NHS
Imperial College Healthcare
NHS Trust

2022/23

Quality account

Contents

Overview

This quality account is an opportunity for us to review our progress against key quality and safety improvement measures in 2022/23. It has been another year influenced by the far-reaching effects of the pandemic, with large waiting lists for care and increased demand for our emergency departments, while still caring for those with Covid-19.

We have nonetheless made good progress in many improvement areas. An important one in patient safety where we have been working to implement the NHS Patient Safety Strategy and have begun transitioning to the Patient Safety Incident Response Framework. We remain well below the national average for incidents causing moderate or above harm despite an increase in our incident reporting rate, which positively reflects our work to embed values and behaviours that allow our staff to feel supported in openly reporting incidents.

Similarly, we have made strides forward in our work to become more 'user-focused' and incorporate the views, preferences and insights of our patients and families into our strategic goals and improvement priorities. This year we have recruited six patient safety partners from our local community to be a 'critical friend' on elements of our patient safety work as we develop plans and policies in this area.

As in previous years, we continue to have among the lowest mortality rates in the country. We also have some of the lowest rates for unplanned patient readmissions for both adults and children. We have maintained our focus on infection prevention and control measures, with a new package of education and support for staff. Disappointingly, despite these efforts, we have seen a slight increase in some hospital-acquired infections, but we are confident that we will see the full benefits of our new approach in the coming year.

Our priorities for 2023/24 largely mirror those of 2022/23 with ongoing efforts to reduce waits in planned care and ease pressure on our urgent and emergency care pathways. We remain committed to supporting our staff to feel valued, motivated and healthy, and to continue to press the case for redeveloping our aging hospital estates. We will also continue to progress our local safety improvement programme priorities to achieve long-term, sustainable changes over short-term fixes.

This activity will sit alongside our work with our new North West London Acute Provider Collaborative partner trusts: Chelsea and Westminster Hospital NHS Foundation Trust, London North West University Healthcare NHS Trust, and The Hillingdon Hospitals NHS Foundation Trust.

Collectively we have identified four areas for improvement based on our shared local challenges: quality; people; finance and operational performance; and infrastructure. With responsibility for leading the quality domain, Imperial College Healthcare drives collective priorities including: improving care for deteriorating patients and end of life care; standardising processes for clinical harm and mortality reviews; more effectively gathering and responding to the needs and preferences of our patients and local communities; and, co-designing improved ways of working on other clinical pathways to increase quality and reduce unwarranted variations. This will allow us to provide better care for more people, more fairly and we look forward to progressing these in the next year.

Thank you to everyone who has helped us put this quality account together including Healthwatch, our commissioners and our local authorities, and to our staff who are so committed to providing our patients with the highest quality of care.

Professor Tim Orchard
Chief executive

PART 1:
PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

1.1 Priorities for improvement

This section of the report provides an overview of our approach to quality improvement, our improvement priorities for the upcoming year and a review of our performance over the last year.

Our improvement methodology

We have a dedicated improvement team whose aim is to build learning, improvement and innovation into everything we do across the Trust. The team continues to ensure the rigorous application of the Institute for Healthcare Improvement's methodology by coaching individuals and teams in their area of work, and through large-scale improvements to drive change. An extensive education programme – available to all staff – that aligns to our Imperial improvement competency framework, supports this work. This framework sets out how we embed improvement knowledge and skills across all levels of our organisation at scale and pace.

To date, there have been 5,589 attendances at improvement training and 1,290 (nine per cent) current members of staff are trained in improvement, of which 152 are trained as improvement coaches (one per cent of the organisation).

The Imperial Management and Improvement System (IMIS)

IMIS is the Trust's operational mechanism to help the organisation, our divisions, directorates, specialties, frontline and corporate teams deliver on their objectives. This in turn enables teams to incorporate learning, improvement and innovation into everything they do, building a culture of continuous improvement.

IMIS is now being deployed to directorates within the surgery, cancer and cardiovascular division. It aims to provide teams with a consistent and systematic approach to prioritising, monitoring and managing (i.e., improving and sustaining) strategic and operational change. Work is also progressing with select frontline teams to embed improvement within the ward routine via 'improvement huddles'. This allows any member of staff to raise improvement ideas or issues and proactively problem solve with their multidisciplinary team.

2023/24 improvement priorities

The priorities for the quality section of the annual report focus on the quality and safety improvement programme and are set out in the table below. The other strategic priorities are addressed and covered in our annual report.

We have made good progress with many of the safety improvement priorities we set ourselves for 2022/23, including the implementation of the NHS Patient Safety Strategy and in particular our work to begin transitioning to the Patient Safety Incident Response Framework (PSIRF), following its publication in September 2022.

We will continue to focus our efforts in 2023/24 on implementing all elements of the national strategy, whilst working on the priority improvements set out in the table below. These have been developed following review of quality insight data, including: incidents, complaints, patient feedback, claims and inquests, audit, mortality data including structured judgement reviews, outcomes from our ward accreditation programme, risks and emerging issues, as well as national, acute collaborative and local priorities and planned improvement work.

We are committed to focusing on these priorities, along with a wide range of other work aiming to improve the quality and safety of care provided to our patients, the experience they receive, and the environment and culture in which our staff work.

In addition to our local priorities, we are also working with the other three acute trusts in the North West London Acute Provider Collaborative (Chelsea and Westminster Hospital NHS Foundation Trust, London North West University Healthcare NHS Trust, and The Hillingdon Hospitals NHS Foundation Trust) on a number of priority areas. Many of our local priorities are aligned with these collaborative workstreams, which are focused on streamlining and ensuring consistent processes and reporting across the four acute collaborative trusts in the following key areas:

- care of the deteriorating patient and end of life care (including treatment escalation);
- user insights and focus;
- mortality and clinical harm review outcomes;
- national patient safety strategy (with focus on PSIRF);
- maternity standards;
- GIRFT (Getting It Right First Time) and the clinical pathway redesign.

Focus area	Reduce harm to patients through our safety improvement programme
Rationale for selection	We have had a safety improvement programme in place since 2018. The programme is supported by the safety improvement team, with steering groups in place for individual workstreams and overall reporting to our executive management board quality group. Following review of our quality insights and data, and progress with our previous priorities, we have agreed nine priority improvement areas for the safety improvement programme in 2023/24. These have been identified as our key areas of risk internally. Some of these are not new priorities but will build on the work which we did throughout 2022/23, described in the next section along with plans for our ongoing improvement work. These are: • reduce infection transmission through improving basic standards of infection prevention and control practice with a focus on hand hygiene • improve the treatment of patients with sepsis, signs of deterioration with a focus on appropriate treatment escalation • reduce harm from inpatient falls through a focus on improving the completion of a high-quality falls multi-factorial risk assessment (MFRA) at the point of admission and the completion of post-fall assessments for people who have fallen • reduce the harm caused when undertaking invasive procedures by implementing the new National Safety Standards for Invasive Procedures (NatSSIPs2) • improve nutrition and hydration, in particular the identification and management of adult patients with dysphagia (swallowing problems) • improve the safety of blood transfusion • reduce harm in maternity care through a focus on fetal monitoring during labour and implementing a new process for the management of test results, including urine specimens. Our new safety priorities for 2023/24 are: **Reduce medication related harm with a focus on anticoagulants and insulin** Issues related to medications are one of our most frequently reported types of patient safety incidents, however the percentage of these causing moderate or above harm to patients remains low at 0.48 per cent (11/2274). Through regular review of our incident data we have identified two specific areas where we have an opportunity to improve patient safety: anticoagulant therapy and insulin. Our thrombosis and anticoagulation committee will lead on an action plan to improve how we manage anticoagulant therapy, especially for patients who may need to have their medication paused before a procedure and then re-started at an appropriate time afterwards. A newly established safe use of insulin task and finish group has developed an improvement plan which will support staff with the safe management of blood sugars. This will focus on the implementation of an intervention bundle, including education and training for staff and improvements to the dispensary process and the electronic process for ordering insulin. **Improve the experience of patients who are waiting for care through a focus on targeted harm review** Following the loss of elective care activity and reduced productivity as a result of Covid-19, in 2020 we introduced a process for clinical prioritisation and harm review of patients waiting for elective surgery. This process was designed to ensure that treatments are prioritised for the most urgent patients (those whose surgery is classified as P1 – emergency, or P2 – urgent and needs to occur in less than one month) and to identify any potential or actual harm which may have occurred as a result of delays. We have not found any significant harm through this process so far. An incident involving the death of a patient on the waiting list was investigated and confirmed as low harm as the patient had a number of reasons why they were not operated on within six months. We were however identifying a small number of cases of harm through our incident reporting process for patients who have had their diagnostics or treatment delayed. This would not have been picked up through our original clinical harm process because it did not include review of potential or actual harm to patients on a diagnostic or outpatient/non-admitted pathway. At the beginning of 2023, through our new clinical harm review assurance group, we developed some targeted clinical harm processes to ensure that we are reviewing those patients where harm is more likely to occur, some of which have now launched. These processes include audit, data monitoring using real-time dashboards, and harm review for the following: • patients who had long waits in our emergency departments • patients who experienced ambulance handover delays • patients who had delayed discharges after being deemed medically fit for discharge • patients who were 'boarded' (cared for temporarily in other areas when there are no suitable beds to admit them to) • patients who were diagnosed with sepsis but had a delay in their antibiotics being administered • patients who are on the waiting list for a diagnostic procedure • patients whose surgery has been classified as P3 (should occur within three months), or P4 (can occur within three to 12 months). In 2023/24 we will continue to implement these processes and use the outputs to drive improvements in patient experience and outcomes.

