<b>Executive lead</b>	Director of people and organisational development

Improvement priority 13	Specialty review and clinical strategy development
<b>Rationale for inclusion</b>	<p>The Trust specialty review programme (SRP) is our clinically led process to develop a five-year clinical strategy, which is built upwards from specialty level strategic plans (see page 78 for more details). The outputs of the SRP will be used to inform the bottom-up development of a refreshed clinical strategy. The refreshed clinical strategy will set out how we propose to organise, deliver and develop our services over the next five years, providing excellent high quality care whilst responding to the significant challenges faced by the NHS. The clinical strategy will be a core product of the Trust's wider strategy and, in turn, will influence the development of other Trust-wide strategies. The clinical strategy will also sit within the wider strategic context of the north west London STP.</p> <p>A key feature of the SRP is that the reviews are 'owned' by each specialty, with a focus on MDT input, such that specialty teams recognise the resulting strategies and are able to engage with and buy into them. Specialty specific strategies ensure teams are clear on what they need to do to support the delivery of the Trust clinical strategy.</p>
<b>What will we do?</b>	<p>All 37 specialties will have completed their three workshops by July 2018. The outputs of the SRP will be used to inform the bottom-up development of a refreshed Clinical Strategy.</p> <p>A series of 'wash-up' sessions are in progress to further develop the specialty plans where there are inter-dependencies between specialties and also physical co-adjacencies across our sites. As a result the specialty specific plans will need to be iterated to ensure that they are aligned with the refreshed clinical strategy. This will form part of the continuing programme of specialty review into 2018/19 as part of the wider sustainability and transformation programme.</p> <p>Following on from the refreshed clinical strategy, there will be a continuing programme of specialty review. The review method will be adapted to provide a mechanism for assessing how specialties are progressing their ambitions outlined in the strategy and to allowing us to understand our portfolio of services in even further strategic depth. The frequency of review for each specialty will be determined by needs and risk assessment.</p> <p>Next year we will also ensure opportunities for improvement are mapped and support is prioritised for those areas where capacity/capability is required. We will also continue to iterate the approach to support directorates to make improvements to meet the Trust's objectives and vision as well as further developing our approach to measuring the impact and outcomes.</p> <p>The evolving SRP will become a key part of the wider sustainability and transformation programme in the medium and longer term. The ongoing SRP will inform and be informed by other related trust-wide programmes such as Reducing Unwarranted Variation and GIRFT (see page 69).</p>
<b>Measureable target for 2018/19</b>	<ul style="list-style-type: none"> <li>Specialty specific strategic plans developed for all 37 specialties.</li> <li>Refreshed clinical strategy published.</li> <li>Ongoing series of specialty reviews                             <ul style="list-style-type: none"> <li>define adapted methodology and approach</li> <li>begin reviewing specialties as part of the adapted approach.</li> </ul> </li> </ul>
<b>Executive lead</b>	Medical director

## Scorecard quality metrics

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

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



QUALITY DOMAIN 1:

# SAFE

**Aim/CQC definition:**

People are protected from abuse and avoidable harm

Area	Description	Target
Patient safety – incidents and reporting	To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing extreme harm/death	Below national average
Patient safety – incidents and reporting	To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing severe/major harm	Below national average
Patient safety – incidents and reporting	We will maintain our incident reporting numbers and be within the top quartile of trusts	Top quartile
Patient safety – incidents and reporting	We will have zero never events	0
Patient safety – incidents and reporting	We will ensure all patient safety alerts and medical devices alerts issued through the national central alerting system are reviewed and acted on in the specified timeframes	0 outstanding
Patient safety – incidents and reporting	We will ensure 100% compliance with Duty of Candour requirements for every appropriate incident graded moderate and above	100%
Infection 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 ensure our cleanliness audit scores meet or exceed the required standards	98% (very high risk patient areas) 95% (high risk patient areas)
Infection prevention and control	We will meet flu vaccination targets for frontline healthcare workers as part of the national seasonal flu campaign	National target
Medicines management	We will ensure that fridges containing medicines in clinical areas remain within recommended storage temperatures (2-8°C)	95%
Medicines management	We will ensure controlled drugs are checked every day	100%
VTE	We will assess at least 95% of all patients for the risk of VTE within 24 hours of their admission, and maintain zero cases of avoidable harm	95%
Sepsis	We will ensure at least 50% of our patients receive antibiotics before the sepsis alert or within one hour of a new sepsis diagnosis	50%
Maternity standards	We will maintain the ratio of births to midwifery staff at 1 to 30	1:30
Maternity standards	We will 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 medical devices maintenance compliance according to risk categorisation	98% high risk; 75% medium risk; 50% low risk.
Estates and facilities	We will ensure lifts are kept in service to minimise disruption and inconvenience	90% availability (main passenger and bed lifts)
Estates and facilities	We will improve the number of reactive maintenance tasks completed within the allocated timeframe	70%
Estates and facilities	We will ensure that planned maintenance tasks are completed within the allocated timeframe	70%
Estates and facilities	We will ensure compliance with statutory and mandatory estates requirements	85%
Staff training	We will achieve compliance of 85% with core skills training	85%
Staff training	We will achieve compliance of 85% with clinical skills training	85%
Staff training	We will ensure that 90% of eligible staff are compliant with level 3 safeguarding children training	90%
Workforce and people	We will have a general vacancy rate of 10% or less	10%
Workforce and people	We will have a nursing and midwifery vacancy rate of 12% or less	12%
Health and safety	We will ensure we have no reportable serious accidents, occupational diseases and specified dangerous occurrences in the workplace	0
Health and safety	We will have a departmental safety coordinator in 75% of clinical wards, clinical departments and corporate departments	75%
Health and safety	We will ensure at least 10% of our staff are trained as fire wardens	10%





# SAFE

## Goal

Safe: People are protected from abuse and avoidable harm.

## Primary drivers

1. We follow best practice standards (clinical, professional, safeguarding, Information governance and operational) to provide the safest possible patient care

2. We have oversight of risks and issues affecting the safety of patients & staff and proactively learns from mistakes & best practice

3. There is a culture where safety is our number one priority

4. There are always enough staff on duty with the right skills, knowledge and experience and equipment

## Secondary drivers

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

Systems and processes for recording safety related risks and issues are in place and being used

There is strong quality governance arrangements from board to ward

We are managing and learning from safety risks and issues that occur internally and externally to the organisation

There is a safe space to speak up when things go wrong and listen and respond to all

Share patient and staff stories related to safety when things go wrong and when they go right

Collective leadership is promoted in which everyone takes responsibility for the safety of patients

Staff are aware and trained in safety culture concepts, practices and responsibilities

We are exploring how to embed a "just" culture

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

# EFFECTIVE

**Aim/CQC definition:**

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

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





# EFFECTIVE

## Goal

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

## Primary drivers

1. Supporting self-care and self-management of conditions and promote a healthy lifestyle

2. Produce and translate the latest advances in research and technology for better patient outcomes

3. Systematically review outcomes and clinical practice to identify improvement opportunities and implement evidence based practices

4. Reduce unwarranted variation to provide consistently good services

5. Making sure care is coordinated to meet patient need

## Secondary drivers

Self-care: Partner with patients to recognise, treat and manage their own health

Self-management: Encourage and enable patients to protect their own health, choose appropriate treatments and manage long-term conditions

Promote healthy lifestyles and every interaction with patients

Collaborate with research partners

Promote pioneering research to 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

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

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

Support transitions of care between different services and settings of care within the organisation

Support transitions of care between different organisations

# 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 to 94% or above	94%
Friends and family test	We will achieve and maintain an FFT response rate of 20% in A&E	20%
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% (extremely likely or likely to recommend the service)
Mixed sex accommodation	We will have zero mixed-sex accommodation (EMSA) breaches	0





# CARING

## Aim

**Caring:** The service involves and treats people with compassion, kindness, dignity and respect

## Primary drivers

1. Patients are looked after in a caring environment

2. Patients have access to the most up-to-date and accurate information to make decisions about their own care

3. Staff recognise and treat every patient as an individual

## Secondary drivers

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

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

Improve feedback and learning from events, complaints and compliments

Embed the Trust values into all interactions between staff, patients and the public

Recruit and develop team leaders based on their values

Provide emotional and social support for staff

QUALITY DOMAIN 4:

# RESPONSIVE

**Aim/CQC definition:**

Services meet people's needs.

Area	Description	Target
Referral to treatment – elective care	We will reduce the percentage of patients waiting over 18 weeks to receive consultant-led treatment in line with trajectories	92%
Referral to treatment – elective care	We will reduce the percentage of patients waiting over 52 weeks to zero in line with trajectories and implement our agreed clinical validation process	0
Cancer	We will maintain the percentage of cancer patients who are treated within 62 days from urgent GP referral at 85% or more	85%
Theatre management	We will increase theatre touchtime utilisation to 95% in line with trajectories	95%
Cancelled operations	We will reduce cancelled operations as a percentage of total elective activity	Below national average
Cancelled operations	We will ensure patients whose elective operations are cancelled are rebooked to within 28 days of their cancelled operation	Below national average
Critical care admissions	We will ensure 100% of critical care patients are admitted within 4 hours	100%
Accident and Emergency	We will admit, transfer or discharge patients attending A&E within 4 hours of their arrival in line with trajectories	95%
Accident and Emergency	We will reduce the number of A&E patients spending >12 hours from decision to admit to admission to zero	0
Bed management	We will reduce the percentage of patients with length of stay over 7 days and 21 days as a percentage of occupied beds in line with national planning assumptions	A reduction of 50% from baseline (for 21 days)
Bed management	We will maintain the average number of delayed beds in the month as a percentage of occupied beds in line with national planning assumptions	3.5% of beds
Bed management	We will discharge at least 33% of our patients on relevant pathways before noon	33%
Diagnostics	We will maintain performance of less than 1% of patients waiting over 6 weeks for a diagnostic test	1%
Outpatient management	We will maintain the average waiting times for first outpatient appointment at 8 weeks or below	8 weeks or below
Outpatient management	We will reduce the proportion of patients who do not attend outpatient appointments to 10%	10%
Outpatient management	We will reduce the proportion of outpatient clinics cancelled by the trust with less than 6 weeks' notice to 7.5% or lower	7.50%
Outpatient management	We will ensure 95% of outpatient appointments are made within 5 working days of receipt of referral	95%
Complaints management	We will maintain numbers of PALS concerns at less than 250 per month	Less than 250 per month

Complaints management	We will maintain the numbers of formal complaints at less than 90 per month	Less than 90 per month
Complaints management	We will ensure that we respond to complaints within an average of 40 days	40 days
Complaints management	We will ensure that at least 70% of complainants are satisfied with the overall handling of their complaint	70%
Patient transport	We will improve pick up times for patients using our non-emergency patient transport service	Collection within 60 minutes: 97% Collection within 150 minutes: 100%
Patient transport	We will improve drop off times for patients using our non-emergency patient transport service	No longer than 60 minutes 0-5 miles: 95% 5-10 miles: 85%
Data quality	We will improve data quality by reducing diagnostic and surgical orders waiting to be processed on our system in line with trajectories	0
Data quality	We will improve data quality by reducing outpatient appointments not checked-in on our system in line with trajectories	0





# RESPONSIVE

## Aim

**Responsive:** Services meet people's needs

## Primary drivers

1. Care and treatments are designed to meet individual patient needs

2. Promote equality and equity in access to our services

3. Patients have timely access to our services

4. Listen to and act on feedback from patients and the public

## Secondary drivers

Have accurate and clear information covering patients' past and present condition/ Improve the availability, quality and sharing of medical records in line with guidelines

Patients are able to access and control their information

Patients (with long term conditions) have and are support to design their own care plans

Patients, families and carers are at the centre of decision-making about their care

Develop proactive relationships with healthcare professionals in primary, community and mental health settings.

Make adjustments to care to take account of age, disability, gender, gender identity, race, religion or belief and sexuality

Improve transport services to and from hospital

Support physical and mental health in a more integrated way

Understand care needs for specific patients groups

Patients have access to timely planned care (from pre-referral advice and outpatients, to diagnostics to patient admissions)

Patients have access to timely acute, emergency and urgent care

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

# WELL LED

**Aim/CQC definition:**

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

Area	Description	Target
Workforce and people	We will have a voluntary staff turnover rate of 12% or less	12%
Workforce and people	We will have a general staff retention rate of 80% or more	80%
Workforce and people	We will maintain our sickness absence rate at below 3%	3%
Workforce and people	We will achieve a performance development review rate of 95%	95%
Workforce and people	We will achieve a non-training grade doctor appraisal rate of 95%	95%
Workforce and people	We will have a consultant job planning completion rate of 95% or more	95%
NHSI segmentation	We will maintain or improve NHSI provider segmentation	3





# WELL LED

**Goal**

**Safe:** 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.

**Primary drivers**

1. Build improvement capacity and capability at all levels

2. Recruit, develop and retain a highly motivated and expert workforce

3. Become a learning organisation

4. Develop strategic and operational plans to meet current and future needs of our population

**Secondary drivers**

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

Effective recruitment, attraction and onboarding strategies are in place

Prioritise professional development opportunities and networks

Focus on talent management

Ensure effective staffing levels and working patterns are in place

Prioritise staff mental and physical wellbeing

Promote equality and diversity

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

Develop strategies with our partners in north west London to improve the health of our communities

Ensure our estates are fit for purpose

Emergency preparedness plans

# Statements of assurance from the Trust board

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

## A review of our services

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

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

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

## Participation in clinical audits and national confidential enquiries

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

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

During 2017/18, 41 national clinical audits and three national confidential enquiries covered NHS services that Imperial

College Healthcare NHS Trust provides. During that period Imperial College Healthcare NHS Trust participated in 98 per cent national clinical audits and 100 per cent national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

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

National Clinical Audit and Clinical Outcome Review	Host Organisation	Eligible	Participated	% Submitted
Acute Coronary Syndrome or Acute Myocardial	National Institute for Cardiovascular Outcomes	✓	✓	Ongoing data collection
Adult Cardiac Surgery	National Institute of Cardiovascular Outcomes	✓	✓	Ongoing data collection
BAUS Urology Audits: Percutaneous nephrolithotomy	British Association of Urological Surgeons	✓	✓	N/A
Bowel Cancer (NBOCAP)	Royal College of Surgeons of England	✓	✓	100%
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	✓	✓	N/A
Case Mix Programme (CMP)	Intensive Care National Audit Research Centre (ICNARC)	✓	✓	Ongoing data collection
Child Health Clinical Outcome Review Programme	The National Confidential Enquiry into Patient Death	✓	✓	N/A
Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research (NICOR)	X	X	Service decommissioned
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research (NICOR)	✓	✓	100%
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health	✓	✓	100%
Elective Surgery (National PROMs Programme)	NHS Digital	✓	✓	Ongoing data collection
Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons	✓	✓	N/A
Falls and Fragility Fractures Audit programme (FFFAP)	Royal College of Physicians	✓	✓	Ongoing data collection
Fractured Neck of Femur	Royal College of Emergency Medicine	✓	✓	Ongoing data collection
Head and Neck Cancer Audit (HANA) (TBC) Foundation	Saving Faces – The Facial Surgery Research	✓	✓	Ongoing data collection
Inflammatory Bowel Disease (IBD) programme	Inflammatory Bowel Disease Registry	✓	X	Did not participate
Learning Disability Mortality Review Programme (LeDeR)	University of Bristol	✓	✓	N/A
Major Trauma Audit	The Trauma Audit & Research Network (TARN)	✓	✓	97.2%
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-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
National Audit of Breast Cancer in Older Patients (NABCOP)	Clinical Effectiveness Unit, The Royal College of Surgeons of England	✓	✓	N/A
National Audit of Dementia	Royal College of Psychiatrists	✓	✓	100%
National Bariatric Surgery Registry (NBSR)	British Obesity and Metabolic Surgery Society (BOMSS)	✓	✓	N/A
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre (ICNARC)	✓	✓	100%
National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	Royal College of Physicians	✓	✓	N/A



National Clinical Audit and Clinical Outcome Review	Host Organisation	Eligible	Participated	% Submitted
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	London North West Healthcare NHS Trust	✓	✓	N/A
National Comparative Audit of Blood Transfusion programme	NHS Blood and Transplant	✓	✓	100%
National Diabetes Audit – Adults	NHS Digital	✓	✓	100%
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	✓	✓	Request for data only
National End of Life care audit	TBC – to be commissioned by HQIP in 2017	✓	✓	Ongoing data collection
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR)	✓	✓	N/A
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership	✓	✓	Ongoing data collection
National Lung Cancer Audit (NLCA)	Royal College of Physicians	✓	✓	91%
National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	✓	✓	100%
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Royal College of Paediatrics and Child Health	✓	✓	100%
National Ophthalmology Audit	Royal College of Ophthalmologists	✓	X	Did not participate
Paediatric Intensive Care (PICANet)	University of Leeds	✓	✓	100%
Pain in Children	Royal College of Emergency Medicine	✓	✓	N/A
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists	N/A	N/A	N/A
Procedural Sedation in Adults (care in emergency departments)	Royal College of Emergency Medicine	✓	✓	N/A
Prostate Cancer	Royal College of Surgeons of England	✓	✓	100%
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians	✓	✓	100%
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Serious Hazards of Transfusion	✓	✓	100%
UK Parkinson's Audit	Parkinson's UK	✓	✓	N/A



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

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

## Participation in clinical research

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

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

to more successful patient outcomes – and work closely with academic staff in Imperial College in order to translate research findings into improved treatments and diagnostics in the healthcare setting.

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

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

The number of patients receiving NHS



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

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

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

Translational research highlights:

- BRC investigators demonstrated a new class of experimental drugs which reduced hot flushes in menopausal women by almost three-quarters in just three days. The hope is that these types of compounds may provide an alternative to hormone replacement therapy (HRT), which is a risky treatment for many women due to possible side effects.
- As part of a multi-centre collaborative study, Imperial BRC researchers are developing new techniques which allow the brains of fetuses and babies to be scanned, thus helping doctors and scientists to understand how the brain grows and how problems may arise.
- The launch of 'gripAble™' as a commercial product, which aims to make the training of arm and hand functions more accessible and improve physical rehabilitation following strokes, for example

- RAPID, a one-stop-shop for men with suspected prostate cancer, is being trialled at Charing Cross Hospital, aiming to reduce diagnosis times from six weeks to just one week.
- Cardiovascular clinical academics developed a software 'learning algorithm' that can more accurately predict when the heart may stop in patients with pulmonary hypertension. In addition to accurate disease risk prediction, these artificial intelligence (AI) techniques can help clinicians tailor their treatments to better suit individual patients, without the need for invasive procedures.
- A joint initiative between the Trust and Imperial College academics, funded by NIHR infrastructure, analysed group B streptococcus infections in neonates, providing new understanding more about how such infections may be transmitted in a hospital setting.