Key metrics	Each of our safety improvement priorities has its own set of defined metrics for improvement. The main metric is a reduction in the percentage of incidents causing harm to patients for each of these key areas of risk.
Focus area	**Implement the NHS patient safety strategy with a focus on the Patient Safety Incident Response Framework (PSIRF) and Learn from Patient Safety Events (LFPSE); including the launch of our new incident reporting/risk management system**
Rationale for selection	Throughout 2022/23 we have been working on our plans to implement key elements of the NHS patient safety strategy, including the patient safety syllabus and the framework for involving patients in patient safety. Progress so far and some of our ongoing plans are described in the next section. Our main focus has been on working towards the implementation of the new Patient Safety Incident Response Framework (PSIRF) which will replace the current serious incident framework as the way the NHS investigates and learns from patient safety incidents. The framework has four key aims: • compassionate engagement and involvement of those affected by patient safety incidents (patients, families and staff) • application of a range of system-based approaches to learning from patient safety incidents • considered and proportionate responses to patient safety incidents • supportive oversight focused on strengthening response system functioning and improvement Through our PSIRF task and finish group, we have been developing and delivering our implementation plan so that we will be ready to launch PSIRF by the national deadline of September 2023. We are also working collaboratively to implement the PSIRF standards across the North West London Acute Provider Collaborative in a consistent manner to support shared learning and improvement. During 2023/24 we will continue this work, using our patient safety insights, to develop our Trust's patient safety incident response plan and patient safety incident response policy, ahead of final transition in September 2023. Key next steps include the commissioning of training across the acute provider collaborative; agreement of our patient safety profile and patient safety incident response plan; agreement of our model to meet the required roles and how we will resource this, with plans to progress this through business planning; and development of our approach for engaging patients, families and carers in learning responses and improvement, with support from our patient safety partners. We will also continue work to transition to the new national way of reporting incidents (Learn from Patient Safety Events – LFPSE). We will work closely across the North West London Acute Provider Collaborative to align working practices and tender for a joint local risk management system for the four acute trusts in north west London. This will be designed to make it easier for staff to report incidents and for themes and trends to be identified to support improved learning.
Key metrics	• Percentage of staff who have completed PSIRF training. Other measurements related to PSIRF will be confirmed on completion of our patient safety incident response plan • Number of projects/programmes in which we involve our patient safety partners • Qualitative feedback from patient safety partners • Percentage of staff who have completed parts 1b and 2 of the patient safety syllabus (target is 90 per cent by October 2023).
Focus area	**Improve the treatment of patients with deterioration in their mental health**
Rationale for selection	The demand for mental health support for patients within the acute hospital healthcare setting has continued to rise and is projected to increase by up to a further 20 per cent over the coming years. Managing mental health presentations here in the Trust has become increasingly challenging, partly because we do not always have the right environment or enough staff with the right training to provide the required level of care. This impacts upon the patient and staff experience and creates a challenge in regard to how to best support the patient therapeutically whilst minimising potential risks to the patient and all others in that environment. We have invested significantly in the development of a new mental health nursing team to support patients on wards and also in our emergency departments, but concerns raised through serious incidents and a recent inquest highlighted the need to do more. In August 2022, we held a mental health summit that brought together key stakeholders within the Trust and from partner organisations, including local mental health trusts. The summit highlighted increasing demand, increasing cause of concern about quality of care for patients and concern from staff about the management of patients. Following the summit, we developed a comprehensive improvement plan. This is being led by a monthly mental health care improvement steering group, chaired by our chief nurse. Successful delivery of the actions will be our key focus in 2023/24. This will require a multi-provider approach with a number of work streams to consolidate existing pieces of work and develop new and innovative approaches to improving the care for people with mental health needs, as well as creating a safe working environment for staff.

Key metrics	• Reduction in agency and bank use for mental health nursing staff • Improvements in compliance with the use of the Mental Health Act • Reduction in serious incidents relating to mental health • Improved staff training levels and reported knowledge and awareness.
Focus area	**User insights and focus**
Rationale for selection	The Trust has set a strategic goal to become more 'user-focused' – to better understand the needs, views and preferences of our patients, staff, local communities and partners. We already gather a huge amount of information including operational information, feedback from surveys (including the friends and family test and national CQC surveys), complaints and compliments received from patients, research activities and community engagement. We want to use this information in better ways, including connecting insights and data to help inform our strategy and our improvement priorities. This will allow us to confidently shape and improve our services and care according to needs of the diverse population we serve. There are many benefits of becoming more 'user focused.' It will help us to design experiences for individuals within our clinical pathways – of which are safe, straightforward, easy to understand, comfortable, dignified, and efficient. We aim to improve clinical outcomes, reduce health inequalities, and become more operationally efficient. We have already begun some key user focused improvement projects, including: • development of a user insights package for wards, which can support continuous local improvement, and feed into other programmes of work, for example safety improvements • development of an action plan to improve our patient interpreting service so that it meets the needs of our patients and staff. This will also improve translation of patient information and written materials given to patients and support us to fully meet the requirements of the accessible information standard • launch of a project to better understand how we can improve end of life care. The work will help us to improve communication with patients and their loved ones, support us to develop personalised care to suit people from a range of cultures and backgrounds, support staff, particularly when they need training or lack confidence, and help us to develop new ways of working • undertaking user research to understand issues, needs and expectations of outpatient digital, communications and administration services • continuing to make improvements to help users navigate our services, including completing our wayfinding programme, working to improve the environment by redecorating and decluttering many public areas across our hospitals. In 2023/24 we will implement zoning and install digital signage at Charing Cross Hospital outpatients and we will also be making improvements to our website and appointment letters. We will also be working alongside the other three trusts in the North West London Acute Provider Collaborative to identify opportunities for shared learning and support, focusing on connecting insights from different sources to build a more accurate picture of key issues and potential improvements. In the coming year, research and insights gathered from these projects, will support us to co-design, alongside patients, improved services of which meet user needs.
Key metrics	To be confirmed – will include improved patient feedback and survey results.
Focus area	**Embed our ward accreditation programme as an enabler for Pathway To Excellence®**
Rationale for selection	Our ward accreditation programme+ (WAP+) aims to support our ambitions to create a positive practice environment and embed a culture of continuous improvement. The programme accredits wards in a variety of metrics across the six Pathway to Excellence® standards (leadership, shared decision making, safety, quality, professional development and wellbeing). In May 2022 we began roll-out of our new WAP+ methodology following a successful trial and have so far accredited 63 clinical areas, with local improvement work then implemented as a result of the findings. Next year, we will focus on embedding the programme, and ensuring that the WAP+ measures and outputs are aligned to, and support the delivery of, Pathway to Excellence®. This is an internationally recognised accreditation scheme which celebrates and recognises the essential contribution that nurses and midwives provide to high quality, evidence-based patient care. We are one of 14 NHS trusts selected to participate in it by the chief nursing officer for NHS England and have started the process initially for Charing Cross Hospital.
Key metrics	Improvements in ward-based quality standards

Progress against our 2022/23 improvement priorities

This section describes the progress we made with the quality and safety improvement priorities we agreed for 2022/23. These were chosen following a review of our quality insights, the NHS patient safety strategy, and in consultation with staff and our partners.

Improve: We will develop and support safety improvement programmes that prioritise the most important safety issues and employ consistent measurement and effective improvement methods

Focus area	What did we achieve?
Improve hand hygiene practice, and the safe use of PPE in our clinical areas	We know that hand hygiene is the single most important factor in the control of infection. This was one of our improvement priorities throughout the Covid-19 pandemic as this increased the risks associated with hand hygiene further but also increased the risk associated with the use of personal protective equipment (PPE). We continued this priority into 2022/23 as our incident and audit data showed that there was further work to be done to embed best practice. In summer 2022 we launched a new approach to infection prevention and control education, training and support, following review of our infection-related data and feedback from our staff, and a review of what similar organisations have in place. This new approach involved an improved online training package, which over 90 per cent of required staff (excluding doctors in training) had completed by the end of February 2023. Further work is under way to support improved compliance with all core skills training amongst our junior doctors. This is being enhanced by a rolling programme of structured education and training visits across the Trust by members of our infection prevention and control team with divisional colleagues through our 'Better Together Thursday' campaign. The first of these took place in September 2022, with positive feedback from staff involved, with the second due to take place in April 2023. The Change Lab team at Imperial College London have also been working with our infection control teams and frontline clinical staff on three wards at St Mary's Hospital to develop behavioural insights informed interventions designed to improve compliance, which are now being tested and will be rolled out Trust-wide if successful. With the government's move towards 'living with Covid-19' our successful 'PPE helper' support programme, which was implemented in response to the new PPE requirements introduced during the pandemic, was stood down this year. We now have in post three infection prevention and control support practitioners who will help lead PPE education on each of our three main sites. This will be enhanced by a new clinical practice educator who will start this year. Overall results in the Trust-wide annual infection prevention and control practice audit showed a small decrease in compliance compared to when it was last conducted, from 65 percent in October 2021 to 60 per cent in November 2022. The results have been shared with divisions and who are creating local action plans in response to areas of risk. Despite a huge amount of work, we have continued to see an increase in infection related incidents. This is partly related to Covid-19, with infection rates rising in line with community rates during the surges. We also exceeded our yearly thresholds for MRSA blood stream infections (though we are pleased that there was a reduction – five in 2022/23, compared to 11 in 2021/22), E. coli blood stream infections and Clostridium difficile cases, on a backdrop of a national increase. Our key improvement action is the continued roll-out of our education and support programme to improve basic standards of infection prevention and control practice, with a focus on hand hygiene. This will continue to be a safety improvement priority in 2023/24.
Improve how we agree and document appropriate treatment escalation plans for our patients in an individualised, compassionate and inclusive manner	This priority was originally chosen in 2020 as we were seeing incidents where patients had not had an individualised discussion regarding the action that we think should be taken if their heart stops. Following a scoping exercise for this improvement priority in 2021, we identified that to improve the timeliness and quality of treatment escalation plans, we needed to make wider improvements to how we care for patients who are at the end of their life, and their families. This was also a key theme highlighted by our medical examiners and in our structured judgement reviews. Our key action in 2022/23 was the development and launch of a new online training module designed to help staff deal confidently with cardiopulmonary resuscitation (CPR) treatment and escalation decisions. By the end of March 2023, 80 per cent of eligible staff had completed this module (excluding doctors in training), with plans in place to reach our 90 per cent target before the end of quarter one 2023/24. Recognising that we needed to do more, at the end of 2022 we agreed the funding to establish an end-of-life education and training team. Recruitment to this team will be completed in 2023. Once in post they will support key improvements including: • improved symptom control and communication regarding end-of-life issues • improved holistic assessment and individualised planning for end of life to meet identified need in conjunction with patients and those important to them • increased discharge to patients' preferred place of death • improved knowledge and understanding of CPR and treatment escalation decisions • improved ability to support Trust-wide service improvement programmes, education and training delivery including culture change programme and communications skills. This improvement priority feeds into end-of-life care planning but also into the care of patients when they are deteriorating. Following review of key themes from incidents, we plan to expand the scope of this priority for 2023/24 to include improving the treatment of patients with sepsis and signs of deterioration with a focus on appropriate treatment escalation.
Improve how we document that our patients have provided informed consent prior to relevant procedures	We have a consent policy and process in place which we audit annually, with actions implemented where the audit identifies issues. However, we identified this as a priority area in 2020/21 as we had issues remaining around ensuring consent forms are uploaded onto the electronic patient record. In addition, our process made it difficult to determine if informed consent has taken place. During 2022/23, our aim was to roll out our digital consent process to all elective specialties, which we have achieved. The process allows patients to review clear information on their treatment, ask questions directly of the clinical team, and electronically consent to their procedure. We have received positive feedback from both patients and staff as a key measure of improvement. As we have achieved the aim of this priority, we will be transitioning this to business as usual and will continue to monitor user insights and uptake through continued measurement and reporting.

Reduce avoidable harm and improve performance and outcomes associated with invasive procedures	The aim of this priority is to improve performance and outcomes associated with invasive procedures with a focus on team performance and safety culture. It was originally chosen as a priority in response to a series of never events in 2019/20 related to invasive procedures which highlighted the need to improve our processes, safety and staff experience. This improvement priority is led by the invasive procedures group and includes work to improve compliance with our existing policies and procedures that are designed to reduce the risk of avoidable harm during invasive procedures. We made the following achievements in 2022/23: • developed and launched a Trust-wide checklist to improve the safety of central line insertions and a supporting e-learning module • completed a review of over 100 local safety standards for invasive procedures ('LocSSIPs'). The review identified key priority areas for audit. Audits completed so far have provided good levels of assurance that the LocSSIPs audited are being effectively used • rolled out the new national standard operating procedure (https://www.salg.ac.uk/salg-publications/stop-before-you-block/) to prevent wrong side blocks – prep, stop, block. A survey with anaesthetists following implementation provided good feedback on the new process and has been used to inform ongoing improvement. We are pleased that operations and procedure incidents causing moderate or above harm have further reduced to 0.9 per cent in 2022/23, compared to 1.5 per cent in 2021/22. However, we are still seeing incidents where failure to follow key safety checks is a factor. Reducing avoidable harm and improving outcomes associated with invasive procedures will therefore remain a priority for 2023/24. Our focus for the next year will be on implementing the new national safety standards for invasive procedures (NatSIPPs) 2, which was published in January 2023. The key aim is to standardise, harmonise and educate across organisations and procedural teams to enable safe, reliable and efficient care for every patient having an invasive procedure.
Reduce the number of patient falls and associated harm levels	This has been an improvement priority for two years following an increase in the number of falls reported on our incident reporting system as causing harm to patients. Trust-wide improvement work is led by our falls prevention and safe mobility steering group. Key achievements in 2022/23 include: • development of metrics and processes to improve oversight of safe mobility and falls prevention – this will now be used to develop a dashboard to target key areas for improvement • agreement to develop a shared falls prevention e-learning packages with the other acute trusts in the integrated care system (ICS) which will now be taken forward • implementation of a new adult basic admission assessment and falls workflow in the electronic patient record • implementation of a pilot of divisional sponsorship for improvement work to support spread and reduce variation • scoping of options to improve assurance of compliance with bed rails guidance. This will be part of our Trust priority audit plan in 2023/24. Despite this work, the percentage of patient falls reported on our incident reporting system as causing moderate or above harm increased to 2 per cent in 2022/23 from 1.5 per cent in 2021/22. Analysis of our falls incidents and investigations has identified a number of themes which we will continue to work to improve during 2023/24. These include work to improve consistent completion of falls multifactorial risk assessments and post-falls assessments.

Improve the checking of blood components prior to transfusion	Patients can be seriously harmed if given the wrong type of blood during a transfusion. During 2021/22 we reported two 'never events' where patients were incorrectly administered incompatible blood, which could have been avoided if the right pre-administration checks had been carried out. Fortunately, neither patient came to harm because of the incident. This priority aimed to improve the checking of blood components at the bedside before transfusion. During 2022/23 we have achieved the following: • development of a new e-learning package on all aspects of blood transfusion with modules for specific roles. We achieved compliance of 76 per cent for doctors in training and 91 per cent for all other staff • delivery of face-to-face training in clinical areas on how to complete the pre-administration checks at the bedside, including the use of the electronic pre-administration checklist on Cerner. This included sharing learning from incidents to show why these checks are important and need to be done this way • introduction of digital handheld checking devices to assist with bedside checking in areas where the Cerner checklist cannot be used, such as in theatres where a different electronic system is used • design of a paper checklist which sits on the compatibility tag attached to each blood component. These will be introduced in April 2023 and will provide a checklist for use during information communication and technology down times and in areas that do not have access to the checklist in our electronic patient record. It also provides a visual reminder and learning aid for staff. We have not reported any never events related to blood transfusion since August 2021, however we do still see incidents. Improving the safety of blood transfusions will therefore continue as an improvement priority into 2023/24. In 2023, we will also participate in a national comparative audit on the process of administering blood, including bedside checking which will help identify further improvements.
Improve the identification and management of adult patients with dysphagia	Patient nutrition and hydration is a cornerstone of meeting patients' basic health and care needs. In 2019 a patient died in Sheffield Teaching Hospital Trust from an incident of dysphagia (the medical term for swallowing problems) resulting from the ingestion of the wrong consistency diet. This incident led to publication of the National Confidential Enquiry into Patient Outcome and Death, "Hard to Swallow?". Following review of an increase in incidents, including two serious incidents which occurred in 2021, we identified some gaps in our assurance around the recommendations of this inquiry and this was therefore confirmed as a safety improvement priority for 2022/23. Due to emerging safety risks in year, we have been unable to focus on making improvements in this area. For this reason, we will continue to ensure this is a priority for 2023/24 and have sourced additional speech and language resource within the safety improvement team to take forward this work. This will include the development of an education and training plan and improvements to our Trust-wide processes and systems, as well as locally led improvements at ward level. We will also look to scope other improvements in overall management of nutrition and hydration within the Trust based on our insights and learning.

Improving fetal monitoring during labour	Cardiotocography (CTG) is the most widely used technique for assessing fetal wellbeing in labour and monitoring is performed during labour to identify if fetal hypoxia is developing (this occurs when the fetus is deprived of an adequate supply of oxygen and may occur for several reasons). In line with the saving babies' lives care bundle (2016, 2019), at least hourly, the CTG should be systematically reviewed by two qualified professionals – this is called 'fresh eyes'. This was identified as an improvement priority in mid-2022 following concerns raised due to learning from recent incidents, and the compliance with hourly fresh eyes reviews of CTGs on our labour wards. Safety improvement team resource was diverted to support our maternity services with this new priority. During the remainder of the financial year, the following was achieved: • a deep dive to understand the problem and to collect ideas for improvement. This included visits to the departments, conversations with many staff members in different roles and review of multiple data sources such as incidents • our helping our teams transform (HOTT) team was prioritised to support maternity staff through completion of a series of conversation cafes to gain further insight and learning • the addition of a co-sign function to the fresh eyes form on Cerner in October. This helped staff to document fresh eyes compliance more easily and accurately, as they no longer had to log on independently • fresh eyes compliance is being shared with staff on a monthly basis using an infographic poster, to help motivate them to improve and celebrate successes. This also includes key messages and highlights areas for further improvement • compliance with fresh eyes increased from 63 per cent in March 2022 to 91 per cent across both sites by March 2023. This safety improvement priority will continue into 2023/24, focusing on improving fetal monitoring, interpretation and escalation.
Improving follow up of abnormal urine results in maternity	The aim of this priority is to reduce variability and provide assurance that abnormal midstream specimen of urine (MSU) results in maternity across all teams are acted upon according to our agreed processes. This became a safety improvement priority in July 2022 because missed follow-up of results had been highlighted as a contributory factor in incidents. In addition, patient safety research nationally and internationally has identified poor test result management as a key priority area for improving all patient safety. Following scoping of current issues and processes, several local improvements have been made to reduce risk and improve efficiency, such as introduction of a communications leaflet in the antenatal clinic at St Mary's Hospital. The next step is to introduce an electronic system for checking and following up results which will reduce the potential for human error and create a single standard process across all areas. This safety improvement priority will therefore continue into 2023/24.