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

## Our CQUIN performance – CQUIN framework

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

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

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

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

NHSE 2017-19 CQUIN schemes	Description of scheme	Full year Plan value £	Achieved % (Q1 – Q3)
<b>BI1</b> HCV Improving Treatment Pathways through ODNs	The Trust is an HCV ODN lead provider. The CQUIN requires prioritisation of patients with highest clinical need and supports the sustainability of treatment. The outcomes anticipated from this CQUIN are: <ul style="list-style-type: none"> <li>• improvement in patient engagement</li> <li>• the planned roll-out, of new clinical treatment guidance to improve outcomes through multi-disciplinary team treatment plans</li> <li>• Improved participation in clinical trials</li> <li>• Enhanced data collection to demonstrate the effectiveness and equity of this way of working and the availability of new treatments.</li> </ul>	£3,357,631	Q1 – 100% Q2 – 100% Q3 – 100%
<b>GE3</b> Hospital Medicines Optimisation	This CQUIN is to support trusts and commissioners to realise agreed targets and metrics that will unify hospital pharmacy transformation programme (HPTP) plans and commissioning intentions. This CQUIN also includes year 2 of the antiretroviral drug switches scheme. The outcomes anticipated are: <ul style="list-style-type: none"> <li>• 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</li> <li>• improved drugs data quality in the drugs MDS and outcome registries as well as to meet the requirements of the ePharmacy and Define agendas</li> <li>• the consistent application of lowest cost dispensing channels</li> <li>• compliance with policy/ consensus guidelines to reduce variation and waste.</li> </ul>	£1,017,464	Q1 – 100% Q2 – 95% Q3 – 95%
<b>IM4</b> Complex Device Optimisation	Clinical decision making around device selection varies between implanting units. This scheme seeks to ensure that device selection remains consistent with the commissioning policy, service specification, and relevant NICE guidance while new national procurement and supply chain arrangements are embedded. The outcomes anticipated are: <ul style="list-style-type: none"> <li>• enhancement and maintenance of local governance systems to ensure compliance</li> <li>• development of sub-regional network policies to encourage best practice including minimum standards for patient consent to ensure optimal device selection</li> <li>• to improve timely access to all patients</li> <li>• to ensure that referral pathways and robust MDT decision making processes are developed for appropriate cases.</li> </ul>	£223,842	Q1 – 100% Q2 – 100% Q3 – 100%
<b>CA2</b> Nationally Standardised Dose Banding Adult Intravenous SACT	This CQUIN is to incentivise the standardisation of doses of SACT in all chemotherapy units. The outcomes anticipated are: <ul style="list-style-type: none"> <li>• have the principles of dose banding accepted by local teams</li> <li>• have the drugs and doses approved by local formulary committees</li> <li>• have SACT prescribed in accordance with the doses of drugs listed in the national dose-banding tables</li> <li>• agreement and adoption of standardised product definitions.</li> </ul>	£203,493	Q1 – 100% Q2 – 100% Q3 – 100%
<b>WC5</b> Neonatal Community Outreach	To improve community support and to take other steps to expedite discharge, pre-empt re-admissions, and otherwise improve care such as to reduce demand for critical care beds and to enable reduction in occupancy levels. Babies receiving specialist neonatal care would have their health and social care plans coordinated to help ensure a safe and effective transition from hospital to community care.	£284,890	Deliverables not due until Q4



NHSE 2017-19 CQUIN schemes	Description of scheme	Full year Plan value £	Achieved % (Q1 – Q3)
WC4 Paediatric Networked Care	<p>This scheme aligns to the national PIC service review and aims to gather information which allows the demand across the whole paediatric critical care pathway to be considered. PICUs will be asked to review the delivery of activity undertaken by the acute hospitals in their usual catchment that trigger the Paediatric Critical Care Minimum Data Set.</p> <p>The outcomes anticipated are:</p> <ul style="list-style-type: none"> <li>• work with local acute hospitals to collate data over a six month period in 2017</li> <li>• provide a summary report by February 2018</li> <li>• oversee the review of each of the referring acute hospitals in their usual catchment against the Paediatric Intensive Care (PICS) standards</li> </ul>	£203,493	Deliverables not due until Q4
STP Renal	<p>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:</p> <ul style="list-style-type: none"> <li>• to support patients to be more pro-active in the management of their care through the use of self-management tools.</li> <li>• to support the management of renal patients across the whole pathway by supporting primary care and providing rapid assessment and diagnosis.</li> <li>• to increase home dialysis uptake</li> <li>• increase rate of haemodialysis with AV Fistulas</li> <li>• to improve rates of pre-emptive transplantation as a therapy of choice for those suitable with chronic kidney failure.</li> </ul>	£406,986	Q1 – 95% Q2 – 95% Q3 – 95%

In addition to these national schemes, we also agreed with our local north west London commissioners to work to all best endeavours to achieve nationally set CCG CQUINs. This agreement was made on the basis of

achieving sector wide control totals while still demonstrating substantial quality outcomes within these areas. The value of the schemes would normally amount to 2.5 per cent of the contract value, though in meeting the

financial obligations of the local health economy this was reduced to 1.7 per cent; equating to £6.71m of our planned CQUIN income from north west London CCGs. A brief summary of what we achieved in 2017/18 is as follows:

CQUIN scheme	Description of scheme	Achievements
1. Improving staff health and wellbeing	Improvement of health and wellbeing of NHS staff, health food for NHS staff, visitors and patients, and improving the uptake of flu vaccinations for front line staff	<p>The overall staff FFT engagement score increased from 77 per cent in 2016 to 80 per cent in 2017. 86 per cent of staff recommend the Trust as a place for care or treatment, and 72 per cent recommend the Trust as a place to work. This is the highest performance to date in the last three years. Attendees at our Schwartz Rounds increased dramatically in 2017, and it gives our staff to opportunity to share personal reactions to clinical cases, allowing staff to reflect on and connect with stories.</p> <p>The final submission has been made to NHS England showed that 60.5 per cent of our HCWs were vaccinated against flu in 2017/18. This is a significant 39.9 per cent increase in uptake compared to 2016/17.</p> <p>By the end of 2018 we have also agreed to better promote healthy eating and drinking at our on site retail outlets by removing price promotions and advertising of all sugary drinks and food high in fat, salt and sugar, as well as removing them from checkouts.</p>

CQUIN scheme	Description of scheme	Achievements
2. Reducing the impact of serious infections	<p>Timely identification and treatment for sepsis in emergency departments and acute inpatient settings</p> <p>Reduce antibiotic consumption and improve antibiotic review</p>	<p>We introduced a Cerner sepsis alert designed to help identify adult patients who are at high risk of sepsis. The alert is based on a similar algorithm to the NICE guideline and has been validated in a number of hospitals across the US and UK and pulls in data from various sources including patient biochemistry and observations to identify patients who are at risk and require urgent clinical review. The number of sepsis alerts increased over the winter period, conversely confirmed cases decreased. 50 per cent of patients with a sepsis alert in our EDs and acute inpatient wards received antibiotics within one hour. As part of the flow programme, the Trust has developed a weekly sepsis 'big room' which allows us to design, test and implement changes across the Trust to improve identification and treatment of sepsis.</p> <p>The latest bi-annual antibiotic point prevalence survey has found that all indicators of antibiotic prescribing quality are in excess of the target level of 90 per cent. Overall there has been a one per cent decrease in the antibiotic consumption from 2016/17 to 2017/18.</p>
4. Improving services for people with mental health needs who present to A&E	Identify cohort of frequent A&E attenders that could benefit from input from specialist mental health staff, sharing data with key system partners, and work to reduce attendances	Reviews of frequent attending mental health patients arriving in our EDs at the St Mary's and Charing Cross hospitals are conducted on a monthly basis. The Trust's frequent attender service seeks to identify and support repeated users of UEC services. To reduce attendances to ED and subsequent hospital admission we work intensively with these patients. The service has undertaken collaborative working with a core cohort of 15 patients on each site. This involves bespoke MDT case working providing up to six 1:1 sessions and developing long term clinical relationships with the patients. We have introduced an escalation process with our partners at CNWL for both in and out of hours. The CNWL CRHT (crisis team) model of care review has proposed to stop duplication of LPS assessments for those cases referred for community follow up.
6. Advice and guidance	Provide good quality A&G services to GP practices	The Trust maintains its GP advice service for 19 specialties, all of which are easily located on the Trust's website. The e-mail addresses are manned by clinical leads who aim to respond to queries within 24 hours. Phone lines also exist for elderly medicine, maternity, microbiology, ophthalmology, paediatrics, pathology, and stroke and neurosciences. As part of our joint outpatient transformation programme we hold with commissioners, we have agreed on a model where there are templates for referral, smart information and guides for GPs.
7. E-referrals	Primary care referrals to outpatient First attendance to be received through e-RS	e-RS Steering Group formed with local commissioners, RFSSs, and GP colleagues to increase the number of primary care referrals received via e-RS; dedicated project team established to map all specialties and sub-specialties to the DoS and upload to e-RS. Training and presentations have been given in practices and GP members forums. We anticipate achieving paper switch-off by 1 August 2018, in advance of the 1 October 2018 deadline.
8. Supporting proactive and safe discharge	Map existing discharge pathways and produce credible plan to achieve submission of the Emergency Care Dataset	The Trust meets with our partners Vocare, CNWL, WLMH, LAS, 111, and other commissioned services such as Home First Rapid Response and CIS on a monthly basis as an escalation point for bottlenecks to be resolved. Mapped discharge pathways have been developed jointly with CCGs to improve inpatient bed flow. We have developed a standardised operating procedure to accurately report DToCs. The plan to implement ECDS was produced earlier in the financial year. The SAFER patient flow bundle has also been introduced to facilitate a reduction in length of stay and improve patient flow and safety from admission to discharge.

## Care Quality Commission registration status

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. It makes sure health and social care services provide people with safe, effective, caring,

well-led and responsive care that meet fundamental standards.

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

The CQC has taken enforcement action against Imperial College Healthcare

NHS Trust during 2017/18. This was in the form of requirement notices, which relate to regulatory breaches identified during inspections carried out in 2016/17 and 2017/18, and were set during 2017/18. Summary of findings and actions being taken in response are summarised below.

CQC requirement notice	Summary of related findings	Summary of action being taken
<b>Regulation 12:</b> Safe care and treatment	Medicines management policies were not always being adhered to in: <ul style="list-style-type: none"> <li>maternity at St Mary's Hospital</li> <li>medical care at St Mary's, Charing Cross and Hammersmith hospitals</li> <li>urgent and emergency services at Charing Cross Hospital.</li> </ul>	Changes were made to the Trust's medicines management quality improvement programme, including a shift to focusing on human factors in why medicines policies/procedures are not followed in practice
	Statutory and mandatory training was not always completed as required, with completion rates below the Trust target: <ul style="list-style-type: none"> <li>in maternity at St Mary's Hospital</li> <li>in medical care at St Mary's, Charing Cross and Hammersmith hospitals</li> <li>among medical staff in surgery at St Mary's Hospital.</li> </ul>	<ul style="list-style-type: none"> <li>Introduction of a core skills group to oversee Trust-wide improvement activities</li> <li>Development of a Trust-level business case to improve the IT systems used for recording completion of training</li> <li>Additional actions were taken in maternity, specifically in relation to CTG training</li> </ul>
	Airway and emergency trolleys were not always appropriately checked in urgent and emergency services at Charing Cross Hospital	<ul style="list-style-type: none"> <li>All trolleys now have checklists attached for daily completion</li> <li>Completion of checklists is audited weekly</li> </ul>
	Clinical and hazardous waste management guidelines were not always adhered to in surgery at St Mary's Hospital	Training is being delivered to staff to alert them to finding and improve awareness of the guidelines/requirements
	Daily cleaning requirements were not always being completed and checks were not being undertaken to identify this in surgery at St Mary's Hospital	<ul style="list-style-type: none"> <li>Documented cleaning schedules are now in place</li> <li>Weekly cleaning audits will be jointly carried out by the Trust's cleaning team and theatre staff (these are currently carried out by the cleaning team only), monitored by the theatre manager</li> <li>Completion and outcomes of audits will continue to be monitored at monthly meetings with the Trust's cleaning subcontractor, and will be reported by exception to the Trust's cleaning sub-group</li> </ul>
	Deep cleaning of theatres were not taking place in line with Trust policy in surgery at St Mary's Hospital	<ul style="list-style-type: none"> <li>A deep cleaning schedule was in place at the time of the inspection; action is being taken to ensure the schedule is communicated to all relevant staff</li> <li>Completion of deep cleans and outcomes of cleaning audits will continue to be monitored at monthly meetings with the Trust's cleaning subcontractor</li> </ul>
	The poor state of repair of seven theatres is reflected in an infection control risk in surgery at St Mary's Hospital	The scope of theatre refurbishment has been agreed and works will be undertaken between April and December 2018, one theatre at a time.
<b>Regulation 15:</b> Premises and equipment	Portable equipment (medical devices) did not always having safety tests and planned preventative maintenance completed when these are due, in urgent and emergency services at St Mary's and Charing Cross hospitals	The Trust has a planned preventative maintenance programme in place which is overseen by the medical devices and management group, Chaired by the associate medical director. Following the CQC's findings the timeframe for the current year's programme was accelerated.

CQC requirement notice	Summary of related findings	Summary of action being taken
<b>Regulation 17:</b> Good governance	Performance was not always monitored against agreed standards in urgent and emergency services at St Mary's Hospital	The inspection findings are being taken account of as part of the Trust's annual review of the performance framework and related governance arrangements

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

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

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

## Our data quality

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

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

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

An executive-led data quality steering group is in place and meets every month. It provides leadership and oversight of the development and delivery of all aspects of our data quality framework.

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

## NHS number and general medical practice code validity

The Trust submitted records during 2017/18 to the Secondary Users Service for inclusion in the Hospital Episode Statistics (see glossary on page 119 for definitions) which are included in the latest published data. The percentage of records in the published data to month nine 2017/18 (most recent available) which included the patient's valid NHS number was:

- 97 per cent for admitted patient care
- 98 per cent for outpatient care

- 91 per cent for accident and emergency care.

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

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

## Information governance toolkit scoring

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

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

## Clinical coding quality

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



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

## National Outcomes Framework Indicators 2016/17

The NHS Outcomes Framework 2017/18 sets out high level national outcomes which the NHS should be aiming to improve. For full information about our performance, please see pages 96-99.

# A review of our quality progress 2017/18

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

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

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





# 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.

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

## Safety culture programme

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

The programme has been designed using intelligence from research and learning including from our staff informally through workshops and formally through the staff survey and the safety attitudes questionnaire which

was used in 2016 as well as through analysis of incidents. A number of pieces of work were planned this year and our progress is described.

## Incident reporting improvement work-stream

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

- simplified the Datix reporting fields to minimise the time taken to complete
- launched a range of communication tools to widen the learning for key safety improvement messages including a monthly safety briefing
- supported a number of areas with low reporting rates to understand the barriers and explore their local “trigger lists” which should be reported
- amended the incident management workflow to provide more timely feedback to reporters by removing an unnecessary management approval step
- introduced anonymous reporting
- developing an app based reporting

Incident reporting rate



tool with the Patient Safety Translational Research Centre (see glossary on page 120) with a pilot planned in the coming months.

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

## Serious incident improvement programme

A serious incident (SI) was declared in May 2016 following the death of a baby at St Mary's Hospital. An internal review and an external review by the Royal College of Obstetricians and Gynaecologists were commissioned which took place in March and April 2017. A number of the recommendations from these reviews helped inform our serious incident improvement programme and we have worked hard this year to improve the quality of our serious incident investigations. An end to end review of our processes revealed many areas for improvement including candour, compliance with the national framework, education and training, support for staff and patients/families when things go wrong. A number of tests of change have already completed including changes to the management of Duty of Candour, new report templates and the introduction of new training for those involved in investigating and assurance.

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

## Duty of Candour

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

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

## Safety improvement programmes

### Sepsis

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

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

## Safety streams

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

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



Safety stream	Rationale	Progress to date	Key areas for improvement
 <b>Abnormal results</b>	<p>The Trust previously reported a number of serious incidents which related to the management of abnormal results. Immediate action was taken in response to these serious incidents including escalation of unsuspected abnormal results to the clinician and to the appropriate multidisciplinary team; however it was recognised that the issue of endorsement of results was a key risk area.</p>	<ul style="list-style-type: none"> <li>• A large amount of background work has been undertaken to understand the difficulties and variations in practice.</li> <li>• Engagement of the Information Governance team to provide data from the electronic patient record to identify clinical teams who perform endorsement well.</li> <li>• An evidence scan and investigation into other trusts process and procedures.</li> <li>• Abnormal ranges of results agreed which once implemented into the electronic patient record will lead to all normal results being automatically endorsed.</li> <li>• A Standard Operating Procedure has been agreed by the Trust.</li> </ul>	<p>The key priority is to start working with teams to support change and ensure sustainability; Once teams with most variation identified engagement will begin to understand problems, barriers and key tests of change.</p> <p>A pilot with the division of medicine to understand and develop a process to support junior doctor rotations.</p> <p>Building capability and providing staff with training to support the information technology process and understand the importance of endorsement from a safety perspective.</p> <p>Our potential measures include:</p> <ul style="list-style-type: none"> <li>• increase in endorsement of results</li> <li>• reduction in incidents</li> <li>• potential reduction delays in activation of treatment</li> <li>• potential reduction in length of stay.</li> </ul>
 <b>Falls</b>	<p>National Institute of Clinical Excellence (NICE) updated existing guidance on falls prevention in 2013. This emphasised the prevention of falls in hospital and highlighted that all patients aged 65 or older and those judged by a clinician to be at higher risk of falling because of an underlying condition are regarded as being at risk of falling and that their care be managed according to a number of evidence based recommendations.</p> <p>The aim of the safety stream is to support patients to mobilise safely and to reduce the rate of inpatient falls with harm.</p>	<ul style="list-style-type: none"> <li>• Policy refresh.</li> <li>• Quality sprint.</li> <li>• Embedding falls assessment and care plans in the electronic patient record (EPR).</li> <li>• Staff engagement in identifying falls as a trigger for incident reporting.</li> <li>• Undertaking the national Royal College of Physicians (RCP) audit in 2017.</li> <li>• Local divisional action plans agreed, the delivery of which will be supported by the improvement team.</li> </ul>	<p>To support this programme of work across the Trust, we have engaged with the divisions to identify six wards to pilot a six month programme of work to support staff to drive small tests of change.</p> <p>This will comprise of improvement training to build capability and provide facilitation in practice to understand tests of change utilising measurement for improvement.</p> <p>Our measures will focus around compliance of the three key areas of the RCP data including:</p> <ul style="list-style-type: none"> <li>• lying and standing blood pressure</li> <li>• assessment of medications that increase fall risk</li> <li>• objective assessment of vision.</li> </ul> <p>And also</p> <ul style="list-style-type: none"> <li>• staff and patient experience</li> <li>• reduction in falls with harm</li> <li>• continued and potential increase of falls reporting.</li> </ul>
 <b>Fetal monitoring</b>	<p>This safety stream aims to reduce the number of fetal monitoring related incidents resulting in clinical harm and litigation. The stream intends to reduce the risk of incidents through improved training and improved clinical performance.</p>	<p>A central monitoring IT system, 'Fetal Link', and the day-to-day use and training for it has been delivered (e.g. induction training, multidisciplinary team meetings). The 'Fetal Link' system provides a mechanism to monitor key clinical metrics (including fetal heart rate or cardiotocography) and escalate any issues quickly.</p>	<p>Our measures include:</p> <ul style="list-style-type: none"> <li>• reduction in intrapartum still births or neonatal intensive care (NICU) admissions relating directly to CTG interpretation</li> <li>• reduction in incidents, complaints and claims relating to CTG</li> <li>• CTG used in all appropriate cases</li> <li>• intermittent fetal monitoring done as per protocol</li> <li>• converted to CTG from intermittent fetal monitoring at the correct point and in a reasonable time</li> <li>• unexpected neonatal admissions to NICU due to CTG concerns</li> <li>• time between classification of CTG as pathological to definitive action taken.</li> </ul> <p>We are investigating the use of a dashboard to monitor fetal monitoring outcomes and process.</p>
 <b>Hand hygiene</b>	<p>Our hands are the principle route by which cross-infection happens, and hand hygiene is the single most important factor in the control of infection. The aim of this safety stream is to improve adherence to recommended hand hygiene procedures realised through a strong communication and education campaign and a new audit process that promotes awareness and supports bespoke ward level engagement and improvements.</p>	<ul style="list-style-type: none"> <li>• A steering group has been formed.</li> <li>• Initial 'five moments' (hand washing technique – see glossary on page 119) audit tested and rolled out.</li> <li>• Baseline audit data collected.</li> <li>• Ward champions identified and test wards identified to pilot new approach.</li> <li>• Communications plan developed.</li> <li>• Establish a hand hygiene awareness week identified and follow up launch activities in planning stages.</li> <li>• Hand hygiene champions to attend an improvement sprint.</li> </ul>	<ul style="list-style-type: none"> <li>• Audit redevelopment to be launched in April 2018</li> <li>• Hand hygiene communication campaign and key messaging</li> <li>• Development of education packages/bundles to roll out with new audit</li> <li>• Hand hygiene week</li> <li>• Ensuring robust hand hygiene stock management and consumables in place</li> </ul> <p>Our measures include the number of ward champions, improvements as a result of audit, engagement with staff and quantity of consumables used.</p>

 <b>Patient identification</b>	<p>Ensuring that patients are correctly identified every time care or treatment is given including where samples are taken and processed is central to the safe delivery of care.</p>	<p>A steering group to address positive patient confirmation within the Trust has been established and a new policy is due to be published in June 2018.</p> <p>A draft policy has been written and is currently out for consultation. We hope to launch the policy in May 2018.</p> <p>Regular reporting of patient identification errors within the Trust has been established for the group, to assist in identifying themes and clinical areas requiring improvement support.</p>	<p>Pilot an innovative new way to launch policies in the Trust to ensure staff understand their responsibilities with regards to positive patient identification.</p> <p>Thematic analysis of patient identification errors has highlighted areas of practice with the higher levels of patient identification errors. These relate to:</p> <ol style="list-style-type: none"> <li>1. pathology including blood gases and wrong blood in tube</li> <li>2. major trauma pathways</li> <li>3. imaging and interventional radiology IR(ME)R (see glossary on page 119) incident reporting.</li> </ol> <p>Pilot projects to reduce reported patient identification errors have been planned for these areas, each with bespoke measures.</p>
 <b>Pressure ulcer</b>	<p>Pressure ulcers cause pain, discomfort and distress to patients and can delay recovery and discharge from hospital. Whilst many patients are at risk of pressure ulcers they remain largely avoidable; therefore pressure ulcer prevention remains a key patient safety priority for the Trust.</p>	<p>Patients in the intensive care at the highest risk of pressure ulcers due to the complex nature of their underlying condition. Implementing a care bundle based on evidence based practice standards has delivered a reduction in pressure ulcers – particularly the most severe grade of pressure damage -in this group of patients.</p> <p>We have not reported a Trust acquired category 4 (the most severe pressure damage) since March 2014.</p>	<p>We will continue to measure rates of pressure ulcers by grade, and also monitor which clinical areas have the highest incidence of pressure ulcers in order to target improvement work.</p> <p>Actions we are currently undertaking:</p> <ul style="list-style-type: none"> <li>• a nominated champion in each clinical area disseminating education from the in-house tissue viability study days</li> <li>• exploring the data into device related pressure damage</li> <li>• further work in our intensive care areas to look at pressure damage to the ears</li> <li>• review of the mattress contract and piloting of a new hybrid mattress in high risk areas</li> <li>• communications campaign to improve the use of the pressure ulcer prevention app</li> <li>• a regular newsletter.</li> </ul>
 <b>Deteriorating patient</b>	<p>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.</p>	<ul style="list-style-type: none"> <li>• A large amount of diagnostic work was completed to identify key issues.</li> <li>• A steering group with consistent membership from all clinical divisions has been established.</li> <li>• Relational communication workshops engaging frontline staff tell us what works and co-design resources that encourage good escalation conversations.</li> <li>• Undertaking of Adult Inpatient National Warning Score Audit across all inpatient beds with paediatrics and private patients on-going.</li> <li>• Piloting data collection reporting at safety briefings in a small number of clinical areas to identify and increase awareness at local level.</li> <li>• Engagement with close partners to improve surveillance using national tools e.g. National Early Warning Score 2 (NEWS 2), alerts on the electronic patient record (EPR).</li> </ul>	<p>Actions which we are currently looking to improve:</p> <ul style="list-style-type: none"> <li>• continue to test and spread the communication tools once developed from the relational workshops to other areas</li> <li>• resolve electronic patient record documentation variation of the Trust escalation tool (SBAR), NEWS (see glossary on page 121) totals and adjusted parameter values</li> <li>• develop an implementation plan for NEWS 2</li> <li>• continue to test and spread the data collection charts to improve observation compliance and awareness of deterioration risk</li> <li>• develop a deteriorating patient guideline and appropriate monitoring strategy, which will include defining our measures</li> <li>• include sepsis management with the roll out of the electronic alert and improved time to antibiotics.</li> </ul> <p>We are working with the PSTRC who have a dedicated research theme on deteriorating patients.</p>
 <b>Safer medicines</b>	<p>Our own audits and the Care Quality Commission have identified the need to improve our medicines management processes. There is variation in practice across wards and sites, often driven by our complex estate.</p>	<p>We have focused on four key topics to date (storage, security and disposal of medicines) and held five engagement events with staff (32 in total from nursing, pharmacy and estates) to understand the issues staff face in undertaking best practice, and their ideas for improvement.</p>	<p>Our focus is on pulling out the key messages from policies and making these messages easy to follow and available at the point of need. This will be a co-designed process with staff to ensure any products are fit for purpose Also establishing the staff roles and responsibilities to enable and empower staff to do the right thing.</p> <p>A communication strategy is being developed.</p> <p>Our measures will include monitoring our existing audits of compliance with policy and practice.</p>
 <b>Safer surgery</b>	<p>Following a series of surgical 'never events' we aim to create a culture of safety in our theatres and areas where we carry out invasive procedures to reduce avoidable harm and improve performance and outcomes.</p> <p>We are doing this by seeking to improve the use of the five steps to safer surgery which has been evidenced to improve teamwork, communication and safety.</p>	<p>Work has focused on strengthening the framework for the practice of safe surgery in the Trust, including:</p> <ul style="list-style-type: none"> <li>• review of policies to align them with national standards</li> <li>• review of all interventional checklists</li> <li>• commencing 'no brief, no start' in operating theatres across the Trust</li> <li>• establishing an annual trust wide audit and divisional monthly audit programme, supported by divisional action plans to provide assurance</li> <li>• strengthening education and training (including mandatory module)</li> <li>• interviews with staff to understand cultural barriers in theatres.</li> </ul> <p>Significant progress has been made with no surgical 'never events' declared since November 2016.</p>	<p>Work to date has focused on setting clear expectations. Key areas for improvement moving forward are reviewing our measurement strategy to focus on the quality of the checks rather than the ticking of the boxes. Observational measurement has begun, and the plan is to accompany this with peer to peer feedback and coaching in situ, focusing on good practice as well as areas for improvement. Sharing stories will form a large part of the work moving forward to share learning and improve culture.</p> <p>Our measures will include monitoring for an improvement in our existing audits of compliance with the checklist.</p>



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

Goal/target	National target / national average	Performance in 16/17	Target for 17/18	Outcome in 17/18	Target achieved?
To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing severe/major harm	0.28% (Apr 17 – Sept 17)	0.1% (7 incidents) (April-Sept 16)	Below national average	0.07% (14 incidents)	Yes
To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing extreme harm/death	0.11% (Apr 17 – Sept 17)	0.0% (2 incidents) (April-Sept 16)	Below national average	0.08% (13 incidents)	Yes
We will maintain our incident reporting numbers and be within the top quartile of trusts	41.68 (Apr 17 – Sept 17)	42.3 (April-Sept 2016 as published by NRLS) 44.85 (full year)	Over 46.76	48.97 (Apr 17 – Sept 17)	Yes
We will have zero never events	0 never events	4 never events	0 never events	1 never event	No
We will promote safer surgery by ensuring 100 per cent compliance with all elements of the WHO checklist in all relevant areas	N/A	Element 1: 100% Element 2: 100% Element 3: 100% Element 4: 100% Element 5: 92%	100% compliance	Briefing: 100% Sign in: 97% Time out: 98% Sign out: 96% Debrief: 100%	No
We will have no serious incidents where failure to follow the WHO checklist properly is a factor	N/A	2	0	1	No
We will have a general vacancy rate of 10 per cent or less	N/A	11.6%	10% or less	12.1%	No
We will have a vacancy rate for all nursing and midwifery staff of 12 per cent or less	N/A	19%	10% or less	14.7%	No
We will maintain the percentage of shifts meeting planned safe staffing levels at 90 per cent for registered nurses and 85 per cent for care staff	90% for registered nurses 85% for care staff	97% for registered nurses 95% for care staff	90% for registered nurses 85% for care staff	97% for registered nurses/midwives 95% for care staff	Yes
We will ensure we have no avoidable MRSA BSIs and cases of <i>C. difficile</i> attributed to lapse in care	N/A	12 (3 MRSA BSIs, 9 <i>C. difficile</i> lapses in care)	0 avoidable infections	10 (3 MRSA BSI, 7 <i>C. difficile</i> lapses in care)	No
We will maintain 90 per cent for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams	N/A	89%	At least 90%	91.5%	Yes
We will reduce avoidable category 3 and 4 Trust-acquired pressure ulcers by at least 10 per cent	N/A	27	Less than 24 (at least 10% reduction)	17	Yes

Goal/target	National target / national average	Performance in 16/17	Target for 17/18	Outcome in 17/18	Target achieved?
We will assess at least 95 per cent of all patients for risk of venous thromboembolism (VTE), complete root cause analysis (RCAs) for all potentially avoidable Trust acquired cases within the agreed timeframe and prevent avoidable death as a consequence	over 95%	95.33%  0 avoidable deaths	over 95%  0 avoidable deaths	Q1: 92.71% Q2: 91.63% Q3: 95.53% Q4: 95.64%  93.87% (full year data) 0 Trust acquired avoidable deaths	No  Yes
We will ensure that we comply with Duty of Candour and being open requirements for every incident graded moderate and above	N/A	New target not previously measured	Slis: 100% Other incidents: 50% by end of Q2	Slis: 98% Level 1: 89% Moderate: 79% (Apr 17-Feb18)	No

## Safe quality highlights and challenges

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

We investigate all patient safety incidents which are reported on our incident reporting system, Datix. In addition, those graded moderate and above are reviewed at a weekly panel chaired by the medical director. Incidents that are deemed to be serious (SIs) or never events undergo an investigation which involves root cause analysis (see glossary on page 120 for definitions).

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

Our HSMR and SHMI results triangulate well with our harm profile from incident reporting as both show a positive picture of outcomes for patients

in our care. More information on our HSMR and SHMI results are included on page 70.

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

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

**We reduced our never events:** Although we did not meet our target, we reported one never event this year, compared to four in 2016/17. Never events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The incident reported this year was a 'wrong route medication' incident where an epidural line was connected to a peripheral cannula. There was no clinical harm caused to the patient. Mitigation actions are in place and are being monitored through audit. A national patient safety alert has since been released outlining the actions

trusts should take to introduce connections that prevent incidents like this one. However these products are still not yet fully available. A task and finish group has been established to review the available devices and manage the roll out across the Trust.

**We reported no peri-operative never events and one SI related to WHO checklist failure:** In 2016/17 the Trust reported four never events related to practice in surgery, and two serious incidents due to a failure to follow the WHO safer surgery checklist (see glossary on page 121 for definition). Focussed improvement work commenced in 2016 under the safer surgery stream.

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

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





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

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

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

**We reported 10 avoidable infections:** In 2015 we began to report 'avoidable' infections of MRSA blood stream infections (BSI) and Clostridium difficile infections. For how we define 'avoidable infections' please see the glossary on page 118. Although we did not meet our target, we saw a decrease in avoidable infections in 2017/18, reporting 10 compared to 12 last year.

We reported the same total number of cases for both infections as we did last year.

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

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

**Supporting programme: CIP**

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

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



**Below national average for incidents causing extreme and severe harm**



**Our incident reporting rate is within the top 25% nationally**



# EFFECTIVE

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

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

## Mortality review programme

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

Cases are reviewed monthly by our mortality review group, focussing on any avoidable factors and learning themes. Early emerging themes map to our 'falls' and the 'responding to the deteriorating patient' safety streams. As more cases are reviewed the group will recommend workstreams to be considered as part of the Trust

improvement programme.

In 2018/19 we will:

- continue to train, coach and support our cadre of reviewers
- streamline the process between SJR and serious incident investigations
- implement the national recommendations on how best to engage families in SJR and how to comply with Duty of Candour
- improve learning and sharing of improvements from the reviews.

## Clinical audit programme

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

The Trust priority audit programme continues to evolve with examples of trust wide improvement being taken forward as a result which are included in appendix B. In 2018/19 it will be expanded to include an assessment of performance against the updated never

event list. We will also continue to make links between this programme and the safety improvement streams ensuring that audit is driving improvement.

## Clinical guidelines programme

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

## Quality surveillance programme

In July 2015 it was announced that the National Peer Review Programme Team would become the Quality Surveillance Team (QST). The role of the QST is to improve the quality and outcomes of clinical services by delivering a sustainable and embedded quality assurance framework for all NHS England (NHSE) specialised commissioned services and all cancer services irrespective of how they are commissioned. This is done through a programme of provider self-assessment and targeted peer review.

The annual self-assessment process was completed at the end of June by

our clinical teams. All 66 services required to self-report did so. Action plans for services which were non-compliant with the quality indicators were developed.

## Local and NICE guidance

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

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

## Getting It Right First Time (GIRFT)

Getting It Right First Time (see glossary on page 119 for definition) is a national programme designed to improve clinical care within the NHS by reducing unwarranted variations in quality, outcomes and costs. GIRFT reviews are being conducted nationally across 30 clinical specialties. GIRFT is led by frontline clinicians who are expert in the areas they are reviewing. This means the data that underpins the GIRFT methodology is being reviewed by people who understand those disciplines and manage those services on a daily basis. The GIRFT team visit every trust carrying out the specialties they are reviewing, investigating the data with their peers and discussing the individual challenges they face.

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

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

## Seven day services

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

## West London Genomic Medicine Centre

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

The project was established to sequence all the genes of patients and their families with rare diseases as well as patients with certain common cancers, with a view to sequencing 100,000 genomes by 2017. These areas were selected due to their strong link to changes in the genome with the aim to transform diagnosis and treatment for patients.

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

In October 2018 the 100,000 Genomes Project will move into routine clinical care as part of the new Genomic Medicine Service where laboratory services for genetic testing will be centralised and all DNA based testing will be centrally commissioned by NHS England.

Below are some examples of where exemplar pathways for genetic testing have been happening at Imperial College Healthcare NHS Trust.

## Rare diseases

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

## Cancers

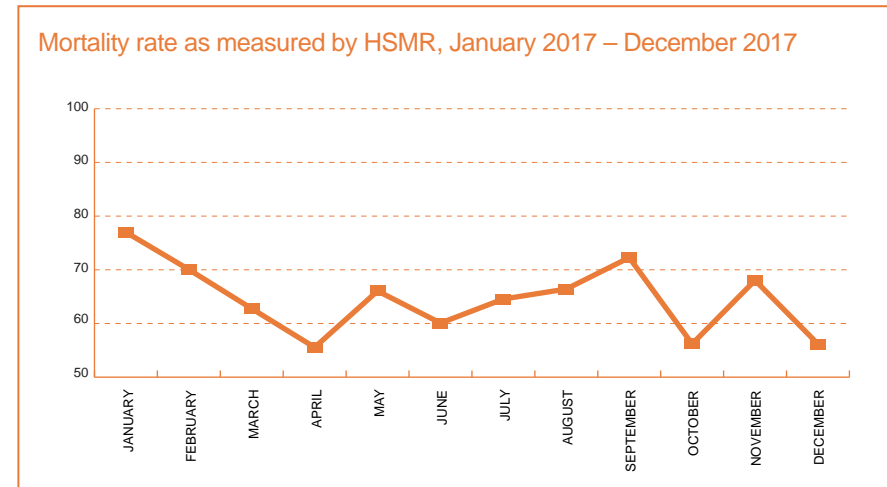
- commenced routine genetic testing for some patients in the Haematology Department at Hammersmith Hospital
- genetic testing for prostate patients at Charing Cross Hospital
- genetic testing for upper GI, colorectal, thyroid and oesophagus at St Mary's Hospital
- sequenced results for cancer are discussed at a weekly tumour sequencing board.

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

Goal/target	National target / national average	Performance in 16/17	Target for 17/18	Outcome in 17/18	Target achieved?
To show continuous improvement in national clinical audits with no negative outcomes	N/A	We have not been able to fully report against this goal	All show continuous improvement No negative outcomes	Not measurable. The target has been revised for 2018/19	N/A
We will improve our mortality rates as measured by SHMI (summary hospital-level mortality indicator) to remain in the top five lowest-risk acute trusts	100	75.54 2nd lowest risk	Top 5	74.29 (Q2 16/17 – Q1 17/18) 2nd lowest risk	Yes
We will improve our mortality rates as measured by HSMR (hospital standardised mortality ratio) to remain in the top five lowest-risk acute trusts	100	64.17	Top 5	67.37 (Jan – Dec 17) 2nd lowest risk	Yes
We will ensure that palliative care is accurately coded	N/A	100% (for all reviewed deaths)	100%	100% (for all reviewed deaths)	Yes
We will ensure mortality reviews are carried out in all cases and report specified information on deaths in line with national requirements, including those that are assessed as more likely than not to be due to problems in care, and ensure learning and action as a consequence	N/A	91% (Feb 2016 – March 2017)	100%	91%	No
We will increase PROMs participation rates to 80 per cent	<b>Groin hernia:</b> 0% <b>Hip replacement:</b> 42.8% <b>Knee replacement:</b> 21% <b>Varicose vein:</b> 29%  (April 2017 – Sept 2017)	<b>Groin hernia:</b> 4.5% <b>Hip replacement:</b> 90.8% <b>Knee replacement:</b> 113.5%* <b>Varicose vein:</b> 71.9%	80%	<b>Groin hernia:</b> 7.3% <b>Hip replacement:</b> 67% <b>Knee replacement:</b> 70% <b>Varicose vein:</b> 80.6%  (April 2017 – Sept 2017)	Yes – varicose vein  No – groin hernia, hip replacement & knee replacement

Goal/target	National target / national average	Performance in 16/17	Target for 17/18	Outcome in 17/18	Target achieved?
We will improve PROMs reported health gain to be better than national average	See table on page 96 for full results	Health gain was unable to be calculated for groin hernia, and hip replacement due to insufficient Part forms returned. <b>Knee replacement:</b> EQ-5D: 0.298 EQ-VAS: 4.572 Oxford Knee score: 16.742 <b>Varicose Veins:</b> EQ-5D: 0.080 EQ-VAS: -1.177 Aberdeen: -1.282	Over national average	See table on page 96 for full results	No - Health gain below average for varicose veins  Health gain unable to be calculated for groin hernia, knee and hip replacement
We will review all out-of-ICU/ED and coronary care unit cardiac arrests for harm and deliver improvements as a result	N/A	Cases reviewed from December 2016	All cases reviewed	100%	Yes
We will ensure that 90 per cent of clinical trials recruit their first patient within 70 days	54% (Q1 – Q3 2017/18)	85.4%	More than 90%	55.5% (Q1 – Q3 2017/18)	No

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



## Effective quality highlights and challenges

Our mortality rates remain consistently low and we have a system in place to review all deaths that occur in the Trust: As part of our drive to deliver good outcomes for our patients we closely monitor our mortality rates, using two indicators, HSMR (hospital standardised

mortality ratio) and SHMI (summary hospital-level mortality Indicator), which enable us to compare our mortality rates with our peers. Both of these have remained low, with our Trust being amongst the top five lowest risk acute trusts in the country throughout the year. This year we have also moved up to have the second lowest SHMI of all non-specialist providers in England.

As part of this, we also monitor the percentage of deaths with palliative care coded as this may affect the data (for definitions see glossary on page 120). Although our palliative care coding rates are high, we are confident that they are accurate with a clinical coding review process in place.

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

In 2018/19 we will ensure our processes are expedited to evidence actions to variance in results, use the CQC insights report to target areas for improvement and continue to learn from the audit results, sharing outcomes



and stories of where we have done well and where we have not.

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

**We are reviewing all cardiac arrests which occurred outside the intensive care unit (ICU), emergency department (ED) or coronary care unit for harm:**

When cardiac arrests occur outside these departments it can be because patients are not being monitored properly, or their deterioration has not been recognised. The Trust now has an increasingly robust process in place to review each of these cardiac arrests for care or service delivery issues. Two cases have been found to have resulted in harm this year, compared to one last year.