Insight: we will improve our understanding of safety

Focus area	What did we achieve
Improve patient safety incident reporting rates and implement Learn From Patient Safety Events (LFPSE)	Incident reporting is one of the most important sources of patient safety information, helping us to identify risks to patients and staff. Consistent reporting across the organisation enables us to identify with more accuracy actual or potential harm; analysing this data alongside other sources of intelligence helps us to learn and continuously improve. We believe that high rates of incident reporting are an important measure of how we are embedding our values and behaviours framework, supporting staff to be open and to report and we chose this as a priority as it is something that every member of staff at every level can improve as part of their role. Over the course of the year we have seen an overall improvement in our incident reporting rate, which is positive, particularly as our harm levels remain low (our rolling 12-month percentage of incidents causing moderate or above harm is 1.13 per cent, below the national average of 2.61 per cent). Our patient safety incident reporting rate per 1,000 bed days is consistently above national average and our annual rate is the highest it has been for over four years. This year we have been focused on preparing for the transition to LFPSE. This has included the mapping of our current incident form with the new LFPSE questions and stakeholder engagement to review user requirements for both reporting and learning from incidents. Other progress we have made includes: • emphasising the importance of reporting incidents alongside other key safety messages through our Trust-wide 'Set the Standard' communications campaign, which included improved guidance for staff on how to report incidents and what we do to investigate and learn from them • developing and launching a new dashboard of incident data. This has had positive feedback from clinical staff as it allows them to track and monitor their incidents in real-time, identify themes and implement actions quickly in response • implementing a newsletter for junior doctors which helps share learning and reflections, explain the process, and provide greater support for junior doctors involved in incidents. This was developed by our junior doctor safety improvement working group in response to feedback that junior doctors sometimes found the process around incident reporting and investigation stressful. As described in the above section, in 2023/24 we will implement LFPSE and re-tender for a new incident reporting system with the other North West London Acute Provider Collaborative trusts. As well as making it easier to report, and identify themes and learning from incidents, this will provide further opportunity to highlight the importance of reporting incidents through the communications and training we will need to develop to support the launch.
Improve our response to patient safety incidents and implement the patient safety incident response framework (PSIRF)	We are continually working to improve our approach to investigating patient safety incidents. We are pleased that in 2022/23 we have not had any serious incidents or internal 'level 1' investigations which went overdue, but we know we have more work to do to improve the timeliness and quality of our investigations. During 2022/23 we focused on embedding the use of 'after action review' as our primary method of investigation (this approach involves a rapid review of the incident, with all staff involved coming together to discuss the incident in a structured and facilitated manner. This helps support a systems approach to investigation and ensures staff are fully supported when they are involved in an incident, the learning is rapidly shared and any immediate action is taken to mitigate recurrence). Our main action was to develop our implementation plan for PSIRF, as described in the section above. Once in place, the new framework will help improve our approach to patient safety incident investigation, with a clear focus on improvement and ensuring those affected by the incident are fully involved in the process, something which we do not currently always get right.

Involve: we will ensure that patients, staff and our partners have the skills and opportunities to improve patient safety	
Focus area	**What did we achieve**
Implement the framework for involving patients in patient safety	We are passionate about ensuring we involve patients, families and carers within our patient safety programme, and have been working to deliver the requirements of the NHS England framework for involving patients in patient safety throughout the year. During 2022/23, we recruited six patient safety partners to become active partners in all elements of governance, monitoring and improvement related to patient safety. We completed a robust induction programme with our patient safety partners and are now working collaboratively to align our patient safety partners with our safety improvement priorities, including work to implement PSIRF. We will continue to work to progress delivery of the overall framework throughout all of our patient safety work in 2023/24.
Support our staff to complete the patient safety syllabus training modules	Training is a fundamental part of the national patient safety strategy. A new patient safety syllabus was published in 2021 which includes online training which is required for all staff across the NHS. Our aim during 2022/23 was to ensure that 90 per cent of our staff had completed level 1: essentials for patient safety by April 2023. We just missed this target, with compliance at 81.9 per cent at the end of March 2023. We have improvement plans in place to achieve our 90 per cent target by the end of quarter one 2023/24. During 2023/24 we will roll out level 1b training (for senior leaders) and level 2 (access to practice) in a consistent way across the North West London Acute Provider Collaborative with regular reporting of compliance. We will develop our implementation plans for levels 3 to 5 once these are available.
Develop the patient safety specialist model for the Trust	Patient safety specialists, defined as the lead patient safety experts in healthcare organisations, are key to local delivery of the national patient safety strategy. We now have two patient safety specialists at our trust. During 2022/23, they engaged in all national meetings and shared learning through our ongoing patient safety workstreams. However, given the scale of the work, and the size and complexity of our trust, we have agreed to increase the number we have and implement a mixed model of corporate oversight and management of the overall strategy with divisionally based specialists. Development of this model will be a continued focus for us in 2023/24.

Covid-19 quality improvement activities

For the third successive year we have had to reprioritise our efforts to caring for patients with Covid-19, while also dealing with the wider impact of the pandemic, including an increase in patients whose elective, planned care had been delayed, higher demand than usual in our emergency departments, and supporting the biggest vaccination programme in the history of the NHS. Throughout the year, we have continued to respond and adapt quickly to the changing impact of the pandemic. As we enter the fourth year of the pandemic, we will carry on reviewing the changes and additional services and processes that we have implemented to ensure that we provide high quality care to our patients and support to our staff.

Hospital-associated Covid-19 infection, transmission and deaths

During 2022/23, Covid-19 has continued to cause significant disruption to services as well as continuously posing a threat of transmission for our patients, visitors and colleagues across the Trust.

Although we have adopted strategies to live with Covid-19, balancing the risks of access to care versus the risks to individuals through infection, waves of Covid-19 continue to pose challenges, particularly with regard to patient flow.

In line with national guidance and by engaging collaboratively with infection prevention and control teams across the sector, we have adopted a pragmatic approach to Covid-19 testing to give consistency across clinical areas and to aid patient flow. We moved away from blanket screening to a more targeted approach for symptomatic patients. However, in high-risk areas where patients are at a greater risk of poorer outcomes from the virus, we have kept tailored approaches to ensure patient safety.

We have also had to manage other respiratory viruses such as influenza and RSV, placing greater pressure on finite resources. Our vaccination programme – discussed in further detail below – contributed to the successful navigation of an extremely difficult winter period. Moving forward, our focus will switch to preparation for coming waves and winters, drawing on the lessons learned from 2022/23.

We are continuing to operate a robust Covid-19 surveillance platform, with daily reports on hospital-onset Covid-19 infections (HOCI) shared with clinical and managerial staff, facilitating timely flagging of risks and providing valuable time to plan mitigation measures.

The surveillance platform uses the UK Health Security Agency (UKHSA) HOCI definitions of cases and reports new Covid-19 positive laboratory samples as:

- **hospital-onset indeterminate healthcare associated (HOIHA):** Positive test result three to seven days post admission
- **hospital-onset probable healthcare-associated (HOPHA):** Positive test result eight to 14 days post admission
- **hospital-onset definite healthcare-associated (HODHA):** Positive test result on or after 15 days post-admission.

We recorded 668 HOCIs in 2022/23, broken down as follows:

HOIHA (positive test result three to seven days post admission)	250
HOPHA (positive test result eight to 14 days post admission)	165
HODHA (positive test result on or after 15 days post-admission)	253

Sadly, of these 668 cases, 60 patients (nine per cent) died within 30 days of a positive sample following either an indeterminate, probable, or definite HOCI.

Our clinical incident management systems are used to investigate and learn from Covid-19 outbreaks and related incidents. All outbreaks trigger a 72-hour report and are reviewed weekly by a multidisciplinary panel to assess cases' suitability for investigation under the serious incident framework. Up until October 2022, all deaths following a HOCI were automatically referred for a structured judgement review, as per our learning from deaths process (see section 1.2 for more information).

The Covid-19 board assurance framework and associated action plan is regularly reviewed and presented to our executive and board quality committees. It is anticipated that the board assurance framework will continue into 2023/24 with a focus more generally on respiratory pathogens, rather than Covid-19 specifically.

Vaccination programme

Our vaccination programme has continued to provide staff, patients and eligible members of the local community with convenient access to seasonal Covid-19 and influenza boosters in 2022/23, as well as continuing to offer first and second doses.

We remain committed to improving uptake of vaccinations in our staff and patients. We have worked with clinical services to minimise referral processes and wait times, offering walk-in appointments for staff and patients who are in our hospitals for inpatient treatment or outpatient appointments. An initiative with maternity services staff has encouraged pregnant women already on-site for antenatal care appointments to attend vaccination centres with 'express lanes' set up to ensure minimal waiting times.

We have also improved access by operating a regular roaming vaccination service, with trained vaccinators visiting areas of the hospital to provide vaccinations in other clinical settings. Pop-up 'mini hubs' have been mobilised across our estate to further improve ease of access for eligible groups.

The vaccination programme has continued to make appointments available to the local community via the national booking system. Over 5,700 appointments were booked in 2022/23, taking the total number of appointments booked via the national system to over 28,000 since the service began in November 2021.