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

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

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

Capita and are pursuing alternative providers for PROMS data.

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

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

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

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





# CARING

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

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

## Accessible information standard

We have continued to implement the accessible information standard (see glossary on page 118 for definition) by providing information in a range of formats and languages, undertaking promotional work to raise awareness about the need to ask patients if they have any specific communication needs and adding hearing loops in rooms where public meetings are held. We have also introduced an assessment process through our electronic patient record which enables automatic flagging of specific communication requirements patients may have.

## Schwartz Rounds

These meetings provide an opportunity for staff from all disciplines to reflect on the emotional aspects of their work. Their purpose is to understand the challenges and rewards that are intrinsic to providing care, not to solve problems or to focus on the clinical aspects of patient care. The underlying premise is that the compassion shown by staff can make all the difference to a patient's experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work.

Research shows the positive impact that they have on individuals, teams, patient outcomes and organisational culture. We have continued to run Schwartz Rounds throughout 2017/18 with positive feedback from those who attended.

## Wayfinding strategy

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

## Experience lab

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

teams involved achieved success shown through the sustained and consistent 10 per cent increase in their local survey patient experience scores.

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

## Improving how we use patient experience data

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

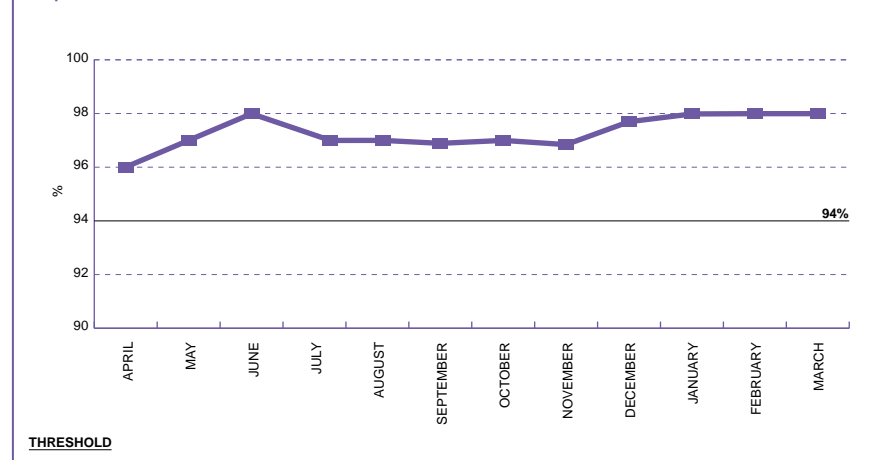
A new project funded by the Health Foundation was launched in September 2017. This is a joint collaboration with

the PSTRC, to apply novel analytics to free text in the Friends and Family Test (FFT) feedback to transform how quickly we can learn from patient feedback and use it to make improvements.

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

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

Inpatient FFT results





## Caring quality highlights and challenges

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

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

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

- Introduced a 'super user' award for our staff, to recognise those who access the patient feedback system the most. This system enables staff to see what our patients are saying at ward or department level. We have seen excellent examples of staff using this information to drive patient experience.
- Commenced our new patient support volunteer programme (kindly sponsored by Imperial Health Charity) with the initial pilot phase being conducted at St Mary's Hospital. The intention is for these to be implemented across all sites by summer 2019. The volunteers offer a befriending service and are able to identify, resolve or refer any patient

advice and liaison service (PALS) issues as they occur. During 2018/19, the volunteers will be supporting us to understand more about what matters to our patients and we will be conducting focussed conversations during this time, looking at areas such as 'noise at night' and quality of food where we have seen an increase in negative feedback.

- Continued to build upon our work for patients with learning disabilities. The Trust has been involved in a Health Education England initiative to train staff across west London in how to care for people with learning disabilities, autism and challenging behaviour. More than 400 staff members have completed the training.
- Worked with NHS Improvement on the new national learning disability improvement standards for NHS trusts. As part of this we were a pilot site for the national quality checking pilot undertaken by Changing our Lives. The audit highlighted the positive impact of the 'purple pathway' (our learning disability pathway as part of our Learning Disability and Autism policy).
- Developed bespoke communication resource folders that are now in use in all areas. To support our staff to communicate with people who have communication problems.
- Continued work to improve care for our patients with dementia. We were the first London trust to sign up for John's Campaign (a national campaign to give carers of patients right to stay with their loved ones). The Trust is now a John's Campaign ambassador.

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

When patients report a negative experience, the cause is usually due to ineffective systems and processes. We continue to take steps to improve and

ensure that waiting and delays are kept to a minimum and, where they are unavoidable, patients are kept informed and the environment and staff are as welcoming and supportive as possible.

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

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

**We have maintained, but not improved, the percentage of outpatients who would recommend our Trust since last year:** Although we are disappointed that our outpatient FFT rate has not improved, we are confident that the changes we are making as part of our outpatient improvement programme (see page 78 for more details) will significantly improve outpatient experience in the long run.

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

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

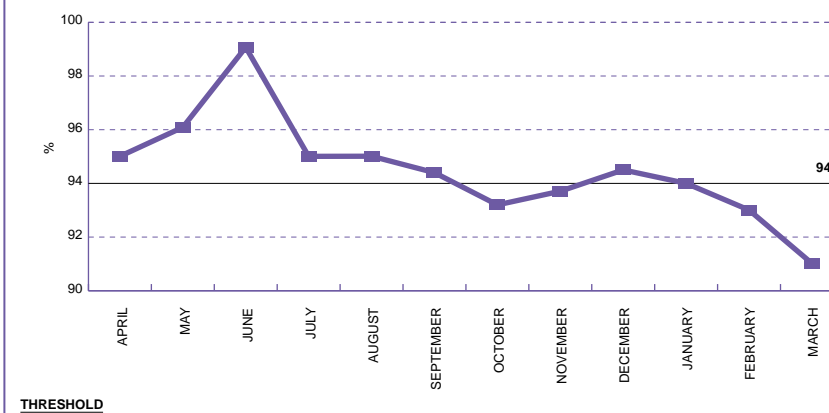
- the on-going work around the role of the CNS and strengthening links with primary care
- the clinical haematology teams participation in the experience lab project, focusing on making real improvements to patient experience in this area. As this programme started in April 2017, the impact of this work should be evident in 2018 (see page 74 for more information on the Experience lab project).

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

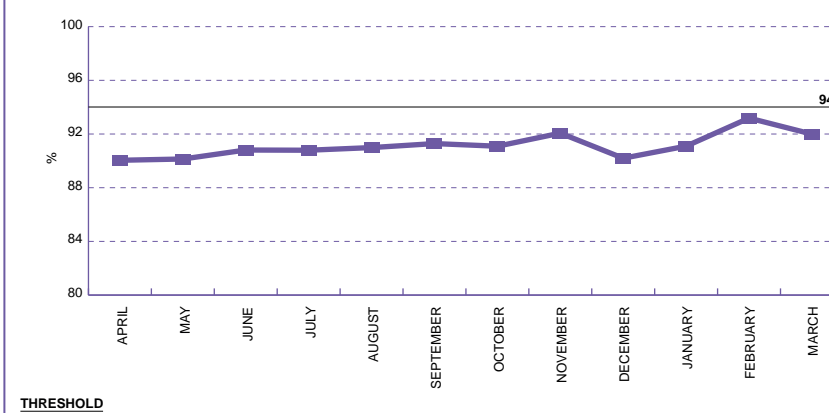
**We have exceeded our target to respond to 95 per cent of complaints within the timeframe agreed with the patient:** The process for complaints handling is fully embedded and effective. With a strong commitment to resolving concerns as promptly and effectively as possible and with better access to complaints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

The complaints team have strengthened links with the clinical

A&E FFT results



Outpatient FFT results



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

In 2018/19 the complaints team will continue to provide a responsive service for complainants and to identify further areas for improvement. We will introduce an online version of

the complaints survey so that we can monitor the level of satisfaction with the services provided.



**99.5%**  
of complaints  
responded to within  
the timeframe agreed  
with the patient

# RESPONSIVE

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

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

## Specialty review programme

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

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

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

## Outpatient improvement programme

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

### Patient environment

Imperial Health Charity supported this programme with £3 million of investment which was used to redesign and refurbish our clinics at Charing Cross and Hammersmith hospitals. This work is close to completion. Waiting areas are now more open and comfortable with new zones and

updated signage which will make it easier for patients to navigate the departments and check in at the right place for their appointments.

### Using technology to improve our services

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

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

### Redevelopment of patient services centre (PSC)

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

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

### Thinking differently about outpatients – models of care

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

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

## Flow Coaching Academy Imperial

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

### Sepsis

- Improvement in the identification and management of sepsis.
- Progress towards using real-time data.
- Staff reporting improved engagement with their job.
- Junior staff empowered to lead improvement and change and increased motivation in their roles.
- New multidisciplinary work.

### Diabetic foot

- Decrease in length of stay for MDT foot patients.
- Increase awareness of diabetes foot checks and subsequent increase in referrals to podiatry team.
- Development of key Cerner EPR products to reduce variation and improve data quality.
- Improvements in the way data is used.

### Asthma and wheeze in children

- New collaboration across ED, paediatrics and specialist allergy resulting in improved engagement.
- Establishment of a base from which all children with asthma/wheeze will have an asthma management plan, check of inhaler technique and education.
- Design and build of coding folders, work lists (to form a patient registry) and asthma M-page all on Cerner.

foot and children's asthma and wheeze clinical pathways.

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

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

Learning from the work this year has demonstrated the value of using the big room as a means of bringing the multidisciplinary team together to design, test and implement improvements. Across all three big rooms benefits were seen across the key themes of improvement culture, improvement skills & capability and

demonstrable improvements in patient care. The table above describes some of the specific improvements realised.

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



## Waiting list improvement programme

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

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

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

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

As part of the Trust's waiting list improvement programme, a number of clinical review processes have also been established. The purpose of these are to monitor the impact waiting for

treatment is having on our patients and to ensure that avoidable harm has not/ is not occurring as a result of delays in treatment on the RTT pathway. A senior nurse coordinates and oversees the process to review all patients waiting over 52 weeks for treatment and ensures that if appropriate the patient's medical records are reviewed by a senior clinician. The clinical harm and individual treatment plan reviews are discussed within speciality team meetings, which allows each patient to be tracked and for service to expedite admission and investigation dates when required. If any cases of clinical harm are found resulting from an extended wait for treatment, the patient details are recorded on the Trust's incident reporting system and investigated.

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

Goal/target	National target / national average	Performance in 16/17	Target for 17/18	Outcome in 17/18	Target achieved?
To consistently meet all relevant national access standards	N/A	4 out of 12 met in all 4 quarters	All targets met in all 4 quarters	4 out of 12 met in all 4 quarters	No
We will reduce the unplanned readmission rates for patients aged 0-15 and be below the national average	9.1% (Oct 16 – Sept 17)	4.95%	Below national average	4.92% (Oct 16 – Sept 17)	Yes
We will reduce the unplanned readmission rates for patients aged over 16 and be below the national average	8.2% (Oct 16 – Sept 17)	6.76%	Below national average	6.92% (Oct 16 – Sept 17)	Yes
We will have no inpatients waiting over 52 weeks for elective surgery, reduce the number of patients waiting over 40 weeks, and implement our agreed clinical validation process	N/A	52 week waits: 1,578 (16/17 total)	0	52 week waits: 1,896 (17/18 total) Clinical validation process described on page 80	No
We will reduce the proportion of outpatient clinics cancelled by the trust with less than six weeks' notice to 7.5 per cent or lower	N/A	8%	7.5%	8.5%	No
We will reduce the proportion of patients who do not attend outpatient appointments to 10 per cent	N/A	11.8%	10%	11.8%	No
We will ensure 95 per cent of outpatient appointments are made within five working days of receipt of referral	N/A	77%	95%	83.7%	No
We will improve our PLACE scores year-on-year; aiming to maintain our score above national average for cleanliness; meet the national average for food; be above the bottom 20 per cent for condition, appearance and maintenance and for privacy and dignity; and improve our scores compare to last year for dementia and disability	<b>Cleanliness:</b> 98.38% <b>Food:</b> 89.68% <b>Privacy, Dignity &amp; Wellbeing:</b> 83.68% <b>Condition, Appearance &amp; Maintenance:</b> 94.20% <b>Dementia:</b> 76.71% <b>Disability:</b> 82.56%	<b>Cleanliness:</b> 98.73% (above average) <b>Food:</b> 87.1% (below average) <b>Privacy:</b> 71.77% (bottom 20%) <b>Condition:</b> 91.02% (below average) <b>Dementia:</b> 62.62% (bottom 20%) <b>Disability:</b> 64.82% (bottom 20%)	Score above national average for cleanliness; meet the national average for food; be above the bottom 20% for condition, appearance and maintenance and for privacy and dignity; and improve our scores compare to last year for dementia and disability	<b>Cleanliness:</b> 99.53% (above average) <b>Food:</b> 89.41% (below average) <b>Privacy, Dignity &amp; Wellbeing:</b> 74.74% (below average) <b>Condition:</b> 95.72% (above average) <b>Dementia:</b> 80.61% (above average) <b>Disability:</b> 76.29% (below average)	No
We will discharge at least 35 per cent of our patients on relevant pathways before noon	33%	17.5%	35%	11.7%*	No
We will ensure 98 per cent of admissions to an intensive care bed occur within two hours of the decision to admit/completion of surgery	N/A	New target not previously measured	98% within 2 hours	78.2%	No

\* reporting commenced in November 2017

The table below shows our performance against the national access standards throughout 2017/18. The Trust consistently met four out of

the 12 standards however performance was challenged in the others. We know that we still have much work to do to tackle long-standing pressures around

demand, capacity and patient flow to enable us to meet these targets.

National targets and minimum standards	Measure	Threshold	Q1	Q2	Q3	Q4	Target achieved in all quarters
Access to treatment	18 weeks referral to treatment – incomplete pathway	92.00%	84.48%	83.15%	82.77%	82.98%	No
Access to cancer services	Two week wait from referral to date first seen all urgent referrals	93.00%	89.47%	93.70%	94.78%	93.55%	No
	Two week wait from referral to date first seen breast cancer	93.00%	67.71%	95.90%	95.09%	93.25%	No
	31 days standard from diagnosis to first treatment	96.00%	96.97%	98.20%	97.59%	98.00%	Yes
	31 days standard to subsequent cancer treatment – drug	98.00%	99.67%	100.00%	99.72%	100.00%	Yes
	31 days standard to subsequent cancer treatment – radiotherapy	94.00%	98.70%	98.80%	99.02%	96.16%	Yes
	31 days standard to subsequent cancer treatment – surgery	94.00%	97.09%	97.50%	98.61%	96.65%	Yes
	62 day wait for first treatment from urgent GP referral	85.00%	83.47%	86.30%	87.91%	86.80%	No
	62 day wait for first treatment from NHS screening services referral	90.00%	90.07%	93.70%	94.48%	74.20%	No
A&E Performance	A&E maximum waiting times four hours	95.00%	90.03%	88.82%	86.13%	83.64%	No
Cancelled Operations	Cancelled operations for non-clinical reasons	0.80%	0.79%	1.00%	0.96%	1.3%	No
	Rebooking non-clinical cancellations within 28 days	<5%	11.1%	9.1%	11.5%	19.5%	No

## Responsive quality highlights and challenges

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

- the main emergency departments (type 1)
- Western Eye Hospital (type 2)
- the urgent care centres at our three main sites (type 3).

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

Key challenges for the Trust included:

- increased demand and acuity within type 1 departments

- an increase in arrivals via ambulance and major trauma presentations at St Marys Hospital
- high levels of bed occupancy
- the number of days with black capacity alerts.

**The Trust was compliant against seven of the eight national cancer standards in last three quarters of 2017/18:**

Although we did not consistently meet all eight cancer standards across the year, improvements have been seen. These improvements have been the result of a number of actions across each of the targets, including increasing MRI capacity to deliver same day scanning and reporting for prostate

cancer referrals and increasing CTC scanning and reporting capacity to support the colorectal straight to test pathway. In September the Trust signed a memorandum of understanding with RMP Vanguard to deliver the £943k investment over the next two years to fully establish the prostate RAPID diagnostic pathway.

**We have not met the national performance targets for referral to treatment (RTT) and we continue to have significant numbers of patients waiting 52 weeks and over for treatment on a RTT pathway:** In 2016 and 2017, the Trust identified issues with how we were managing our waiting lists as well as underlying capacity problems in a number of areas. We have not met the standard of 92 per cent of patients treated within 18 weeks of referral this year, reporting an average of 83 per cent across the year. Improvement trajectories have been agreed with our commissioners and NHSI and a waiting list improvement programme is in place (for more details see page 80).

The Trust reported 1,896 patients waiting over 52 weeks in 2017/18, which is an increase on the 1,578 patients reported last year. The clinical review process is detailed on page 80. Three cases of clinical harm have been confirmed for patients waiting over 52 weeks since the process began in August 2016.

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

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

**We improved our PLACE (patient led assessment of the care environment) scores in all categories:** PLACE (see glossary on page 120 for definition) was introduced in 2013 as an annual patient led initiative that monitors and scores the environment under the following headings:

- cleanliness
- privacy, dignity and wellbeing

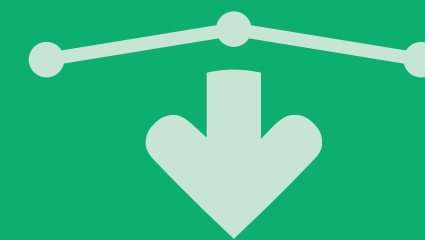
- food and hydration
- condition, appearance and maintenance
- dementia (introduced in 2015)
- disability (introduced in 2016).

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

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

- **cleanliness** – scores above national average.
- **food and hydration** – although our results remain slightly below average, they have improved since last year.
- **privacy, dignity and wellbeing** – although our results remain below average, they have improved since last year and we are no longer in the bottom 20 per cent.
- **condition, appearance and maintenance** – scores have improved and are above national average.
- **dementia** – results show the most significant improvement. We have now moved from the bottom 20 per cent to above the national average.
- **disability** – scores remain below average, but are no longer in the bottom 20 per cent.

These improvements were the result of a detailed action plan led by the PLACE steering group, as well as progress with our wayfinding, clinical and estate strategies. A number of areas have benefitted from major refurbishment programs including works to enable the introduction of new equipment, services



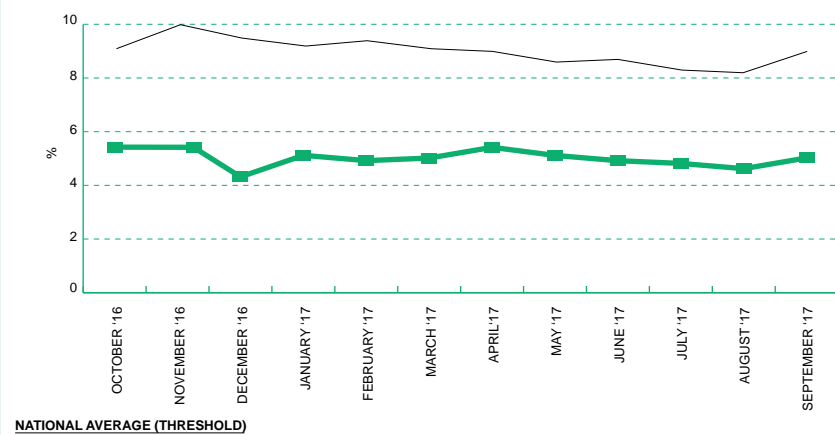
**Unplanned readmissions rates consistently below national average**



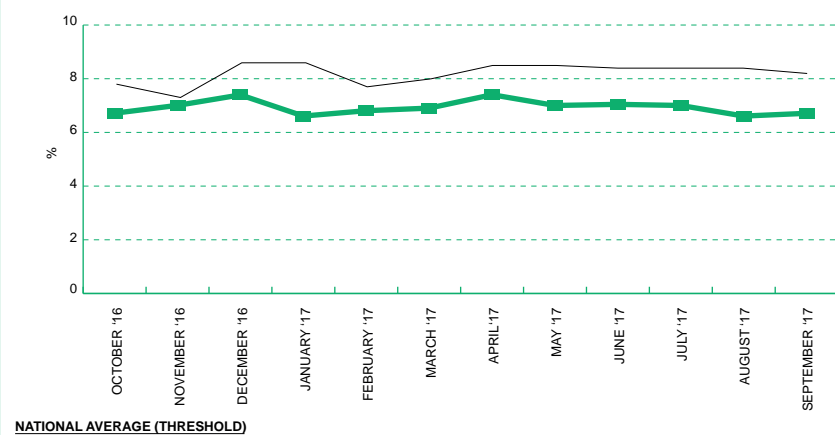
**We improved our PLACE scores in all six areas**



Unplanned readmission rates (ages 0-15 years)



Unplanned readmission rates (ages 16 plus years)



being moved to larger spaces, and replacement of flooring and refurbishment of side room and bathroom facilities across the different hospital sites. In addition regular unannounced cleaning inspections have been introduced in clinical areas and a new seasonal menu has been developed with support from patient representatives to improve the standards of food.

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

**We have not achieved our target to discharge at least 35 per cent of our patients on relevant pathways before noon:** Untimely discharge has been identified as one of the most common reasons why A&E departments fill and patients have long waits to be seen and admitted or discharged. Planning

discharges before the peak in admissions is an effective way to smooth the total demand for beds and run safer, more effective services.

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





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

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

## Leadership development programme

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

Our offer is continually evolving with two new programmes added in 2017; 'Springboard' for band 5/6 nurses in support of our retention strategy and 'Engage' to further improve our employee's experience of working here. In August 2017, following our progress in the 2016 NHS staff survey and the development of our local 'Engage' workshop and toolkit for managers we

were featured as a best practice case study published by NHS Employers.

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

## Retention strategy

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

- creating a new brand for recruitment
- launching career clinics
- automatic offers for students
- extending the Preceptorship to one-year
- introducing a new leavers survey
- implementing a new leadership programme for band 5/6 nurses
- creating a retention toolkit.

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

## Occupational health service review

In July 2017 we commissioned an

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

- an upgrade to the software system to enable more efficient scheduling, processing and delivery of work
- more streamlined working with the recruitment team to enable speedier health clearance of newly-recruited employees
- revision of pricing.

We have also submitted a safe effective quality occupational health services (SEQOHS – see glossary on page 121 for definition) re-accreditation case. As part of the accreditation process, the assessors are scheduled to conduct their on-site visit, which is the final part of the assessment process, in October 2018.

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

## Staff engagement programme

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

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

## Ward accreditation programme

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

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

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

## Patient and public involvement strategy

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

- a new digital patient reference group – providing input and feedback on the development of apps, the use of digital patient records and other online opportunities to help ensure our digital strategy meets the needs and preferences of our patients and communities
- the establishment of an additional 22 lay partner roles – enabling patients and local people to play a full part in the Trust's key projects and programmes, bringing the total to 44 and influencing major developments such as waiting list improvements, estates redevelopment and a new patient transport tender
- the creation of a new volunteer role to support improvement projects – focusing on gathering feedback directly from patients, carers, family and friends in clinical environments
- publishing our first involvement toolkit for staff – offering advice and practical support to involve patients and the public in services and improvement work.

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

## Flu campaign

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

In August 2017, it was agreed that a new approach was needed. The improvement team were asked to design and implement a comprehensive vaccination plan in preparation for the 2017/18 flu season. The vaccination programme was active between 25

September 2017 and 31 January 2018 and by March 60.5 per cent of our frontline healthcare workers had been vaccinated against flu.

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

## Digital

The digital big room (see page 79 for more information on 'big rooms') has identified seven priority areas for 2018/2019. These act as really important enablers across 'improvement priorities' for trust wide digital transformation. The digital priority areas overlap with GDE priorities and comprise:

- optimal use of existing digital features
- going paperless
- introducing voice recognition
- device and system integration; to develop systems that connect and share information safely and securely
- developing a mobile App interface
- Care Information Exchange (CIE)
- analytics to ensure provision of access to data to develop real time feedback mechanisms to collect and act upon data.

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



Goal/target	National target / national average	Performance in 16/17	Target for 17/18	Outcome in 17/18	Target achieved?
To increase the percentage of staff who would recommend this trust to friends and family as a place to work	N/A	65% (internal staff survey published Sept 2016) 62% (national staff survey published March 2017)	67% (internal staff survey) 64% (national staff survey)	72% (internal staff survey published August 2017) 66% (national staff survey published March 2017)	Yes
To increase the percentage of staff who would recommend this trust to friends and family as a place for treatment	N/A	83% (internal staff survey published Sept 2016) 70% (national staff survey published March 2017)	85% (internal staff survey) 72% (national staff survey)	86% (internal staff survey published August 2017) 73% (national staff survey published March 2018)	Yes
We will achieve a voluntary turnover rate of 10 per cent	N/A	10.22%	10%	9.1%	Yes
We will maintain our sickness absence rate at below 3.10 per cent	N/A	3.00%	3.10%	2.9%	Yes
We will achieve a performance development review rate of 95 per cent	N/A	86.24%	95%	88.5%	No
We will achieve a non-training grade doctor appraisal rate of 95 per cent	90.1%	91.13%	95%	84.5%	No
We will achieve compliance of 90 per cent with statutory and mandatory training	95%	85.60%	90%	87.4%	No
We will further develop our ward accreditation programme to ensure it links with other quality initiatives and has quality improvement at its heart	N/A	Programme re-run	Programme re-run	Programme re-run	Yes
We will reduce the number of programmes with red flags in the GMC's national trainee survey by five per cent	N/A	25 red flags	5% reduction	11 programmes with red flags (24 red flags in total)	No
We will increase the overall number of green flags in the GMC's national trainee survey by five per cent	N/A	(50% reduction on previous year)	57 or more		No
We will obtain a minimum score of 0.5 for placement satisfaction for all student placements as measured by SOLE	N/A	54	100% of placements with 0.5 or more	79%	No
We will have a departmental safety coordinator in 60 per cent of clinical wards, clinical departments and corporate departments	N/A	76% (academic year 2016/17)	60%	49%	No
We will ensure at least 10 per cent of our staff are trained as fire wardens	N/A	91.87% (departments with trained coordinators)	10%	9%	N/A
We will ensure we respond to all exception reports from junior doctors within 14 days of an application being made and that we deliver improvements as a result	N/A	New target not previously measured	Within 14 days	45%	N/A





## Well-led quality highlights and challenges

We have achieved our goal and increased the percentage of staff who would recommend our Trust as a place to work and as a place for treatment: We monitor staff engagement through the national staff survey and through our annual internal survey 'Our Voice' which was run between May and June 2017. 2,802 of our people responded, which represents 33 per cent of the total workforce.

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

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

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

Our staff were less positive about the following questions:

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

addressed effectively in this organisation (48 per cent).

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

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

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

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

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

Good progress continues to be made on improving the level of support and information available to our staff in

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

The results for the 2017 national staff survey are currently being analysed to inform local and strategic engagement plans.

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

- the implementation of the Nurse Recruitment & Retention Strategy
- careers clinics (band 2 – 6 nurses and midwives)
- development of Springboard (band 5/6 nurse development programme)
- exploration of flexible benefits for staff
- further development of flexible recruitment and retention premium (RRP)
- becoming an 'employer of choice' for student nurses and midwives
- "Great place to work week", Pulse magazine and "Your working life" intranet pages.

**Our sickness absence rate remains low:** Low sickness absence is an indicator of effective leadership and good people management. We are continuing our focus on supporting the health and wellbeing of our staff along with supportive management interventions for those who are absent due to sickness. There are a range of activities and services available within the Trust including occupation health, staff counselling, stress management,

yoga and meditation classes, and smoking cessation clinics. In September 2017 we also ran our third 'Living week' which is a campaign of events designed to get staff fit, active and having fun.

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

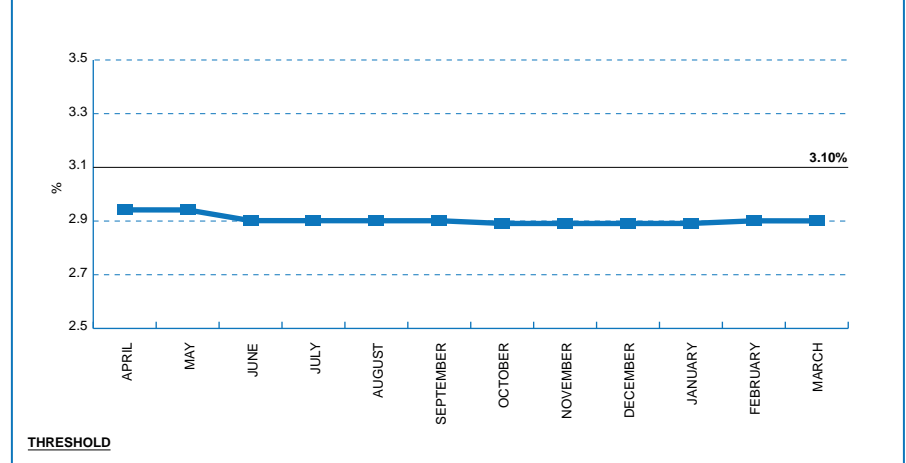
- **Student Online Evaluation (SOLE):** The feedback we receive from our medical students through the local SOLE system has previously been mixed. Our aim is to focus on improving their experience in a consistent manner, with the target of obtaining a minimum score of 0.5 (which corresponds to a 'mostly agree' score) for satisfaction for all student placements. In 2016/17, we achieved this target for 79 per cent of our programmes this year, compared to 76 per cent last year.

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

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

- increasing registrar level posts

Sickness absence rate



- to decrease rota intensity
  - increasing consultant supervision by increasing consultant level posts
  - providing suitable rest facilities for our junior doctors.
- Since the results of the 2017 survey, we have been focusing on driving further change by:
- strengthened governance with education specialty reviews chaired by the medical director and continued support for local faculty groups embedded as business as usual
  - sharing good practice from the specialties with green flags
  - embedding time for education in job plans and making it sustainable
  - supporting the development of the multi-professional workforce through the implementation of the integrated education strategy
  - enhanced our faculty development programme for consultant supervisors to include refresher modules and provision of educational appraisals.

**Although we have not met our percentage target for the number of doctors who have had an appraisal, we had positive feedback from our Higher Level Responsible Officer Quality Review Visit:** It is a national requirement that non-training grade doctors have an annual medical appraisal as part of the General Medical Council's Revalidation process (see glossary on page 120 for definitions), during which doctors have a formal

structured opportunity to reflect on their work and to consider how their effectiveness might be improved, with the focus on enhancing quality and improvements in patient care. A number of actions are being taken to increase compliance including monthly professional development drop-in sessions across all Trust sites and reviewing the PREP system to ensure it is user friendly and easy to navigate by doctors. There is also ongoing contact with doctors who are overdue with application of the Trust policy where appropriate.

In February 2017 the Trust was visited by the London Revalidation Team to assess against the Core Standards Framework for the supervision, support and management of medical staff by the organisation and the Responsible Officer (see glossary on page 120 for definition). The visit highlighted a number of areas of good practice including appraisers having refresher training that was well evaluated by participants, the production of electronic revalidation monthly newsletters, and good working relationships between the medical staff team and the revalidation team. An action plan has been developed for areas highlighted for improvement.

**We have not met our target for the percentage of staff who have had a performance development review (PDR):** Our appraisal scheme 'performance development and review (PDR)' for staff, excluding doctors, is aimed at driving a new performance culture across the Trust. Although we are below target we have improved on



last year's result.

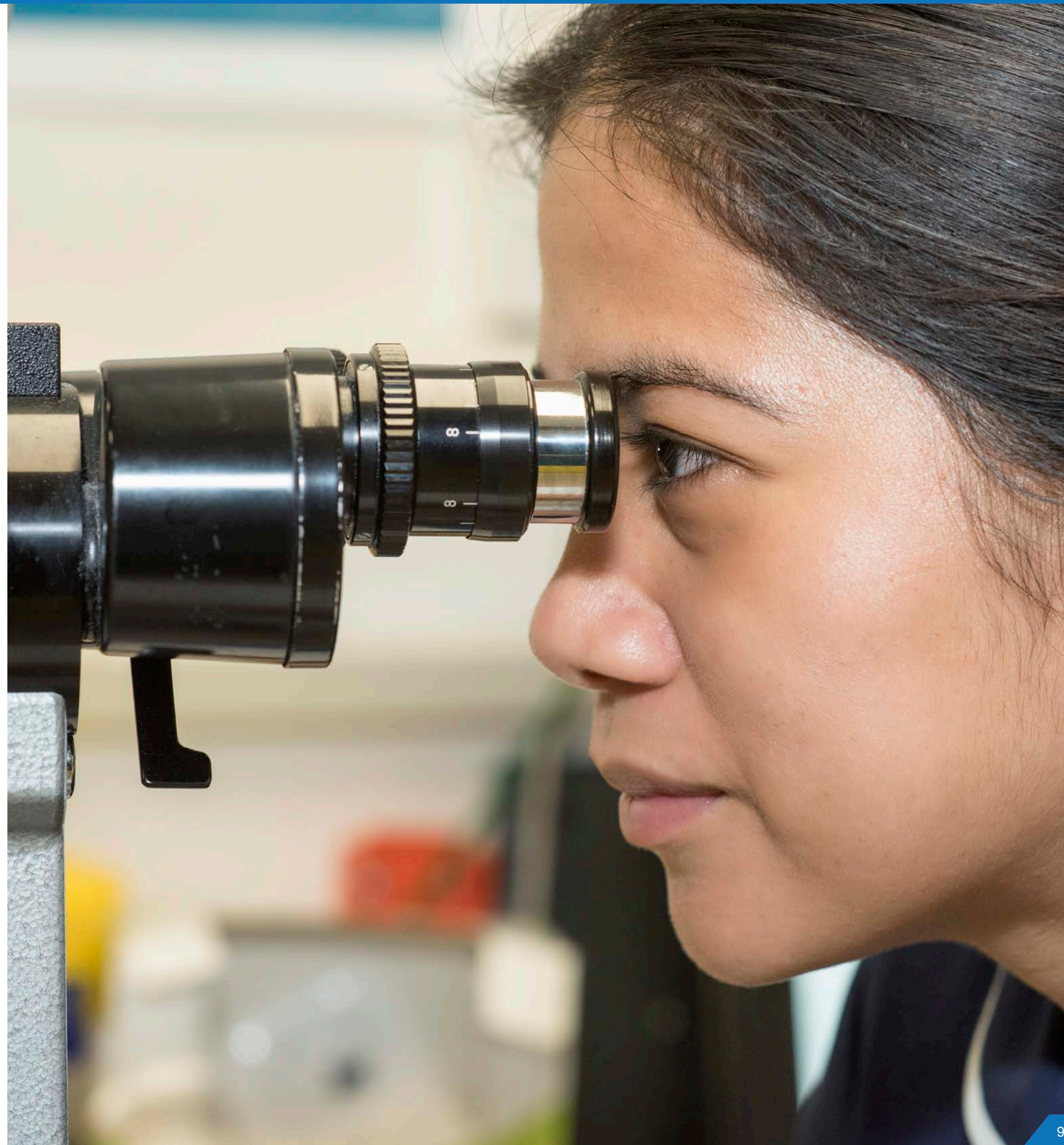
The national staff survey results for 2017 indicate that out of those who completed the survey, 89 per cent had been appraised within the last 12 months which is above the national average. In addition respondents stated that the quality of appraisals was above the national average and was in our top five highest performing results. We continue to run a one day essential training course for all managers undertaking PDRs. We have also introduced an additional half day training to support managers in preparing for specific PDR conversations, maintaining a real focus on making sure that staff have meaningful and positive PDR meetings.

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

**We have not achieved our target to have 10 per cent of staff trained as fire wardens and departmental safety coordinators in 60 per cent of clinical wards, clinical departments and corporate departments:** Targets for the departmental safety co-ordinators (DSCs – see glossary on page 118 for definition) and fire wardens are included to drive improvements in health and safety. Targeted work has been underway to increase the numbers of trained staff, however high demand on our clinical areas has restricted the availability of our staff to attend the training sessions. In response, a more concise training package for fire wardens has been developed this year and a new e-learning course is being considered for DSC training. We are also reviewing the way that we measure

DSC compliance to ensure accurate reporting next year.

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





# The acute quality schedule 2017/18

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

## Maternity performance indicators

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

- 90 per cent breastfeeding initiation rate within 48 hours of the baby's birth. We have also made significant progress towards achieving UNICEF Baby Friendly Accreditation.
- 95 per cent of women receiving one-to-one midwife care in established labour. We are delighted that this key metric is consistently met and this aligns with the findings of the national maternity survey.
- 100 per cent of women with a named midwife or named team. We are using this as a building block for the 'Better Births' early adopter work to improve continuity of care for women.
- 14 per cent of women giving birth in a midwifery led unit. We are very proud of our two highly rated birth centres.
- Less than five per cent of women smoking at the time of delivery. We

continue to work with Public Health Partners to support women to give up smoking.

- Less than three per cent of women experiencing third or fourth degree tears. We monitor this closely and ensure that women are receiving the latest evidenced based care in this important area.
- 98 hours per week consultant presence on the labour ward at St Mary's Hospital.
- 1:30 midwife to birth ratio. We continue to be funded to this ratio and have many mechanisms in place to ensure safe midwifery staffing across our service.

## Areas of challenge

### Maternity booking assessments in 12 weeks and six days

We achieved this performance target for three out of four quarters this year. We did not meet this target for the last quarter following a change in structure of the patient services centre in addition to a shortage of staff. This is a focused area of attention with plans in place to improve this metric.

### Home births

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

### Percentage of women having a non-elective caesarean section and percentage of women having an elective caesarean

Performance against these targets fluctuated, although we met non-elective caesarean section targets in three out of four quarters. We just missed the target (16.1 per cent) in Q2. We have a process in place to review non-elective caesarean sections. We met the elective caesarean section targets in two out of four quarters. Counselling occurs for women requesting an elective caesarean section.

### Postpartum haemorrhage

Our performance against this target has improved since last year. In 2016/17 our performance was 3.1 per cent against a target of 2.8 per cent. Following the introduction of a focussed action plan we have now met the target in all quarters, except in Q2 where we reported 2.84 per cent.

### Hours of consultant labour ward cover

The Trust met the RCOG threshold for the number of hours of consultant presence on the labour ward at St Mary's hospital (60 hours per week for units under 4000 maternities per year), but not at Queen Charlotte's & Chelsea Hospital (168 hours per week). Neither hospital met the London Maternity Quality Standards and CCG target of 168 hours per week. These targets are not evidenced based and recent evidence shows that 168 hour consultant labour ward presence does not lead to an improvement in patient outcomes. Following this emerging evidence, the RCOG wrote to all clinical directors of maternity retracting from its commitment to the 168 hour standard for consultant presence on labour ward in maternity units with over 5000 maternities. The London Maternity clinical leadership group have revised London Quality Standards and are due to imminently publish the updated standards which will not include a

requirement to have 168 hour consultant presence on labour ward. There is currently a significant shortage of junior doctors at Queen Charlotte's & Chelsea Hospital and with Trust board support we have now reduced consultant labour ward presence from 113 to 98 hours and redeployed resident on-call consultants to perform daytime duties. This will maintain safety during the day and night as consultants remain on-call overnight and can be called in to the hospital if required. This will be reviewed when the staffing situation improves. This has been in place now for several months and no significant risks have emerged from the slight reduction in hours.