Through our commitment to the north west London vaccination effort, the St Mary's vaccination centre became the only vaccination site in the region to offer the Nuvaxovid (Novavax) vaccine in the autumn 2022 campaign. This vaccine was the only suitable alternative for people who had previously experienced a severe allergic reaction to mRNA vaccines or their ingredients. A referral process was established with GPs in the region so that their suitable patients could receive their seasonal vaccinations.

We have continued to adapt our vaccination programme in response to changing national requirements and by using our expertise and resources in new and innovative ways to meet the needs of the population.

As well as clinical vaccination services, the vaccination programme has provided an overseas vaccination validation service for people who have had one or more Covid-19 vaccinations outside of England. The service supported over 3,400 people to have their vaccination records added to personal health records in England, including GP records and the NHS app.

In the autumn 2022 campaign, we had the second highest staff uptake of Covid-19 vaccinations of all acute trusts in London. Staff uptake of influenza vaccinations was just above regional and sector averages.

The government recently accepted the recommendation of the Joint Committee of Vaccinations and Immunisations (JCVI) that Covid-19 booster vaccinations for health and social care workers become a seasonal offer like flu vaccinations. This is a significant change from the previous recommendation to make boosters available all year round.

We therefore paused vaccination services at the end of the autumn 2022 campaign and will shift to offering seasonal campaigns, in line with NHS England guidance. This marks the first time we have closed our vaccination centres since they became operational on 20 December 2020. During this time, we have administered over 99,000 Covid-19 vaccinations.

We are incredibly proud of our efforts to date and our role in the biggest vaccination programme in the history of the NHS. However, we recognise that there is room for improvement.

We are constantly reviewing the programme and feedback from colleagues to increase uptake and improve the experiences of those accessing the vaccine at the Trust. The lessons learned from operating the service since December 2020 will be incorporated into future campaigns.

1.2 Statements of assurance from the board

This section includes mandatory statements about the quality of services that we provide, relating to financial year 2022/23. 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.

Review of services

In 2022/23, the Trust provided services to combat Covid-19 and endeavoured to provide its standard commissioned services. We have reviewed all the data available to us on the quality of care in these NHS services through our performance management framework and assurance processes.

The income generated by the NHS services reviewed in 2022/23 represents 96 per cent of the total income generated from the provision of Trust services in 2022/23. The income generated by patient care associated with these services in 2022/23 represents 84 per cent of the total income generated from the provision of services by the Trust for 2022/23.

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 allocate resources to areas requiring improvement and as part of our commitment to ensure the best treatment and care for our patients.

During 2022/2023, 59 national clinical audits covered relevant health services that the Trust provides. During this period, the Trust participated in 97 per cent of national clinical audits and 100 per cent of national confidential enquiries which we were eligible to participate in.

There were two clinical audit programmes in which the Trust did not participate. The first was the Society for Acute Medicine's benchmarking audit. The second audit was muscle invasive bladder cancer audit, which is part of the British Association of Urological Surgeons (BAUS) audit programme (BAUS Urology). The divisions review other relevant metrics to provide assurance through divisional governance processes.

The national clinical audits and national confidential enquiries that we were eligible to participate in are included in a table in Annex 3. The number of cases submitted are presented as a percentage where available. Please note that percentages will be accurate up to March 2023 where host organisations were contacted, but some data collection was still ongoing.

National clinical audit

The Trust reviewed the reports of 49 national clinical audits and confidential enquires in 2022/23. These clinical audits, linked to our focused improvement work, have identified several areas of excellent practice as well as opportunities for development and improvement. Some examples of these national audit reports are given below to indicate the range of work and performance across the Trust.

National Hip Fracture Database (NHFD) Report

The NHFD report was rated as significant risk due to the low percentage of patients with a hip fracture who were admitted to an orthopaedic ward within four hours (1.6 per cent).

There is a decline in performance across other hospitals too (the average for participating trusts in England was 19.4 per cent in 2021 compared to 34.9 per cent in 2020). A ring-fenced fractured neck of femur admission bed has now been commissioned which should improve performance.

National Audit of Inpatient Falls (NAIF)

The NAIF report was rated as acceptable risk/reasonable assurance with some previously known areas for improvement. We are performing above national average for many of the audit standards, including carrying out a prompt medical assessment after a fall (80 per cent vs 60 per cent nationally) and completing a high-quality multifactorial risk assessment (80 per cent vs 30 per cent nationally), although we know we have further room to improve. Actions are being taken forward as part of the safe mobility and falls prevention steering group workplan.

NCEPOD Hard to Swallow?

This study was focused on management of dysphagia (swallowing problems) for patients with Parkinson's disease, however the themes were similar to those identified previously as part of a Trust-wide review of dysphagia management. A local action plan is in place for the services specifically involved in this audit, however wider Trust-wide improvement is required; this will remain a safety improvement priority in 2023/24.

National Audit of Care at the End of Life (NACEL)

NACEL evaluates the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in hospitals in England and Wales.

Results for our Trust suggest strong organisational leadership and governance. The possibility that a patient may die within the next few hours/days was recognised in 97.5 per cent of relevant patients. The audit shows that we routinely discuss CPR and treatment escalation decisions and recognition of dying, but only 59 per cent of patients have an agreed individualised care plan. This falls below the national average. The audit also showed that we do not always discuss nutrition and hydration and potential side effects from anticipatory medications at the end of life. We need to improve our holistic assessment of patients' symptoms in the last hours and days of life, in documenting the benefit of starting, continuing or stopping certain interventions, and in recording preferred place of death.

This remains a safety improvement priority for the Trust.

MBRRACE – UK Perinatal Mortality Surveillance

The perinatal mortality surveillance covers perinatal deaths from 22+0 weeks gestational age (including late fetal losses, stillbirths, and neonatal deaths) of babies born between 1 January and 31 December 2020. The audit showed that our stabilised and adjusted mortality rates were similar to, or lower than, those seen across comparable trusts and health boards in the comparator group with a Level 3 neonatal intensive care unit. Overall, the crude mortality rates for babies born within the Trust shows there has been a reduction in neonatal death rates year-on-year. Three areas for improvement have been identified, with actions underway: timeliness of reporting, completeness of information submitted and recording of ethnicity for all perinatal losses.

National Comparative Audit of Blood Transfusion

The objective of the national audit programme is to provide evidence blood is being ordered and used appropriately, administered safely, and to highlight where practice is deviating from guidelines to the possible detriment of patient care. The national comparative audit based on NICE standards and our performance was rated as acceptable risk/reasonable assurance. The action plan included identification of a location in Hammersmith Hospital for administration of intravenous iron, implementation of a single unit policy across the Trust; and the addition of consent for transfusions to our digital consent platform.

Local clinical audit

As well as participating in national clinical audits, we have a Trust priority audit programme in place designed to support our existing priorities, including our safety improvement programme. Select examples are included in the table below.

Audit title	Audit findings
Consultant ward round audits	The corporate audit team undertook a seven-day services audit related to consultant ward/board rounds and the documentation of these across a number of areas. The audits assessed whether there was documented evidence of a ward round taking place daily, whether a consultant was present at each of these ward rounds and whether any emergency inpatient admission was seen by a consultant within 14 hours. The following clinical areas were audited this year: • cardiology wards at Hammersmith Hospital – substantial assurance • paediatric wards at St Mary's Hospital – reasonable assurance. The next audit will take place in the emergency department, focusing on patient time spent in the department and referral times to other specialties.
LocSSIPs	A rolling audit programme is in place to ensure we are regularly reviewing how effectively our teams are using our local safety standards for invasive procedures (LocSSIPs). The following LocSSIPs were audited in 2023/24: • endoscopy procedure checklist (acceptable risk/reasonable assurance) • cardiac catheter lab safety checklist (low risk/satisfactory assurance) • umbilical venous catheter (UVC) insertion, umbilical arterial catheter insertion (UAC), central line/peripherally inserted central catheter (PICC) line (low risk/satisfactory assurance) • flexible cystoscopy (low risk/satisfactory assurance). Recommendations for improvement include education on the importance of doing verbal checks, highlighting previous near miss cases and ensuring adequate staffing.
MRSA screening and suppression therapy	During 2021/22, we saw an increase in the number of healthcare-associated MRSA blood stream infections. As part of the post investigation reviews of these cases, MRSA screening and suppression therapy were highlighted as areas that need assurance. An audit was therefore completed which identified areas for improvement. These were implemented as part of an overarching improvement plan in response to the increase.

In addition to the Trust-wide audit work described above, specialties within directorates conduct local audit activities which provide information on how their services are performing. Throughout 2022/23 there were 230 local audits registered in the Trust. These reports, including any action plans, are reviewed through local audit and risk governance meetings and logged centrally.

Maternity services

As with many maternity units in the country, during 2022/23 we experienced significant midwifery and nursing staffing shortages. Our maternity services have been focused on continuing to deliver personalised and safe maternity and neonatal care, and to ensure

that the people who use our services are listened to, understood and responded to with respect, compassion and kindness. Our data shows that we have managed to achieve this for most of our patients.

We identified some key areas for improvement including around our approach to fetal monitoring and follow up of abnormal urine results; these are being carried on as safety improvement programme priorities into 2023/24 so that the work can be completed and embedded.

We have also been focused on implementing the requirements from three key national programmes/reports, which are summarised below.