## Safeguarding training

We are committed to the protection and safeguarding (see glossary on page 121 for definition) of all patients, including children and young people. As part of this, we provide staff with different levels of safeguarding training, depending on their role. Throughout 2017/18, compliance with training has remained below our target of 90 per cent for most levels although we have seen gradual improvement for level 2 adult safeguarding training and are now just below target at 87 per cent. Training compliance remains a important but challenging priority for us and we have included compliance with level 3 children's safeguarding training as one of our quality account targets for 2018/19. Level 3 child safeguarding is delivered as a four hour face-to-face session.

Level 1 and 2 training for both adult and child training is delivered via e-learning modules. We have communication plans in place to improve compliance, including regular reminders to staff and reviews of monthly compliance reports with managers. In addition, all staff are required to confirm that they are up to

date with their core mandatory training as part of their annual personal development review.

We have not reported any serious incidents related to adult safeguarding in 2017/18, but two serious incidents were generated by children safeguarding concerns. In order to ensure learning from any incidents, summary care records are disseminated out to staff in the Trust during training and supervision sessions and we have introduced 'learning flyers'. In addition, learning themes from any incidents recorded on our reporting system, Datix, are shared with staff.



# The NHS Outcomes Framework Indicators 2017/18

The NHS Outcomes Framework 2017/18 sets out high level national outcomes which the NHS should be aiming to improve. The framework provides indicators which have been chosen to measure these outcomes. An overview of the indicators and our performance is outlined in the table

below. Some of this data is repeated because we chose to include these indicators as our quality strategy targets for 2017/18. It is important to note that whilst these indicators must be included in the quality accounts, the most recent national data available for the reporting period is not always data for the most

recent financial year. Where this is the case, the time period used is noted underneath. This data is included in line with reporting arrangements issued by NHS England. Further information about what we are doing to improve our performance can be found in the individual target pages.

Indicator	Imperial College Healthcare 2017/18	National average (median reporting rates)	Where applicable – best performer	Where applicable – worst performer	Trust statement	2016/17	2015/16	2014/15
<b>SHMI value and banding</b>	74.29 (Q2 2016/17 – Q1 17/18) Second lowest SHMI ratio of all non-specialist providers in England	100 (Q2 2016/17 – Q1 17/18)	72.61 (Q2 2016/17 – Q1 17/18)	122.77 (Q2 2016/17 – Q1 17/18)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>it is drawn from nationally reported data</li> <li>we have reported a lower than expected SHMI rate for the last three years</li> <li>the Trust has the second lowest SHMI ratio of all non-specialist providers in England.</li> </ul> We intend to take the following actions to improve this rate, and so the quality of our services, by: <ul style="list-style-type: none"> <li>continuing to work to eliminate avoidable harm and improve outcomes</li> <li>reviewing every death which occurs in our Trust and implementing learning as a result. See page 68 for more information on our implementation of the new learning from deaths framework.</li> </ul>	75.54 Second lowest SHMI ratio of all non-specialist providers in England	73.8 Third lowest SHMI ratio of all non-specialist providers in England	73.17 Third lowest SHMI ratio of all non-specialist providers in England
<b>Percentage of admitted deaths with palliative care coded</b>	52.6% (January to December 2017)	29.6% (January to December 2017)	Not applicable	Not applicable	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>it is drawn from nationally reported data</li> <li>it shows we have the second highest rate of palliative care coding as measured by this indicator of all acute non-specialist providers</li> <li>we are confident that we have a robust process in place to ensure that we are coding patients correctly.</li> </ul> We intend to take the following actions to improve this percentage, and so the quality of our services, by: <ul style="list-style-type: none"> <li>continuing to work to improve the accuracy of our clinical coding.</li> </ul>	54.9%	53.5%	24.6%
<b>Patient reported outcome scores (PROMs) for groin hernia surgery</b>	Not available	EQ-5D: 0.089 EQ-VAS: -0.132 (April – Sept 17)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>data was not available on the NHS Digital PROMS database.</li> </ul> We intend to take the following actions to improve this percentage, and so the quality of our services, by: <ul style="list-style-type: none"> <li>groin hernia surgery PROMs collection has been ceased at a national level.</li> </ul> See page 70 for further information.	(Low sample size)	(Low sample size)	(Low sample size)

Indicator	Imperial College Healthcare 2017/18	National average (median reporting rates)	Where applicable – best performer	Where applicable – worst performer	Trust statement	2016/17	2015/16	2014/15
<b>PROMs for varicose vein surgery</b>	EQ-5D: 0.077 EQ-VAS: 1.324 Aberdeen varicose vein score: -1.899 (April – Sept 17)	EQ-5D: 0.096 EQ-VAS: -0.418 Aberdeen varicose vein score: Not available (April – Sept 17)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>it is drawn from the independently administered NHS Digital PROMS database</li> <li>it shows that we had health gain below national average for varicose veins.</li> </ul> We intend to take the following actions to improve this percentage, and so the quality of our services, by: <ul style="list-style-type: none"> <li>whilst varicose veins surgery PROMs collection has been ceased at a national level, the Trust is developing measures to allow on-going monitoring of the outcomes for patients.</li> </ul> See page 70 for further information.	EQ-5D: 0.083 EQ-VAS: 0.3 Aberdeen varicose vein score: -0.1	EQ-5D: 0.038 EQ VAS: -2.966 Aberdeen varicose vein score: -2.724	EQ-5D: 0.047 EQ VAS: -1.093 Aberdeen varicose vein score: -2.224
<b>PROMs for hip replacement surgery</b>	Not available	Not available	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>data was not available on the NHS Digital PROMS database.</li> </ul> We intend to take the following actions to improve this percentage, and so the quality of our services, by: <ul style="list-style-type: none"> <li>implementing our action plan.</li> </ul> See page 70 for further information.	* (Low sample size)	EQ-5D: 0.475 EQ VAS: 14.259 Oxford Hip Score: 24.229	EQ-5D: 0.453 EQ VAS: 12.756 Oxford Hip Score: 22.537
<b>PROMs for knee replacement surgery</b>	Not available	Not available	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>data was not available on the NHS Digital PROMS database.</li> </ul> We intend to take the following actions to improve this percentage, and so the quality of our services, by: <ul style="list-style-type: none"> <li>implementing our action plan.</li> </ul> See page 70 for further information.	* (Low sample size)	EQ-5D: 0.292 EQ VAS: * low sample size Oxford Knee Score: 13.420	EQ-5D: 0.326 EQ VAS: 10.411 Oxford Knee Score: 14.940
<b>28 day readmission rate for patients aged 0-15</b>	4.92% (Dr Foster data – Oct 16 – Sept 2017)	9.1% (Dr Foster data – Oct 16 – Sept 2017)	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>it is drawn from the nationally reported data obtained from Dr Foster</li> <li>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.</li> </ul> We intend to take the following actions to improve this percentage, and so the quality of our services, by: <ul style="list-style-type: none"> <li>continuing to ensure we treat and discharge patients appropriately so that they do not require unplanned readmission</li> <li>working to tackle long-standing pressures around demand, capacity and patient flow.</li> </ul>	5.15% (Oct 2015-Sep 2016)	4.81% (Jan-Dec 2015)	6.31%
<b>28 day readmission rate for patients aged 16 or over</b>	6.92% (Dr Foster data – Oct 16 – Sept 2017)	8.2% (Dr Foster data – Oct 16 – Sept 2017)	Not available	Not available	See above.	6.64 % (Oct 2015-Sep 2016)	7.39% (Jan-Dec 2015)	8.84%
<b>Percentage of staff who would recommend the provider to friends or family needing care</b>	73% [national staff survey – published March 2018]	71% [national staff survey – published March 2018]	Not available	Not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>it is drawn from the nationally reported data from the national staff survey which was published in March 2018</li> <li>the results show an improvement in our national staff FFT score compared to last year, which is also above average for acute trusts</li> <li>results from our local engagement survey also show an improvement, with 86 per cent of staff recommending the Trust.</li> </ul> We intend to take the following actions to improve this percentage, and so the quality of our services, by: <ul style="list-style-type: none"> <li>see page 90 for information on our improvement plans.</li> </ul>	70%	68%	71%

Indicator	Imperial College Healthcare 2017/18	National average (median reporting rates)	Where applicable – best performer	Where applicable – worst performer	Trust statement	2016/17	2015/16	2014/15
<b>Percentage of admitted patients risk-assessed for VTE</b>	93.87% (2017/18 full year data) Q1: 92.71% Q2: 91.63% Q3: 95.53% Q4: 95.64%	95.36% (Q3 17/18)	100% (Q3 17/18)	76.08% (Q3 17/18)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>it is drawn from the nationally reported data published quarterly by NHS England</li> <li>last year, an internal audit identified some issues with our data for this indicator. In response, the Trust moved to assessment for VTE at drug prescription on admission rather than at discharge at the end of March 2017</li> <li>we have monitored VTE risk assessments on a monthly basis throughout the year. After an initial drop in performance across the Trust which we had anticipated, a Trust-wide action plan that included sharing performance data locally was implemented</li> <li>we met our target in Q3 and Q4.</li> </ul> We intend to take the following actions to improve this percentage, and so the quality of our services, by: <ul style="list-style-type: none"> <li>using CRAB outcome data in 2018/19 which should be more specific.</li> </ul>	95.33%	95.87%	96.56%
<b>Rate of C-Diff per 100,000 bed days</b>	17.64 Total cases: 63	13.2 (2016/17 data)	0.0 (2016/17 data)	82.7 (2016/17 data)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>it is drawn from nationally reported data</li> <li>we monitor performance regularly through our Trust Infection Control Committee and weekly taskforce meeting.</li> </ul> We intend to take the following actions to improve this percentage, and so the quality of our services, by: <ul style="list-style-type: none"> <li>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.</li> </ul>	18.03 (63)	20.9 (73)	22.6 (79)
<b>Responsiveness to inpatients personal needs: National inpatient survey score</b>	No new data has been published since the 2016/17 scores that were published in May 2017.	Not available	9.2 [national inpatient survey overall score – published May 2017]	7.4 [national inpatient survey overall score – published May 2017]	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>it is drawn from the nationally reported data from the national inpatient survey which was published in May 2017.</li> </ul> We intend to take the following actions to improve this percentage, and so the quality of our services, by: <ul style="list-style-type: none"> <li>see page 74 for information on our improvement plans.</li> </ul>	8.2 [overall score] 6.72 [responsiveness score]	7.9 [overall score] 6.74 [responsiveness score]	75.8 [overall score] 6.82 [responsiveness score]
<b>Rate of reported patient safety incidents per 1,000 bed days</b>	47.96 (NRLS data April – Sept 17)	41.68 (NRLS data April – Sept 17)	76.2 (NRLS data April – Sept 17)	23.47 (NRLS data April – Sept 17)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>the NRLS data is nationally reported and verified</li> <li>the data shows all incidents reported by the Trust for the period April – September 17: our incident reporting rate for this period was 47.96 against a median peer reporting rate of 41.68</li> <li>our individual incident reporting data is made available by the NRLS every six months.</li> </ul> We intend to take the following actions to improve this percentage, and so the quality of our services, by: <ul style="list-style-type: none"> <li>Improving how we report, manage and learn from incidents as part of our ongoing safety culture work. See page 58 for further information.</li> </ul>	April – Sept 16: 42.3 Oct 16 – March 17: 46.82 (rate per 1,000 bed days)	April – Sept 15: 41.38 Oct 15 – March 16: 43.18 (rate per 1,000 bed days)	April – Sept 14: 42.98 Oct 14 – March 15: 40.69 (rate per 1,000 bed days)
<b>Percentage of patient safety incidents reported that resulted in severe/major harm or extreme harm/death</b>	0.1% severe/major harm (6 incidents) 0.1% extreme harm/death (6 incidents) (NRLS data April – Sept 17) Full year internal data: 27	0.28% (severe harm) 0.11% (extreme harm/death) (NRLS data April – Sept 17)			Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>it is drawn from the nationally reported data from the NRLS</li> <li>we reported 0.1 per cent severe/major harm incidents (six incidents) compared to a national average of 0.3 per cent, and 0.1% extreme/death incidents (6 incidents) compared to a national average of 0.12 per cent</li> <li>based on our full year internal data, we have also achieved a small reduction in the total number of incidents causing extreme harm/death or severe/major harm in 2017/18, reporting 27 compared to 28 in 2016/17.</li> </ul> We intend to take the following actions to improve this percentage, and so the quality of our services, by: <ul style="list-style-type: none"> <li>see page 58 for an update on our improvement plans.</li> </ul>	April – Sept 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)	April-Sept 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)	April-Sept 14: 0.1% severe/major harm (6 incidents) 0.3% extreme harm/death (19 incidents) Oct 14 – March 15: 0.1% severe/major harm (9 incidents) 0.1% extreme harm/death (8 incidents)

Indicator	Imperial College Healthcare 2017/18	National average (median reporting rates)	Where applicable – best performer	Where applicable – worst performer	Trust statement	2016/17	2015/16	2014/15
<b>Inpatient Friends and Family Test</b>	97%	96%	100%	64%	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>it is drawn from the nationally reported data</li> <li>we have actively monitored our performance throughout the year.</li> </ul> We intend to take the following actions to improve this percentage, and so the quality of our services, by: <ul style="list-style-type: none"> <li>see page 76 for an update on our improvement plans.</li> </ul>	97% (2016/17)	96% (2015/16)	95% (2014/15)
<b>A&amp;E Friends and Family Test</b>	94%	86%	100%	46%	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: <ul style="list-style-type: none"> <li>it is drawn from the nationally reported data</li> <li>we have actively monitored our performance throughout the year.</li> </ul> We have taken the following actions to improve this percentage, and so the quality of our services, by: <ul style="list-style-type: none"> <li>see page 76 for an update on our improvement plans.</li> </ul>	95% (2016/17)	92% (2015/16)	88% (2014/15)





# 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. We will take them into account in our improvement plans for the coming year. We look forward to continuing to work with our stakeholders throughout the year as we strive to achieve our goals.

## HAMMERSMITH AND FULHAM CLINICAL COMMISSIONING GROUP RESPONSE TO THE IMPERIAL COLLEGE HEALTHCARE NHS TRUST QUALITY ACCOUNT 2017-2018

Hammersmith & Fulham CCG welcomes 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 reviewed by Associate Commissioners as well as the 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 accurate and reflects a true and balanced description of the quality of the provision of the Trust's services.

The 2017/18 Quality Account is linked to the Trust's current Quality Strategy which expires in 2018. We note the development of the new Quality Strategy and look forward to working with the trust to help shape this. 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. This was first Trust level 'Well Led' inspection, since first inspection in 2014; 17 ratings have improved, 33 ratings have stayed the same and 7 ratings have gone down. The ratings for Outpatients and Diagnostic Imaging Service have improved across the trust sites. However, Maternity and Urgent & Emergency Care continue to require some close working together with Commissioners to mitigate Commissioner Concerns and to drive further improvements over the next year.

Commissioners welcome the further development of Divisional Oversight Quality & Risk Meetings structured with the introduction of the Divisional Senior Triumvirate and

Executives. This will also feed in to the Trust's approach to CQC compliance and improvement management, which Commissioners welcome and look forward to discussions and support through the Clinical Quality Group meetings.

### Safe:

We look towards continuing to work in partnership with the Trust to support the further improvement on incident and serious incident management. We commend the work that the Trust has done around the incident reporting and management process including the reporting of Serious Incidents (SIs) and look towards the embedding of the Serious Incident Improvement Programme and on-going training programme in 2018. Commissioners would like to understand and support learning's from the Trust's thematic reviews to prevent re-occurrence of harm, which commissioner's note in some of the 'Safety Stream' themes. We remain keen to continue to input into the regular Incident Panel and to work together to support robust investigation processes. We can confirm that Duty of Candour (DoC) is being embedded and our observations are that the Trust has gone beyond the legislation by including implementation of DoC in their level 1 (internal SIs) and have reinforced the requirements of the Trust duty to implement DoC for those patients who have undergone treatment with documented complications and where patients have experienced these complications.

The Trust did receive a letter from NHS Improvement commending the Trust's contribution to reducing E Coli bloodstream infections and have been invited to share the learning – this is good news. Additionally the Trust is recognised as a leader in its work around mortality and together with 'Learning from Deaths' guidance. We anticipate continued good practice.

### Caring:

We note disappointingly the experience of cancer patients has not improved, but note with interest that the Trust is seeking to evaluate learning and systems from other partners that would give more immediate feedback on experience. We note that the quality account describes

patient engagement and experience in a mainly quantitative way. For example it does not capture how the project 'Changing our Lives' might be more widely adopted/adapted as a model of patient engagement.

### Responsive:

The Trust indicates its commitment to improving the RTT wait time's position with a target to have zero 52 week waiters, which commissioners welcome. Commissioners are keen to ensure that there will continue to be a high priority focus on the impact across the system of operational flow as links to Accident and Emergency; cancellations of surgery 'on the day' (are issues site or speciality specific?); impact on the management of Mixed Sex Accommodation. This work on capacity and flow is crucial to providing a better experience and outcomes for patients and also staff. We support the work of the Trust to proactively focus on RTT 52 weeks and focusing on limiting delays for patients at 40 weeks and the continuation of review for clinical harm.

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.

Out-Patient Improvement Programme – Commissioners are keen to see improvement delivered from this programme in the coming year.

### Well Led:

Across the Trust the domain of 'Well Led' in the recent CQC Inspection report was rated as 'Requiring Improvement'. We note the intentions of the Trust to develop and retain its staff, together with the suite of leadership programmes. We are encouraged by the link the Trust has made to explore the relationship between leadership and a patient safety culture and Commissioners would be keen to support this.

With the growing importance of securing our future workforce, Commissioners are heartened to see the plans to strengthen governance and experience for healthcare professional students including junior doctors, to make the learning environment an effective one and ensure a high quality return on investment in education. In conjunction with this focus, the Trust recognises that it needs to ensure that its workforce is compliant with statutory & mandatory training which helps to support a safety culture.

Commissioners are keen to see an improvement in the compliance against all safeguarding training and welcome the sharing of learning when safeguarding concerns have been raised.

### Maternity:

Commissioners acknowledge the focus and improvement that the Trust has delivered in relation to many aspects of maternity services. We are keen to see focus remain on the clinical risk areas (post-partum haemorrhage and puerperal sepsis) and also the consultant and junior doctor coverage across sites.

### NHS England Specialised Commissioning response to 2017-18 Quality Account

The document is a fair and accurate account of the current status of quality at Imperial College Healthcare NHS Trust. The Specialised Commissioning team look towards working in partnership with the Trust to ensure quality and risk is adequately managed for our complex and high risk patients receiving care at the Trust.

In 2018/19 we look forward to working with the Trust to embed the Specialised Services Quality dashboard into the emerging quality reporting and governance structures and ensuring work carried out by the Quality Service Team continues to highlight best practice and key areas where we can work together to improve outcomes for patients.

The specialised commissioning team recognises the continued focus and work the Trust has delivered to respond to challenges around Referral to Waiting Times (RTT) in 2017/18. In 2018/19 we would like to work with the Trust to focus on how we can improve the RTT response for patients with a particular emphasis on outcomes in cardiology, cardiothoracic and neurosurgery.

Yours sincerely



Janet Cree  
Managing Director



Tim Spicer  
Chair

# Statements from stakeholders

## HEALTHWATCH CENTRAL WEST LONDON RESPONSE TO IMPERIAL COLLEGE HEALTHCARE NHS TRUST 2017-18 QUALITY ACCOUNT

We welcome the opportunity to comment on Imperial College Healthcare NHS Trust's (the Trust) 2017-18 Quality Accounts (QA), and on the quality of the services delivered locally to meet the health needs of local residents.

In particular, we appreciate our continued close working relationship through the regular meetings of the Quality Steering Group. Healthwatch Authorised Representatives have also been involved through our Dignity Champion work and annual PLACE assessments and ongoing participation in the PLACE Steering Group.

### Patient and public involvement strategy

Our members are pleased to continue to participate in the Strategic Lay Forum. However, they are disappointed at the low level of achievements so far. Some projects have been started but not continued and our members hope that there will be greater continuity in the coming year.