Ockenden independent maternity review at Shrewsbury and Telford Hospital NHS Trust – final report published in March 2022

Since the interim Ockenden report was published in 2020, all maternity services in the country have been working to achieve compliance against a number of immediate and essential actions. This culminated in an externally led assurance visit in September 2022 to review progress and provide additional support where required. Our report from this visit was generally positive and recognised the 'clear and insightful view of both successes and issues' faced and the plan in place to build on well-established achievements. We have since been confirmed as compliant with five out of the seven immediate and essential actions. Actions plans are in place to achieve the remaining recommendations from the review, with regular reporting through our internal governance processes.

'Reading the Signals' – The report of the independent investigation into maternity and neonatal services in East Kent – published in October 2022

The findings of this report were similar to the Ockenden review, highlighting failings in governance and leadership, failure to listen to staff and to patients and families when concerns are raised, issues around culture and teamworking, as well as care and service delivery issues. While the recommendations from the report were for national bodies rather than NHS trusts, we reviewed our systems and processes through the lens of the findings to see if there were any further improvements we needed to implement. We were assured that we have mechanisms and actions in place to monitor safe performance, standards of clinical behaviour, and improve team working and the organisational behaviour. Support is also provided via the North West London local maternity and neonatal system which provides surveillance and assurance of maternity services across the sector.

Maternity Incentive Scheme (year four)

The maternity incentive scheme (MIS) aims to support maternity services to deliver safer care through recovery of an incentive element built into the clinical negligence scheme for trusts' contributions, where trusts can evidence compliance with all ten safety actions. Following completion of a comprehensive action plan in February 2023, we reported compliance with all aspects of scheme. The focus will now be on embedding the progress made to ensure the improvements are sustained.

In March 2023, our maternity units at Queen Charlotte's & Chelsea Hospital, St Mary's Hospital, and our private maternity unit, Lindo Wing, were inspected by the CQC as part of their national maternity inspection programme. Once we have the results of the inspection we will implement any additional improvements required.

A single maternity improvement plan is currently being produced by NHS England and key stakeholders. This will bring the recommendations and improvement actions from the final Ockenden report, East Kent report and maternity incentive scheme year five together. Once this is received, we will develop a full improvement plan which combines all our current work and any further actions we need to take. Where this will add value, we will do this collectively with the other trusts in the North West London Acute Provider Collaborative quality committee through the maternity standards quality priority workstream.

Our participation in clinical research

In collaboration with Imperial College London – and with many other partners in industry, charity and government (local and national) – the Imperial Academic Health Science Centre (AHSC) partnership drives our biomedical and clinical research strategy, coordinates our efforts and aligns priorities across north west London. It ensures we remain at the forefront of new scientific discovery and aids in translating cutting-edge research for the benefit of our patients and the wider population.

Much of our innovative research is enabled through significant infrastructure funding, awarded through open competition by the National Institute of Health Research (NIHR). This includes our NIHR Biomedical Research Centre (BRC), Clinical Research Facility (CRF), Patient Safety Research Centre (PSRC), Experimental Cancer Medicine Centre (ECMC) and MedTech & In Vitro Diagnostics Cooperative (M&IC). The Imperial CRF has recently been awarded funding (£11.3m) for a further five years from 2022 onwards, as has our ECMC (£1.2m) and PSRC (£2.6m).

One of the greatest successes in the past year has been the renewal of our BRC programme – the NIHR Imperial BRC received the largest amount of funding (£95.3m) in the recent competition. The BRC focuses on experimental medicine – early phase discovery science trialled in the clinic for the first time – and is structured around four main strategic areas:

- early diagnosis (developing new tests and improving current testing to speed up diagnosis and allow earlier treatment)
- precision medicine (tailoring treatment to a patient's specific needs to improve outcomes)
- digital health (using computer technology to provide clinicians with more accurate information for better treatment and allow patients to manage their health)
- convergence science (bringing different scientific fields together to provide new perspectives and solve complex health research challenges).

BRC highlights from the past year include new insights into our understanding of how Covid-19 vaccines perform in patients with serious conditions who need to take immunosuppressing drugs, development of a digital platform to enable us to routinely collect data within the home to analyse the well-being of patients living with dementia, the first effective drugs for patients with previously untreatable complement-mediated kidney disease, and the successful completion of the first ever 'human challenge' trials of the Covid-19 virus in healthy volunteers.

We continue to invest in the analysis of large, interlinked datasets, and to develop new artificial intelligence tools to assist in clinical decision-making.

We also have a strong focus on those sectors of our population who are underrepresented or underserved in terms of their involvement and inclusion in clinical research, with a view to addressing the wide variations in health across our local and national populations. We aim to widen access and increase opportunities for participation in clinical research

to better reflect our patient demographics. This is essential to developing and rolling out health technologies which are effective for all.

We continue to work in close partnership with Imperial Health Charity to complement the research we undertake, particularly around clinical academic training and development of nurses, midwives, dietitians, physiotherapists and other allied health professionals.

The total number of patients receiving NHS services provided or sub-contracted by the Trust in 2022/23 that were recruited to participate in research approved by a research ethics committee was 14,504. 14,738 patients were recruited into 420 NIHR portfolio studies in 2022/23 – this includes 470 patients recruited into 90 studies sponsored by commercial clinical research and development organisations.

Our CQUIN performance

Commissioning for quality and innovation (CQUIN) is a quality framework that allows commissioners to agree annual payments to hospitals based on the number of schemes implemented. Following the suspension of the CQUIN programme due to the Covid-19 pandemic, the programme was reinstated in April 2022. However, as opposed to previous years, the Trust's income was not conditional on the achievement of the targets. For the financial year 2022/23 it was agreed that in order to re-establish the programme we would report performance data for only 13 CQUIN schemes, and there was no focused improvement work related to those schemes.

Submissions have been made for the first three quarters of 2022/23, and we are on track for our quarter four end of year submission in May 2023. Our CQUIN goals for 2023/24 have not yet been agreed, however it is possible we will focus on five schemes, and a proportion of our income in 2023/24 will be conditional on achieving quarterly targets for these schemes.

Statements from the Care Quality Commission (CQC)

The Trust is required to register with the CQC for all of its sites; we were compliant with the requirements of our CQC registration during 2022/23 and our current registration status is 'registered without conditions'. Additionally, the Trust was not subject to any enforcement action this year. Our overall CQC rating remains 'requires improvement'.

The CQC did not return to routine activity (including inspections) during 2022/23 as it had planned for a variety of reasons, including the impact of its own internal restructure and work to develop new methodologies on its resources. They continue to carry out urgent and focused inspections for serious concerns; we were not subject to a focused inspection this year. We were included in a national maternity inspection programme which ran from August 2022 through March 2023; the Trust's maternity inspection took place in March 2023. The final report and any updated ratings are expected to be published in quarter one of 2023/24.

We participated in routine engagement meetings with the CQC this year, responded to routine incident requests (as part of the CQC's learning from deaths mandate), and responded to general enquiries from the CQC (complaints or concerns about the Trust are raised either directly by the CQC in response to their intelligence or by others such as patients, families, member of the public, etc.).

We did not participate in any special reviews or investigations by the CQC this year, nor were we captured in any reports published this year following special reviews or investigations undertaken in a previous year.

The CQC requires all trusts to participate in the NHS England patient survey programme. The outcomes of the following surveys were published this year:

- 2021 adult inpatient survey, published September 2022
- 2021 national cancer patient experience survey, published July 2022
- 2022 maternity survey, published January 2023.

We performed favourably in all surveys, both compared to previous performance and in relation to other trusts. No serious concerns were raised in any survey published this year; where improvements were needed, they were managed in line with normal Trust processes. During 2022/23, the Trust participated in the 2022 national cancer patient experience survey, 2022 adult inpatient survey, 2022 urgent and emergency care survey, and 2023 maternity survey, with outcomes expected to be published during 2023/24.

Our data

High quality information leads to improved decision-making, which in turn results in better patient care, wellbeing, and safety. Data quality and security are key priorities for us and essential to our mission.

NHS number and general medical practice code validity

We submitted records during 2022/23 to the commissioning data sets (CDS) dashboard (formerly the secondary uses service) for inclusion in the hospital episode statistics, which are included in the latest published data. The percentage of records in the published data (current to December 2022), which included the patient's valid NHS number, was:

- 98.1 per cent for admitted patient care
- 99.2 per cent for outpatient care
- 94.7 per cent for accident and emergency care.

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

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

Data security and protection toolkit

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

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

Clinical coding quality

Clinical coding is the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment, or reason for seeking

medical attention, into a coded format which is nationally and internationally recognised. The use of codes ensures the information derived from them is standardised and comparable.

The Trust was not subject to any clinical coding audits by NHS commissioners in 2022/23.

Data quality

In 2022/23, the Trust's elective care data quality framework transitioned to business as usual and was also renamed as the waiting list and waiting times data quality framework to ensure that emergency care will be represented in the plan for 2023/24. Progress and metrics related to data quality is reported to the Trust executive on a bi-monthly basis. This provides a comprehensive overview of data quality across the organisation as well as detailed updates on performance across the current data quality metrics and outcomes of internal audits on waiting lists.

A weekly waiting list decision support panel continued to support rapid review of operational process changes, alongside impact analysis and mitigations, for data quality and reporting. Significant work has been completed to monitor, track and report data quality as well as mitigate patient risks throughout the Covid-19 recovery period.

A large-scale review of our waiting list and waiting times data quality commenced during 2022/23 to assess; the outputs of this will inform the plan for data quality improvement in 2023/24.

Learning from deaths

We comply with all elements of the national learning from deaths process with a policy that sets out standards and measures, and compliance with which is regularly reported internally to our quality committee and then to the North West London Acute Provider Collaborative board-in-common. All patient deaths which occur in the Trust are scrutinised by the medical examiner. Through this process, which involves review of clinical notes and, most importantly, a discussion with the bereaved for all deaths occurring in our hospitals, we have ensured that a) the proposed cause of death is accurate, b) there is appropriate and consistent referral to the coroner, c) the bereaved understand the cause of death and have an opportunity to raise any concerns, and d) cases are appropriately referred for structured judgement review when the criteria are met.

Structured judgement review is a validated methodology in which trained clinicians critically review medical records and comment on and score phases of care through the patient journey and determine if there were any problems with the care delivered. These undergo further review and, dependent on any issues identified, may be subject to more in-depth investigation via our serious incident framework to identify further areas for learning and implement actions to improve. In addition to this, a regular death review panel is in place to consider any complex cases and triangulate all associated investigations.

We no longer rate deaths on whether they might have been 'avoidable', but instead on the quality of care (graded from excellent to very poor), with a final decision then being made on whether the death was more likely than not to have occurred due to problems in care.

Prior to October 2022, all deaths of patients who died in our Trust after a hospital-onset Covid-19 infection (HOCI) went through an enhanced mortality review process. In October 2022, our executive approved a proposal to stop automatically undertaking structured judgment reviews (SJR) for patients who die with a HOCI. This was not a national requirement but was an important part of our scrutiny whilst we learnt about the evolving pandemic. Through this process we incorporated learning into our policies and guidelines but we have not found any significant lapses in care and we weren't gaining any new learning. We have now reverted to the standard mortality review process where the medical examiner would trigger a structured judgement review if concerns are raised.

Patient deaths: April 2022 – March 2023

	Q1	Q2	Q3	Q4	Total
Number of patients who died – based on date of death	490	448	486	511	1,935
Number of deaths referred for SJR – based on date of death	61	107	27	49	244

Deaths which occurred in 2022/23

Of the 1,935 deaths that occurred during 2022/23, all deaths were subject to medical examiner review, and 224 were referred for structured judgement review. Of the 260 deaths which have had these reviews completed (the number also includes some structured judgement reviews completed that were allocated in 2021/22 but completed in 2022/23), there were 18 for which some issues were identified in the overall care delivered. The key themes from these were around improving end of life care and recognising and responding to the deteriorating patient. This is one of our safety improvement programme priorities for 2023/24. There was also learning related to communication with the patient's family, in particular around how we approached the concerns they raised as part of the investigation process, which is being fed into our plans for developing our approach and process for engaging patients, families and carers in learning responses and improvement as part of PSIRF.

Of these 18, the death review panel has reviewed 11 cases so far and has confirmed poor care in eight. The panel concluded that in three cases, the poor care had more likely than not contributed to the deaths. There are two cases for which further investigation is required before a final decision can be made. During 2022/23, the panel also reviewed three cases that were completed in 2021/22; poor care was confirmed in three of these and for two it was felt that the poor care contributed to the death.

A separate process is in place nationally for all stillbirths, late fetal losses and neonatal deaths called the perinatal mortality review tool (PMRT). This consists of designated review meetings where each aspect of care is scored and action plans to address any issues are approved. These are recorded on the national PMRT database and the generated reports are collated and analysed nationally and within the Trust for trends and themes to facilitate learning.

Of the six PMRT reviews completed in 2022/23, there were no cases where care or service delivery issues were identified which may have changed the outcome. We have a backlog of PMRT cases from previous years caused by pausing of the review process in pandemic surges. A recovery plan is in progress with escalation processes in place. This will be completed by December 2023. Additional resource has been allocated to support this important work.

We have started work to review the maternity and neonatal death process, including the PMRT process, and align it with our overall mortality review governance and reporting to improve visibility of outcomes and actions. The amended process should be implemented before the end of quarter one 2023/24.

The outcomes of structured judgement reviews and perinatal mortality reviews are shared with the relevant clinical teams and across the Trust through divisional quality and safety committees. A bi-monthly newsletter is now also being produced. Individual action plans are developed in response to each case. Cases are also shared with the safety improvement programme workstream leads to ensure the improvement work covers the findings of the reviews.

In April 2023, we expanded our medical examiner service to include deaths which occur in the community within the London Borough of Hammersmith & Fulham and the City of Westminster, which will improve how we learn from deaths across the local healthcare system.

Seven-day hospital services

From 2018, all NHS trusts have been required to report their activity and progress towards delivering high quality and consistent levels of service and care seven days a week. There are 10 defined standards for seven-day services, of which NHS England classify four as key standards. Through our rolling audit programme we continue to be able to report good levels of assurance against the four priority standards, and full or partial compliance with all other standards. The four key standards are: early consultant review, access to diagnostic services, access to interventions and ongoing review which are described below.

Standard two – early consultant review: Our policies, procedures and staffing models comply with this standard. Previous audit identified areas of improvement which included the quality of documentation and the structured use of consultant-led board rounds. Since then we have worked hard across the trust to improve the quality and multidisciplinary participation of board rounds and have created new standards for these so that everyone, including our patients, gets the best of out of them. Our audit programme will review compliance against these standards in 2023/24.

Standard five – access to diagnostic services: The trust can report compliance against this standard for the provision of ultrasound, computed tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy and microbiology. Our imaging and diagnostic services remain under considerable pressure due to large patient waiting lists which has been mitigated with the use of improved technology and new ways of working, including remote reporting and outsourcing routine reporting.

Standard six – access to interventions: We can still report full compliance with this standard. Twenty-four-hour access is maintained by rostered consultant-led teams and rotas.

Standard eight – ongoing review: We can report partial compliance with this standard. Twice daily consultant review occurs for high dependency/critical care patients as evidenced by regular audits. Most areas are compliant with the requirement for consultant review once every 24 hours. Where a consultant review does not occur every 24 hours, this can be mitigated as outlined in standard eight, by the use of clear patient pathway derogation to other senior decision-maker doctor. The use of comprehensive multidisciplinary consultant-led board rounds can also be utilised to highlight patient's needing daily review or where this can be delegated to another appropriate senior decision-maker. Our audit programme will review compliance against these standards in 2023/24.

Additional standards: We have assessed ourselves as having reasonable assurance against the six additional non-priority standards, although we have improvements to make in some areas, including how we record patient and family involvement with decision making, and how we manage patients with mental health needs in our emergency departments.

Rota gaps

We have 802 doctors in training working at the Trust, with 46 gaps on the rota. Twenty-eight of these gaps have been filled by locally employed doctors. We have 18 unfilled posts, 10 of which are being recruited to. In addition to recruiting, we take action each month to make sure that the rotas are filled, including proactive engagement with Health Education England so we can accurately plan targeted campaigns for difficult to recruit specialties and the use of locums, where necessary.

1.3 Reporting against core indicators

All acute trusts are required to report performance on a core set of eight quality indicators. An overview of the indicators is included below, with our performance reported alongside the national average and the performance of the best and worst performing trusts, where available. This data is included in line with reporting arrangements issued by NHS England.

Mortality

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 (HSMR) and summary hospital-level mortality indicator (SHMI), which enable us to compare ourselves with our peers. Both data sets allow us to understand our mortality rate when compared to our peers. However, the two measures differ slightly in methodology. SHMI measures all deaths that occur in England, including those that occur within 30 days of discharge from hospital and is the official mortality measure for England. HSMR measures more variables than SHMI, such as patients receiving palliative care, deprivation and whether the patient has been transferred between providers. We believe using both measures gives us the best picture of our mortality rate across our hospitals:

SHMI

	National performance 21/22*			Trust performance				
	Mean	Lowest	Highest	2022/23	2021/22	2020/21	2019/2020	OBJ
SHMI	100	62.26	124.7	75.02	72.73	77.02	70.24	OBJ
Banding**	2	3	1	3	3	3	3	OBJ
% deaths with palliative care coding	40.00%	12.00%	65.00%	62.00%	61.00%	56.00%	58.10%	OBJ

*National and Trust position currently rolling 12 months from November 2021 to October 2022
**SHMI Banding 3 = mortality rate is lower than expected
Source: NHS Digital

HSMR

	Trust performance			
	2022/23*	2021/22	2020/21	2019/20
HSMR	77.9	68.03	75.9	67.6
National performance	3rd lowest HSMR of all acute non-specialist providers	6th Lowest HSMR of all acute non-specialist providers	3rd lowest HSMR of all acute non-specialist providers	Lowest HSMR of all acute non-specialist providers

*National and Trust data currently only available to December 2022
Source: Telstra Health

We consider the SHMI and HSMR data to be as described for the following reasons:

- it is drawn from nationally reported data
- our palliative care coding rates are high, and we are confident that they are accurate with a clinical coding review process in place
- we have reported a lower-than-expected SHMI ratio for the last five years
- we have the third lowest SHMI ratio of all acute non-specialist providers in England, across the last available year of data (up to October 2022)
- we have the third lowest HSMR of all acute non-specialist providers across the last available year of data (up to December 2022)
- mortality rates across the Trust remain statistically significantly low. When considered with our harm profile and the outcomes of our structured judgement reviews we can provide assurance that we are providing safe care for the majority of our patients. Where care issues are found we have a robust process for referral for more in-depth review.

We intend to take the following actions to improve our mortality rates, and so the quality of our services, by:

- continuing to work to eliminate avoidable harm and improve outcomes
- reviewing every death which occurs in our Trust and implementing learning as a result, as described above in the 'learning from deaths' section
- continuing to work with the other trusts in the North West London Acute Provider Collaborative to improve our learning from deaths processes collectively
- completing a review of the processes and function of the specialist mortality and morbidity meetings across the Trust, including the data being used, and implement improvements in response.