Healthwatch continues to give full support to PPI initiatives in the Trust. Our members applaud the more structured approach by the Trust to working with volunteers and the increase in recruitment.

Our members welcome the Trust's first involvement toolkit for staff and request that a copy be sent to Healthwatch for information. We also request that this is included in the QA as an appendix.

### Comments on the Quality Accounts (QA)

#### Developing Imperial's 2018-2023 quality strategy

Our members are pleased that the Trust's new quality strategy is currently under development and will outline the direction and plan for how Imperial gets to a CQC rating of 'good', and 'outstanding' where possible, over the next five years. To support this, we would like to see more information about the patient's role in developing the quality improvement methodology and in particular how patients can be involved in this.

In addition, our members would also like to see an explanation of how the priorities identified through the listening campaign are going to influence the quality improvement programme, especially if these are not in alignment with the Trust's own priorities.

### Quality priorities for 2018/19

Our members welcome the Trust goals and the endeavour to match these to the CQC's current domain definitions. Using a scorecard to monitor this is a good way of keeping track. It would be useful to see an example of a scorecard with an explanation of what it shows.

Following our comments last year, our members are pleased to see that this year's QA includes more detail on how the success of each improvement will be measured.

### Quality priorities and outpatient management

Our members note that the Trust does not meet the targets for appointments to be made within five days of referral. In monitoring this it is important to note how long patients do have to wait for their first appointment. If there is a follow up appointment, the wait for that should also be measured. From the experience of our members, the average waiting time seems to be about 5 months and our members ask that this is monitored and improved.

### Improvement priority 3: To improve permanent nurse staffing levels

Our members stated that this is an essential priority. Patients always give full praise to nursing staff, but on visits round the hospitals nurses seem to be rushed off their feet. It can be difficult for them at times to find time to help patients with their food and other care needs. In order to better understand improvements in nursing numbers, our members would like this section to include current vacancy levels and the target vacancy rate.

### Improvement priority 5: To ensure equipment has planned maintenance in line with targets

Whilst our members welcomed the actions to ensure that equipment is well maintained, they would also like the e-learning package to include actions that staff need to take when equipment is due for routine maintenance to ensure that it is carried out.

### Improvement priority 8: To continue to define, develop, implement and evaluate an organisational approach to reducing unwarranted variation

Our members are pleased that the Trust is endeavouring to reduce unwarranted variation across patient pathways. However, they would like to see more analysis of the learnings from the three pilot pathways in 2017-18 and how these are going to inform development of the new pathways in 2018-19.

### Quality Domains and Quality Improvement Priorities

Our members request clear information on how the quality domain tables that address the CQC standards, from page 27 forward are linked to the Trust's quality improvement priorities.

### Quality Domain 4: Responsive

Our members would request that a further note be added to 'Point 4: Listen and act on feedback from patients and the public' that sets out what actions need to be taken based on the feedback collected from patients and the public. This also needs to be communicated back to patients so that they can clearly see how they have contributed.

### Quality Domain 5: Well led

Our members noted that the importance of staff training is highlighted in the Trust's quality improvement priorities but is not included here. They request that it is also included in this section.

### CQUIN scheme achievements

Our members are pleased to note the Trust's achievements against nationally set CCG CQUINS. However, the table is hard to follow and the section on achievements also includes actions taken and future outcomes that the Trust hopes to achieve. Our members request that separate columns are included in the table for each of these so that patients and public can understand what has been achieved – based on which actions, and can clearly see what is yet to be accomplished.

### Complaints

Our members in Hammersmith and Fulham are pleased to receive regular reports on complaints. As last year, we welcome the Trust's continued responsiveness to complaints and reduction of the overall number of complaints.

### Wayfinding strategy

The Wayfinding Strategy has been delayed. A pilot is now under way and our members look forward to seeing and evaluating the improvements.

### Presentation of the Quality Account

We find the QA is generally well laid out and uses plain English, and we welcome the use of simple explanations of medical terminology. We have made suggestions in previous sections on how presentation of tables could be improved.

### 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.



# Statements from stakeholders

## THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA RESPONSE TO IMPERIAL COLLEGE HEALTHCARE NHS TRUST'S QUALITY ACCOUNT 2017/18

The Royal Borough of Kensington and Chelsea welcomes the opportunity to comment on the Imperial College Healthcare Trust's ('the Trust') Quality Account for this year. We recognise the useful role that the Quality Account plays in ensuring that NHS health care providers are accountable to their patients, public, and stakeholders for the quality of services they provide.

The Royal Borough of Kensington and Chelsea commends the Trust on its continuous efforts to improve quality. We note that the Quality Strategy which was launched in 2015, was delivered via a number of initiatives and projects, with clear governance to enforce accountability and monitor progress. We are impressed by the Trust's commitment to improve quality overall. However, it is important to highlight that the Trust's CQC rating overall remains 'Requires Improvement'. We have a particular interest in the two sites that provide a significant amount of acute care for our residents, namely St Mary's and Charing Cross hospitals, both of which are rated as 'Requires Improvement' and that the rating of both stayed the same as the previous year. We are keen to hear more from the Trust directors about the impact of the Quality Strategy (2015-18), and subsequent initiatives, within the last three years. We understand that the Trust is working on a new 5-year strategy, we are interested to know how they will incorporate their experience from the previous years into the new strategy to achieve at least a 'Good' rating in the coming years.

We share the Trust's ambition to change the culture around safety and quality. The Trust employs almost 11,000 staff, any change of an organisation of this size will take time, plus huge efforts to embed and sustain. We note that this work started at least as far back as 2014, with what seems to be little impact on current outcomes. The report is not clear on what is going to be different in the coming years to bring about change.

The Quality Account states that the Trust is encouraging staff to report harmful errors and near misses, which are crucial to improving quality. We are pleased to see that increased number of staff feel safe to report more incidents, and the recent survey showed a 7% increase in the numbers (from 30% to 37%) and we note that this is 6% more than the national average (31%). We should like to hear the

Trust's views and plans of how they will bring about further improvements to transparency and openness.

### 4 HOUR A&E WAITING TIMES

We note that the Trust has struggled with the four hour A&E waiting time target throughout the year. The latest published reports state that in St Mary's and Charing Cross hospitals the performance levels were 77.37% which is below the national key target of 95%. We acknowledge that the Trust has ambitious plans to improve the target to 90% by September and 95% by March 2019. A&E waiting times is one of the most common areas where our residents' express dissatisfaction. The Council will be monitoring this target closely in the coming months.

We are aware that the number of people with Mental Health ('MH') problems attending A&E is increasing, needing specialist MH care, and that the prolonged waiting times to access inpatient mental health beds having a significant impact on patients and the overall waiting times in A&E. We should like to hear how the Trust intends to resolve this critical issue with the MH providers, and the CCG not only for the key target achievement, but also for better outcomes for patients with mental ill health.

### ELECTIVE SURGERY (Referral to Treatment (RTT))

We commend the Trust's performance in this area and its commitment to bring about further improvements. It is reported that in March 2018 the Trust achieved 83.29% which is one of the best performances in the UK, against the national target of 92%. We are aware that a number of elective procedures had to be cancelled this winter when the Trust was under pressure with bed capacity. The report highlights that an external review has been commissioned by the CEO to furnish the Trust with a detailed scope of work to support a review of the reasons that affect compliance and evaluate the initiatives required to sustain improvement in this area. We look forward to hearing more about this.

### IMPROVEMENT TARGET IN FIVE KEY CQC DOMAINS

We are in full support of the Trust's efforts to improve performance in the five key CQC domains. We note that there are a number of areas where no target has been set. However, to make it meaningful, we should have liked to see the new targets as well as the current performance levels. This would enable us to evaluate how realistic the targets are and the degree of work needed for improvements.

Readmissions to hospital is an area of concern for the Council. We are aware of the negative impact of

readmissions on patients' health and wellbeing. We understand that nationally, 1 in 5 patients are readmitted within 48 hours of discharge, and 29% increase in readmissions within 24 hours of discharge. Locally we are aware that the Trust has operated below the national average. But we have not seen any data on the number of patients readmitted for reasons different from reasons for the initial admission.

Finally, we would like to reiterate that the Trust's targets to improve the five key CQC domains, Safe, Effective, Caring, Responsive and Well-Led, are only meaningful in comparison to current performance, we should like to see this comparison in future quality accounts.

### DToC; (Delayed Transfers of Care)

In terms of unplanned admissions and demand on the whole system, including community services, the NHS endured one of the toughest winters for many years. The Trust continuously reported 'Black Alert' status throughout the winter. A significant amount of work went into supporting patient flows, monitoring DToC lists, as a result a system wide Standard Operating Procedure (SOP) was established by all the parties working together (the CCG, Council and the Trusts), which is welcomed. The Council has invested in the resource to create the SOP and expects it to be put fully into operation by the Trust to prepare for the winter ahead, and also to ensure patients are at the centre of all discharge planning.

DToC was given the highest importance throughout the year (not just during winter) both nationally and locally, with clear escalation levels, and daily reporting. Despite the pressures Adult Social Care acute DToC has been one of the lowest, in comparison the Trust struggled with the health delays. The Council has met its targets but health teams have not as yet. The quality report briefly mentions DToC under CQUIN Framework however bearing in mind the impact of DToC on the whole system, we feel that the Trust has not given the required importance to DToC in the report.

### WORKFORCE / STAFF SURVEY

The survey results make it clear that the Trust has some fundamental issues with its workforce. The Trust has below average scores when compared to other trusts in relation to the numbers of their staff taking part in the survey. We are very concerned that they report that they experience harassment, bullying or abuse in the workplace as well as discrimination, and witnessing potentially harmful errors, near misses or incidents. We were particularly concerned to read the following:

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

On a balanced view staff survey results show improvement in some areas but staff's view of senior management, and their lack of trust in their ability to deal with poor performance is very clear. We should have liked to have seen initiatives to deal with these important issues.

We have particularly noted the following achievements;

- Improvement in PLACE targets
- 37% reduction in pressure ulcers
- Increases in incident reporting by staff and actions to follow these reports
- Overall CQC rating in the 'Effective' Domain is Good, which is very encouraging
- We are pleased to see that 95% of the complaints were responded to on a timely basis
- The Trust has exceeded its target for the percentage of their inpatients who would recommend the Trust to friends and family.

### We should like to register our concerns in these areas;

- The Trust failed to meet national key A&E targets, Imperial was identified as an outlier for poor performance in the A&E survey
- Only 78.2% of patients were admitted to an intensive care bed within 2 hours of the decision to admit. We hope the new bed configurations across the Trust will improve this performance
- Only 4 out of 12 national standards are met. The Trust must give reassurance of how it will tackle the significant pressures around demand, capacity, and patient flow to improve patient outcomes and meet targets
- As set out above, we are concerned about the workforce issues and would like the Trust to take the messages coming out of the staff survey seriously and address them with the upmost diligence

# Statements from stakeholders

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- We have not seen any improvement in the Trust's overall performance since 2014, this is of concern to the CQC and to us. The Trust has still to reassure us that their new Quality Strategy will improve performance. We will be monitoring this closely
- Although the Trust reports that it maintained safe staffing levels, we are concerned about the sufficiency of the measures taken to address the consistently high vacancy levels. We find these measures not sustainable, and may have the effect of putting additional pressures on already stretched staff with implications for safe patient care.

## CONCLUSION

We commend the Trust for producing a transparent and well-balanced report that addresses the quality, performance and workforce issues that they face across the sites. We find encouraging, and key to fostering trust between the organisations the Trust's genuine desire to improve performance and patient outcomes.

We are, however, concerned that the same issues have remained within the Trust for a number of years, that the previous efforts seem to have achieved little change, and by the enormity of the work required to improve the quality standards in the coming years.

RBKC will continue to monitor the Trust's performance, and looks forward to working with the Trust to improve the quality of care for our residents.

**Councillor Catherine Faulks,  
Chairman,  
Adult Social Care and Health Scrutiny Committee  
Royal Borough of Kensington and Chelsea**



# Statements from stakeholders

## LONDON BOROUGH OF HOUNSLOW OVERVIEW AND SCRUTINY COMMITTEE RESPONSE TO IMPERIAL COLLEGE HEALTHCARE NHS TRUST QUALITY ACCOUNT 2017/18

On behalf of the London Borough of Hounslow Overview and Scrutiny Committee ('Scrutiny Committee' and the previous Health and Adults Care Scrutiny Panel ('Scrutiny Panel'), please find below our response statement for inclusion in the Imperial College Healthcare NHS Trust ('the Trust') Quality Account 2017/18.

### LONDON BOROUGH OF HOUNSLOW SCRUTINY RESPONSE

As we received this report during a time where we have no formal Health and Adults Care Scrutiny Panel, I am writing to you in my role as chair of Overview and Scrutiny ('Scrutiny Committee'). It should be noted that the timing of the request for comment is not ideal given this was distributed on the day of the May local council elections. Hence, members were unable to engage with this report in the manner they would have liked.

#### CQC rating: Requires improvement

The Scrutiny Committee notes that there has been no change to the overall outcome of the latest published CQC inspection rating of 'Requiring improvement'. The Committee is concerned over this rating and the recent 2017/18 inspections urgent and emergency services of at St Mary's Hospital and Charing Cross Hospital rating. Although there was no change at St Mary's Hospital, the overall rating at Charing Cross Hospital is worse. The Committee encourages the Trust's plans to include improvements into priority plans for 2018/19 and review its approach to improving core services against CQC standards. We hope to receive an update on the Trust's new 2018-2033 Quality Strategy which is to be published in autumn and how this might be used to work towards an improved rating.

#### Accessibility of the report

We commend the Trust on the structure and layout of the report which was detailed but easy to follow, with summary tables and a glossary included to assist engagement with the content. We appreciate the Trust's responsiveness to feedback on report structure and layout from previous years.

#### Priorities 2018/19

Overall, the Scrutiny Committee welcomes and supports the

priorities for 2018/19 as these accord with the London Borough of Hounslow 2014-19 corporate priority of building active and healthy communities by promoting lifestyles that improve people's wellbeing with less need for health and social care. We also note that several of these priorities link to the gaps and issues identified in previous inspections and the 'listening campaign'.

#### Performance on 2017/18 quality priorities

The Scrutiny Committee expresses their disappointment that the Trust has not achieved several important targets. However, we are pleased to hear of the quality improvement plans and actions underway to address these areas.

##### *Domain: Safe*

It is worrying that there was an increase in avoidable deaths and the percentage of staff who reported witnessing potentially harmful errors, from the previous year. The Committee supports and encourages the Trusts' safety improvement programs including the use of electronic alerts to improve diagnosis and administration of antibiotics, to reduce avoidable harm to patients.

It is also concerning that equipment maintenance oversight and management continue to be problematic at the Trust. We understand culture change takes time, and support the Trust's continued efforts to improve safety culture.

The Scrutiny Committee has been focusing on monitoring falls prevention across the Borough over the past year, therefore, we strongly support and encourage the Trust's targets of increasing safe mobility and preventing falls causing harm.

##### *Domain: Effective*

The Scrutiny Committee congratulates the Trust for its low mortality rates and achieving the second lowest rate amongst all non-specialist providers in England. We encourage the Trust to ensure mortality reviews are carried out in line with national requirements.

We also strongly support the Trust's commitment to innovation and research particularly in diagnosis and treatment across a broad spectrum of specialities. We commend the Trust's roll-out of digital tools such as bed-side monitoring, electronic patient record systems and real-time monitoring of babies' heart rates during labour.

##### *Domain: Caring*

The Scrutiny Committee expresses its concern about the vacancy rates for permanent nurses at the Trust, and

would like to be kept updated on the investment into and implementation of the new staffing strategy during 2018/19.

We are pleased to note the Trust's high percentage of patients who would recommend the Trust to their friends and family.

##### *Domain: Responsiveness*

The Scrutiny Committee expresses its disappointment over the Trust's failure to meet several significant targets including the inpatient waiting times for elective surgery, cancelled operations, discharges and admissions to intensive care. Although, this is of great concern to the Committee; we acknowledge the significant number of programmes and initiatives in place to drive improvement in these areas. We also congratulate the Trust on its improved complaints management and low rate of complaints.

The Committee would like to special draw attention to the inability to meet the four-hour A&E access standard or the 18-week referral-to-treatment waiting time target. A&E and Acute services have been a focus area for the Health and Adult Care Scrutiny Panel and the North West Joint Health Overview and Scrutiny Committee (JHOSC) over the past year. As such, we would encourage that this is a priority area going forward. It would also be useful to know when the Trust anticipates their interventions will bring enable them to achieve the 4-hour A&E target.

##### *Domain: Well-led*

The issue of the Trust's ageing estate and lack of space to expand its capacity remains a concern, however we commend the Trust on its securing of planning permissions for the development of St. Mary's ophthalmology and outpatient services buildings.

The Scrutiny Committee also notes their concern over the Trust's failure to meet the target percentage of staff compliant with core skills training, as this has been a repeated area of concern by the CQC in their inspections. We support the Trust in its implementation of a new learning management system in late 2018, and look forward to hearing about progress on this system later in the year.

We are pleased to note the high level of staff engagement and satisfaction reported in the 2017 national staff survey results. The Health and Adult Care Scrutiny Panel and the North West JHOSC has taken a keen interest in looking at employment conditions and job satisfaction of all staff working in NHS Trusts in Hounslow. Staff retention has also been a key area of focus particularly due to the uncertainty

surrounding Brexit and impacts of this on health sector staff retention.

#### Sustainability and Transformation Plan (STP)

The report is largely silent on the anticipated impacts of the STP. The Scrutiny Committee recommends some clear articulation of approaches the Trust intends to use in addressing challenges and opportunities arising from the STP.

On behalf of the Scrutiny function in the London Borough of Hounslow, I thank the Trust for sharing the Quality Account for comment. We hope to continue this positive engagement going forward into the new year.

Yours sincerely

**Puneet Grewal**  
Chair of Overview and Scrutiny Committee  
London Borough of Hounslow

# Independent Auditor's Assurance Report'

## 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 2018 ("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 2018 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:

- Board minutes for the period April 2017 to June 2018;

- papers relating to the Quality Account reported to the Board over the period April 2017 to June 2018;
- feedback from the Commissioners;
- feedback from Local Healthwatch dated 22/05/2018;
- feedback from Overview and Scrutiny committee;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey;
- the latest national staff survey;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 19/05/2018;
- the annual governance statement dated 25/05/2018;
- Care Quality Commission Intelligent Monitoring Report dated May 2015;

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 2018:

- 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  
26 June 2018



# Appendix A:

## National Clinical Audit

As described on page 46, the reports of twenty four national clinical audits and confidential enquires were fully reviewed by the provider in 2017/18. The majority of these have provided a satisfactory level of assurance, however the exceptions are listed below with the actions required to improve the quality of healthcare provided.

### National Audit of Dementia

St Mary's was ranked first place for aspects of care relating to nutrition, which is reflective of the considerable work put in by the dementia care team (NOSH project and other initiatives). There was a significant improvement in the standard of documentation relating to discharge since the 2012/13 audit. The Trust also scored higher than the national average on initial screening, clinical assessment and the summary of symptoms for discharge summary. Recording the functional assessment of the patient was below the national average, and we have updated the delirium pathway as an action to improve this.

The audit highlighted areas for improvement where we are already aware of the challenges, such as creating a dementia friendly environment and adequate social space in the very old estate at St Mary's. The audit also identified inappropriate bed moves for patients with dementia, and this is another area for focus in over the coming year as an issue that requires improvement.

### National Neonatal Audit Programme (NNAP)

This audit monitors whether the care provided to babies and their families matches up to professionally agreed standards, and compares the results against all levels of neonatal units in England, Scotland and Wales. This audit provided substantial assurance

against six of the audit findings, with reasonable assurance for two.

Over the next year we need to improve the number of babies who have their temperature taken within one hour of admission to the neonatal unit. We have utilised posters to raise awareness and have taken additional actions to ensure transport incubators are warmed up in advance to prevent deterioration in body temperature.

### MBRRACE–UK Perinatal Confidential Enquiry

This confidential enquiry focusses on intrapartum-related deaths, specifically those born at term, excluding major abnormality (but including those anomalies where the cause of death was felt to be related to the intrapartum period rather than the anomaly). The enquiry explored preventable failures along the whole care pathway, but with a particular focus on care during labour, delivery and any resuscitation which may have contributed to the death.

Over the next year we are going to continue to train consultants to use Structured Judgement Review (SJR) forms, and plan for all healthcare professionals who are routinely present at births should undertake regular Newborn Life Support training.

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

This audit identified areas for improvement nationally with the transfusion process. We already have a checklist in place beside the patient to record the final administration check before transfusion is commenced. Over the next year we intend to develop a system to formally assess the risk of transfusion associated circulatory overload, as this is the major cause of death and morbidity.

### RCP/BTS Adult Asthma

This audit assessed adult patients with acute asthma exacerbation who were admitted as in-patients, and looked at patient demographics, assessment, management, discharge bundle, follow up arrangements and re-admission rates. This showed that the local patient cohort appears to have more severe or complex disease than the national average. Documentation of PEF post bronchodilation was poor at 84%. Although patients were seen by an asthma nurse on discharge, there was no specific discharge bundle in place. Follow up arrangements were not always conducted in a timely way which led to a slight increase in readmission rates.

Since this audit, and over the next year, we have appointed an asthma lead clinician and implemented the discharge care bundle. We are continuing to recruit to nurse specialist roles and are integrating teams across both acute sites. We are improving training and education of nursing staff and junior doctors to improve standards of care, and are developing improved online training regarding inhaler and PEF technique. We have held a 'Asthma Big Room' quality improvement session since the audit, and these were some of the improvement ideas that were generated at this session.

### Elective Surgery National PROMs Programme

Previous audits had shown that the Trust was a negative outlier for knee surgery, and this was not evident in the latest audit report. Our actions for the coming year include improving our response rates for post-operative questionnaires, tendering a new data collection service and using the information we receive from PROMs to shape improvements in care. The first project using this approach will be a review of post-operative analgesia regimes.

### Critical Care Case Mix Programme (ICNARC)

The Critical Care Units are compliant with quarterly data submission, which is then used to inform the annual report. This year's report showed some extremely positive progress, such as low rates of unit acquired blood stream infections, particularly those related to catheter use, and no non-clinical transfers.

The areas for improvement over the next year are delayed discharges, particularly at the St Mary's site. There is currently work being undertaken to reconfigure Level Two areas and open additional beds on the St Mary's site. There are also actions in place to improve readmissions at Charing Cross, high risk sepsis referrals the Hammersmith, and outcomes for patients at low risk of death at St Mary's.

# Appendix B:

## Local Clinical Audit

### Trustwide Priority Audits

Over the year the trust has identified a number of areas for targeted audit work across the organisation. These have been selected as areas where improvement is needed, areas of risk or in order to support a strategic aim. Audits conducted in these areas have been coordinated centrally and reported to the trust quality and safety group for oversight and monitoring of actions and to provide assurance. Many of these audits are ongoing or form part of a wider improvement project and they will be taken forward with specific actions or a requirement for further or wider audit and QI involvement. These audits include:

- patient falls
- medications and Medicines
- safer surgery and the WHO surgery checklist safety stream
- patient consent
- Duty of Candour
- nasogastric tubes and feeding: Adults; critical care patients
- pain: Assessment, recording and management
- the deteriorating patient: (NEWS and MEWS scoring)
- hand hygiene
- completion of action plans following serious incidents.

Some of the actions taken following the completion of these audits include:

- Changes to Trust policy following Duty of Candour audit. This will be re-audited in 2018/19.
- A safety stream with a Quality Improvement focus has been set up following the safer surgery audit. Regular audits run throughout the year, and there will be a repeat Trust-wide WHO check list audit in Q2 2018/19.

- NEWS and MEWS audit led to improvements in the calculation of early warning scores in the electronic patient record. There was also a focused piece of work within maternity services to improve the standards of documentation of observations.
- Improvements were made to documentation and handover of NG tube placements in Critical Care following the audit. Naso-gastric tube placement will be audited across the Trust during 2108/19.

### Local Clinical Audits

Over 2017/18 there were 365 local audits registered in the Trust. The findings and action plans from these audits are presented at Directorate or Divisional level with local oversight of the action plans. Some of these audits have wider implications for the organisation and are then presented at Quality and Safety sub-group meetings where learning is shared and directed towards improvement.

A selection of these audits where specific learning or improvement has been identified includes:

The colorectal surgery team audited practice within their team undertaking procedures in the out-patient department. From this, they were able to quantify the number of procedures being completed and the grade of doctor performing them. As a result, the team were able to implement improvements in coding to ensure accurate records were kept and that the correct tariff was being applied.

Hammersmith General ICU reviewed the common practice of fasting patients prior to invasive procedures and were able to make improvements to safely reduce the length of time that ICU patients are kept nil by mouth.

The diabetes team looked at the causes of the delays in discharge experienced

by some of the patients on a diabetic foot pathway. This has led to redesign of some clinical pathways around larvae therapy, vacuum assisted closure of wounds and time to theatre.

The trauma and orthopaedic team audited the time to first review and subsequent treatment for patients sustaining hand and wrist fractures. They identified unacceptable delays and have been able to reduce these by modifying patient pathways, improving communication and developing a new virtual fracture clinic. This has been successfully funded in the pilot stage by an NIHR-CLAHRC grant application.

The neurology team have audited the presentation and management of patients with papilloedema in the trust via a number of complex pathways. This is a complex referral system from a regional catchment area including emergency departments, GPs, ophthalmology units and opticians. They have been able to identify potential delays in the pathway and ways to streamline this. These are under discussion with stakeholders to agree a more efficient regional process.

The neurosurgery team reviewed their practice and performance in the provision of driving advice to patients treated for non-traumatic sub arachnoid haemorrhage. They identified a number of areas for improvement and have undertaken a programme of education for their junior medical staff.

The paediatric ophthalmology service audited their practice and performance to identify any serious complications of strabismus surgery. The audit identified no areas of concern.

The maternity team audited the prevalence and outcomes of recorded major obstetric haemorrhage and the use of the trust protocol. Outcomes were generally good however they were able to identify areas for improvement in identification of risk factors, reporting, use of tranexamic acid and cell salvage.

This is now a 'rolling audit' and will be revisited to confirm ongoing improvement.

The trauma and orthopaedic surgery department conducted an audit of the use of aspirin for VTE prophylaxis in hip and knee arthroplasty. This identified that aspirin is safe and effective in selected patients. The department is reviewing the trust guidelines and agreement for future standards with the trust thrombosis committee.

The anaesthetic team conducted an audit of the preoperative fasting of patients before elective surgery and advice given to patients. They found considerable variation in advice and practice and have revisited the guidance and initiated an education programme for staff. This is now an area of joint working between the anaesthetic team and the trust quality improvement team.



# Appendix C: quarterly learning from deaths dashboards

**Description:**  
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

### Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

#### Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
190	162	2	6	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
190	490	2	33	0	3
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1541	0	80	0	7	0



#### Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Probably avoidable but not very likely	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
This Month: 0 (0.0%)	This Month: 0 (0.0%)	This Month: 0 (0.0%)	This Month: 0 (0.0%)	This Month: 0 (0.0%)	This Month: 2 (100.0%)
This Quarter (QTD): 0 (0.0%)	This Quarter (QTD): 0 (0.0%)	This Quarter (QTD): 0 (0.0%)	This Quarter (QTD): 0 (0.0%)	This Quarter (QTD): 0 (0.0%)	This Quarter (QTD): 2 (100.0%)
This Year (YTD): 1 (1.3%)	This Year (YTD): 3 (3.8%)	This Year (YTD): 3 (3.8%)	This Year (YTD): 7 (8.8%)	This Year (YTD): 14 (17.5%)	This Year (YTD): 52 (65.0%)

### Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

#### Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
11	0	2	0	0	0





# Glossary

**Academic Health Science Centre (AHSC)** – a partnership between one or more universities and healthcare providers focusing on research, clinical services, education and training. AHSCs are intended to ensure that medical research breakthroughs lead to direct clinical benefits for patients.

**Accessible Information Standard (AIS)** – launched in August 2016, the standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and with support so they can communicate effectively with health and social care services.

**Anti-infectives** – drugs that are capable of acting against infection. They include antibacterials, antifungals and antivirals. These agents are often referred to collectively as antibiotics.

**Avoidable infections** – within the Trust we define 'avoidable infections' as: a case of MRSA BSI occurring 48 hours after admission; and a case of Clostridium difficile that is both PCR and toxin (EIA) positive occurring 72 hours after hospital admission when there is non-compliance with the antibiotic policy or the patient crossed pathways with a known case of the same ribotype (a method used to compare the genetic relatedness of different C. difficile strains).

**Big Room** – A big room is a regular standardised meeting which provides time and space for a range of staff and patients to come together to discuss improvements to the quality of patient care.

**Carbapenem-resistant Enterobacteriaceae (CRE)** – gram-negative bacteria that are resistant to the carbapenem class of antibiotics. They are resistant because they produce an enzyme called a carbapenemase that disables the drug molecule.

**Cardiac Arrest** – also known as cardiopulmonary arrest or circulatory arrest, a cardiac arrest is a sudden stop in blood circulation due to the failure of the heart to contract effectively or at all.

**Cardiotocography** – a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. The machine used to perform the monitoring is called a cardiotocograph, more commonly known as an electronic fetal monitor (EFM).

**Care Quality Commission (CQC)** – the independent regulator of health and social care in England. It makes sure health and social care services provide people with

safe, effective, caring, well-led and responsive care, and encourages care services to improve.

**Cerner** – supplier of health information technology (HIT) solutions, services, devices and hardware

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

**Clinical Guidelines** – these are recommendations of how healthcare professionals should care for people with specific conditions. They can cover any aspect of a condition and may include recommendations about providing information and advice, prevention, diagnosis, treatment and longer-term management. They aim to help health professionals and patients make the best decisions about treatment or care for a particular condition or situation.

**Clinical Nurse Specialist (CNS)** – provide expert advice related to specific conditions or treatment pathways. They focus on improving patient care and developing services.

**Clostridium difficile** – an anaerobic bacterium that can live in the gut of healthy people where it does not cause any problems, as it is kept in check by the normal bacterial population of the intestine. However, some antibiotics used to treat other illnesses can interfere with the balance of bacteria in the gut which may allow C. difficile to multiply and produce toxins that damage the gut. Symptoms of C. difficile infection range from mild to severe diarrhoea and more unusually, severe inflammation of the bowel.

**Core Skills Training** – nationally defined and mandated training programmes which all Trust staff must complete in accordance with the requirements of their roles.

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

**Datix** – patient safety and risk management software for healthcare incident reporting and adverse events. This is the system the Trust uses to report incidents, manage risk registers and as of 1st April 2016, to record mortality reviews.

**Departmental Safety Coordinator (DSC)** – appointed by departmental managers to assist them in meeting their

health, safety and wellbeing responsibilities.

**DNA ('did not attend')** – when a patient misses a hospital appointment.

**Driver Diagrams** – a visual model used in quality improvement (QI) methodology that identifies all the things that must in place to achieve an aim by breaking it down into small steps that can be directly influenced with change ideas and can be measured.

**Dr Foster** – provider of healthcare variation analysis and clinical benchmarking.

**Duty of Candour** – Secondary care providers registered with CQC in England are subject to a statutory duty of candour, introduced in November 2014. It is a statutory requirement to ensure that patients and their families are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and are supported throughout.

**Emergency readmissions** – unplanned readmissions that occur within 28 days after discharge from hospital. They may not be linked to the original reason for admission.

**Five moments** – The My 5 Moments for Hand Hygiene approach defines the key moments when health-care workers should perform hand hygiene.

**Flow** – the progressive movement of people, equipment and information through a sequence of processes. In healthcare, the term generally denotes the flow of patients between staff, departments and organisations along a pathway of care.

**Flow coaching** – providing training to build team coaching skills and improvement science at care pathway level

**Friends and Family Test (FFT)** – The NHS FFT was launched in 2013 to help service providers and commissioners understand whether their patients are happy with the service provided. It is a quick and anonymous way for patients to give their views after receiving care or treatment.

**General Medical Council (GMC)** – The GMC regulates doctors in the United Kingdom. They set standards, hold a register, quality assure education and investigate complaints.

**Getting it Right First Time (GIRFT)** – is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.

**Hospital Episode Statistics (HES)** – HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England.

This data is collected during a patient's time at hospital and is submitted to allow hospitals to be paid for the care they deliver.

**Hospital Standardised Mortality Ratio (HSMR)** – an overall quality indicator that compares a hospital's mortality rate with the average national experience, accounting for the types of patients cared for.

**Information Governance** – ensures necessary safeguards for, and appropriate use of, patient and personal information.

**Integrated Care** – NHS England has recently changed the name of accountable care systems to integrated care systems. Integrated care happens when NHS organisations work together to meet the needs of their local population.

**IR(ME)R** – the Ionising Radiation (Medical Exposure) Regulations 2000 is legislation which provides a framework intended to protect patients from the hazards associated with ionising radiation.

**Local Faculty Group** – a group in each department which meets regularly to take responsibility for the learning environment, and undergraduate and postgraduate training in that service.

**Luer lock** – an industry standard tapered termination utilized by most syringe manufacturers including medical Hypodermic syringes. Luer Lock needles are common because their design is controlled by a series of universal standards which guarantees compatibility between manufacturers.

**Medical Appraisal** – all doctors must undertake and record an annual medical appraisal in order to demonstrate that they comply with Good Medical Practice as required by the GMC.

**Medical Devices** – any instrument, apparatus, material, software or healthcare product, excluding drugs, used for a patient or client for:

- diagnosis, prevention, monitoring, treatment or alleviation of disease;
- diagnosis, monitoring, treatment or alleviation, or compensation for, an injury or handicap;
- investigation, replacement or modification of the anatomy or a physiological process;
- control of conception

**Methicillin-resistant Staphylococcus aureus (MRSA)** – a type of bacteria that's resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections. Staphylococcus aureus is a common type of bacteria. It's often carried on the skin and inside the nostrils and throat. If the bacteria get into a break in the skin, they can cause life-threatening infections, such as blood poisoning or endocarditis.

**Model for improvement** – a method for structuring an improvement project, guiding the development of an idea and testing it out using a simple framework. The model consists of two parts: 1) Three questions help us define what we want to achieve (aim), what ideas we think might make a difference (change ideas), and how we'll know if a change is an improvement (measures). 2) PDSA (Plan Do Study Act) cycles to implement and test change ideas. Multiple PDSA cycles allows the change to be refined and improved through repeated cycles of testing and learning as a vehicle for continuous improvement.



**National Reporting and Learning System (NRLS)** – the NRLS enables patient safety incident reports to be submitted to a national database on a voluntary basis and is designed to promote learning. Participation enables us to compare our incident reporting rates with our peers.

**Never events** – serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

**NEWS** – national early warning score is a score allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital

**Outpatient parenteral antimicrobial therapy (OPAT)** – OPAT is the administration of intravenous antimicrobial therapy to patients in an outpatient setting or in their own home.

**Palliative Care** – a multidisciplinary approach to specialised medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, physical stress, and mental stress of a serious illness, whatever the diagnosis. Palliative care is normally offered to terminally ill patients, regardless of their overall disease management style, if it seems likely to help manage symptoms such as pain and improve quality of life.

**Patient advice & liaison service (PALS)** – PALS offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

**Patient led assessments of the care environment (PLACE)** – A national system for annually assessing the quality of the patient environment in hospitals, hospices and day treatment centres providing NHS funded care. The assessments see local people go into hospitals as part of teams to assess how the environment supports privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. Results are reported publicly to help drive improvements.

**Patient reported outcome measures (PROMs)** – tools we use to measure the quality of the service we provide for specific surgical procedures. Patients complete two questionnaires at different time points, to see if the procedure has made a difference to their health.

**Patient safety incident** – any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. Patient safety incidents are categorised by harm level, defined as follows by the NRLS:

- Near miss – incident that had the potential to cause harm but was prevented, resulting in no harm.
- No harm – incident that ran to completion but no harm occurred.
- Low harm: incident that required extra observation or minor treatment and caused minimal harm.

- Moderate harm: incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm.
- Severe harm: incident that appears to have resulted in permanent harm.
- Extreme harm/death: incident that directly resulted in the death of one or more persons.

**Patient safety translational research centre (PSTRC)** – The NIHR Imperial Patient Safety Translational Research Centre (PSTRC) is part of National Institute for Health Research (NIHR). It is a partnership between Imperial College Healthcare NHS Trust and Imperial College London, with researchers from a specialised set of research groups working together to improve patient safety and the quality of healthcare services.

**Performance Development Review (PDR)** – our annual performance review process for all staff, excluding doctors, which is aimed at driving a new performance culture across the Trust.

**Patient-Led Assessments of the Care Environment (PLACE)** – system for assessing the quality of the patient environment. The assessments primarily apply to hospitals and hospices providing NHS-funded care in both the NHS and private/independent sectors but others are also encouraged and helped to participate in the programme.

**Pressure ulcer** – a type of injury that affect areas of the skin and underlying tissue. They are caused when the affected area of skin is placed under too much pressure. They can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle.

**Quality Improvement (QI)** – is a formal approach to the analysis of performance and systematic efforts to improve it. It is a method for developing, testing and implementing changes so that improvements can be made quickly.

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

**Responsible Officer** – individuals within designated bodies who have overall responsibility for helping doctors with revalidation.

**Revalidation** – the process by which all licensed doctors and nurses are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field.

**Radio-frequency identification (RFID)** – technology which uses radio waves to identify, authenticate, track and trace objects or devices. RFID has two main components: a tag and a reader

**Root Cause Analysis (RCA)** – a systematic investigation that looks beyond the people concerned to try and understand the underlying causes and environmental context in which the incident happened. Serious incidents and never events undergo RCA as part of the investigation.

**Safe Effective Quality Occupational Health Services (SEQOHS)** – set of standards and a voluntary accreditation scheme for occupational health services in the UK and beyond. SEQOHS accreditation is the formal recognition that an occupational health service provider has demonstrated that it has the competence to deliver against the measures in the SEQOHS standards.

**Safeguarding** – protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care.

**SBAR** – an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication.

**Schwartz Rounds** – meetings which provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work. Research shows the positive impact that they have on individuals, teams, patient outcomes and organisational culture.

**Secondary Users Service (SUS)** – the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

**Serious Incident (SI)** – events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

**Standardised hospital mortality indicator (SHMI)** – a national way of measuring mortality. It includes deaths related to all admitted patients that occur in all settings – including those in hospitals and those that happen 30 days after discharge.

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

**Structured judgement review (SJR)** – based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

**Student Online Evaluation (SOLE)** – online module evaluation which gives medical students the opportunity to feedback on their experience in a simple, secure and confidential way.

**Venous thromboembolism (VTE)** – a blood clot within a blood vessel that blocks a vein or an artery, obstructing or stopping the flow of blood.

**Ward accreditation programme (WAP)** – Reviews of patient areas during which patient care is observed, documentation reviewed, the environment assessed and discussion with patients, carers and staff members takes place.

**WHO checklist** – The World Health Organization Surgical Safety Checklist ensures that surgical teams have completed the necessary listed tasks to ensure patient safety before, during and after surgery.



# Contact us



## **Charing Cross Hospital**

Fulham Palace Road  
London W6 8RF

020 3311 1234

## **Hammersmith Hospital**

Du Cane Road  
London W12 0HS

020 3313 1000

## **Queen Charlotte's & Chelsea Hospital**

Du Cane Road  
London W12 0HS

020 3313 1111

## **St Mary's Hospital**

Praed Street  
London W2 1NY

020 3312 6666

## **Western Eye Hospital**

Marylebone Road  
London NW1 5QH

020 3312 6666

[www.imperial.nhs.uk](http://www.imperial.nhs.uk)

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