Patient reported outcome measures (PROMs)

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

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

The following table reports on patients who have had a hip replacement or knee replacement, where significant numbers of surveys were submitted. Hernia repair and varicose vein treatments outcome data is not included as they were removed as indicators but are still listed in the quality account guidance document from NHS England.

	National performance*			Trust performance			
	Mean	Best	Worst	2020/21*	2019/20	2018/19	2017/18
Hip replacement surgery (EQ-5D)	0.465	0.841	-0.135	0.535	0.468	0.480	0.464
Knee replacement surgery (EQ-5D)	0.315	0.923	-0.165	0.316	0.425	0.310	0.298

Source: NHS Digital
*2020/21 data is latest full year of data available.

We consider that this data is as described for the following reasons:

- we have a process in place to collect, collate and calculate this information monthly, which is then sent to NHS Digital
- data is compared to peers, highest and lowest performers, and our own previous performance
- we are performing above the mean for both hip and knee replacement surgery. We will continue to focus on improving our performance in these areas.

We intend to take the following actions to improve this percentage, and so the quality of our services:

- a dedicated nurse leads the process to ensure quality data input and triggers the patient reported outcome measures pathway
- monthly reports are reviewed so we can monitor performance and introduce improvements where necessary.

28-day readmissions

	National mean*	2022/23*	2021/22	2020/21	2019/20
28-day readmission rate (Patients aged 0-15)	9.79%	4.77%	5.35%	4.80%	4.78%
28-day readmission rate (Patients aged 16+)	8.50%	6.10%	6.32%	6.18%	7.45%

*National data only available up to September 2022

We believe our performance reflects that:

- we have a process in place for collating data on hospital admissions from which the readmission indicator is derived
- we have maintained our low unplanned readmission rate for both paediatric patients and adult patients with both rates remaining below national average throughout the year.

We intend to take the following actions to improve this percentage, and so the quality of our services, by:

- continuing to ensure we treat and discharge patients appropriately so that they do not require unplanned readmission

- continuing to work to tackle long-standing pressures around demand, capacity, and patient flow.

Staff recommendation to friends and family

The extent to which our staff would recommend the Trust as a place to be treated is another way to measure the standard of care we provide. Our performance, compared to our peers and our previous performance, is listed in the table below and shows we are above the average compared to other acute trusts. We are also above the acute trust average for staff who would recommend their organisation as a place to work.

We also scored well for staff saying care of patients is their organisation's top priority, up from 80 per cent in 2021 to 82 per cent in 2022, compared with a drop in the average for all acute trusts (from 76 per cent to 74 per cent).

	National performance			Trust performance		
	Average (acute trusts)	Best	Worst	2022	2021	2020
Percentage of staff who would recommend the Trust to friends and family needing care	62%	86%	39%	73%	74.3%	79%

	National performance			Trust performance		
	Average (acute trusts)	Best	Worst	2022	2021	2020
Percentage of staff who would recommend the Trust as a place to work	57%	75%	41%	66%	64.5%	71.4%

Another key measure in the NHS Staff Survey is the overall measure of engagement and morale. Overall engagement measures motivation, involvement and advocacy. In 2022, our overall score for engagement remained 7.0 and is above the average for acute trusts. The same trend is seen in the overall score for morale, where we are above the average for acute trusts.

These results show that we are making progress in a number of areas, despite the continuing and incredibly challenging demands on our staff.

We saw increased scores for the themes, 'we are compassionate and inclusive', 'we are always learning' and 'we are a team', and we achieved above average scores, compared with other acute trusts, in five out of nine categories, up from three out of nine categories in 2021. We are particularly encouraged by the increased scores for questions that relate directly to initiatives we have put in place over the past few years. This includes increased scores for questions about team working, line management and compassionate leadership that show the impact of our "improvement through people management programme", and values and behaviours work providing a range of training and support for our people managers across the Trust.

Our equality diversity and inclusion programme has also been a significant priority in 2022/23. This included:

- the launch of the Calibre leadership programme designed for staff with disabilities
- an inclusive recruitment approach for senior roles to improve representation of Black, Asian and minority ethnic (BAME) staff
- the introduction of 19 BAME ambassadors to provide a safe and supportive space for BAME staff to raise concerns
- a bespoke team-based race equity training for managers
- the relaunch of our equality impact assessment process which helps us to consider the impact of our policies on all groups of people.

We have also focused on improving our health and wellbeing programme, which this year included a winter wellbeing plan including breakroom supplies, Christmas vouchers for staff, completion of the further 'rest nest' and staff room renovations, a programme to support staff with financial wellbeing support and guidance, a programme to improve the support for staff who experience violence and aggression, and the training of 88 of wellbeing champions.

Areas where scores were lower in the staff survey and require further action include flexible working, retention, and in tackling violence and aggression, harassment and bullying or discrimination. The only people promise theme we fell just below the acute average in is "we work flexibly", where we scored 5.9 which is the same score as in 2021, but lower than the acute average of 6. For the "thinking about leaving" subtheme under "morale", we scored 5.7 compared to the 5.9 acute average. We were also below the acute average for the subtheme "diversity and equality" at 7.7 compared to the 8.1 average. All these areas have been incorporated into our 2023/24 people priorities and improvements will be driven through this work programme.

Patient feedback and experience

One of our quality priorities for 2023/24 is to become more user focused. Please read the improvement priorities section of this report for information. Patient feedback is a core component within this objective. Below we describe in more detail some of the work we already doing, as well as our plans for the next financial year.

Patient recommendation to friends and family

From 2015, the Trust has used the national friends and family test (FFT) question as a tool to collect patient feedback across all of our clinical areas, including accident and emergency (A&E), inpatients, maternity and outpatients. The question is added into our feedback surveys. You can see a list of the surveys we use on the Trust website: https://www.imperial.nhs.uk/about-us/how-we-are-doing/patient-experience

Prior to 2020, the FFT asked patients, their families and/or carers whether they would recommend our services to friends and family if they required similar treatment. In 2020 revisions were made to the survey, following an extensive review by NHS England, this included a change to the question itself. We now ask: 'Overall how was your experience of our services?' Those who respond can choose from the following options: very good, good, neither good or poor, poor, very poor or don't know.

We publish monthly FFT results on the Trust website (https://www.imperial.nhs.uk/about-us/how-we-are-doing/patient-experience#Results) and on the NHS England website (https://www.england.nhs.uk/fft/). You can also view our average performance scores for 2022/23 A&E and inpatient services below. The rating is based on the percentage of people who describe the service as very good or good.

FFT feedback is processed using a digital system which enables us to view and review the insights collected and to identify trends and improvements. This information is shared with services, clinics and wards.

Through engagement with teams, we are exploring means to improve the reporting of this information, including how we can combine with other insights and data we collect – to make it more useful, and to help quickly translate feedback into quality improvement projects within each ward, clinic and area.

During the next year we also plan to review feedback trends based on protected characteristics including ethnicity, sex, religion, gender identity, age, sexual orientation, religion and disability status. This will help us to see if we can improve experiences for specific groups of patients, and the information can also be used to support our health inequalities programme.

We use various methods to collect feedback – including text message, tablets on our wards and paper forms so that we avoid digitally excluding anyone visiting our hospitals. We are currently in the process of designing and testing new and potentially more inclusive methods of promoting our feedback surveys.

A&E friends and family test

Participation rate

The average participation rate over the past year has been 7.3 per cent. This was a very similar response rate to 2021/22.

	National performance 2022/23			Trust performance					
	Mean	Best	Worst	2022/23	2021/22**	2020/21*	2019/20	2018/19	2017/18
Score	76%	85%	16%	82%	84%	N/A	93%	94%	94%

*Reporting was suspended for most of 2020/21 due to the Covid-19 pandemic
**The 'FFT' question was changed in 2020/21 so our data for this year is not comparable to previous performance

We believe our performance reflects that:

- at a time of extreme pressure and competing demands due to the continuing impact of Covid-19, extended winter pressures and strike action, we have tried to maintain a high standard of care.

We have taken the following actions to improve this score, and so the quality of our services, by:

- introducing patient liaison volunteers into the emergency department to support patients in accessing drinks and snacks in the department
- continually trying to improve communication with patients. We have:
  - produced a leaflet which can be given to patients during the busiest times, and which explains how we are ensuring the safety of all patients and what patients can expect
  - provided useful information on our plasma screens in the department including videos which cover topics such: what to do if your condition worsens, how we manage our waiting lists and priortise care, explanation for why there might be delays, and what patients can do to support staff
  - improved signage throughout the department – including information on facilities such as wifi, refreshments, and accessing translation services. Signage also explains the pathway to patients and the different stages of care they are likely to experience.

Within our surveys we collect free text comments to help us gather more information from patients, their families, friends and carers, and so that they can describe their personal experiences. Questions include: 'Where are we doing well?' and 'Where could we do better?' The digital system enables us to review the sentiment of each comment, identifying if it is positive, negative or neutral. Over the last year we have received 55 per cent more positive comments than negative.

Inpatient friends and family test

Participation rate

The average participation rate over the past year has been 32.25 per cent. This was a very similar response rate to 2021/22.

	National performance 2022/23			Trust performance			
	Mean	Best	Worst	2022/23	2021/22	2020/21*	2019/20
Score	94%	98%	91%	96%	95%	N/A	97%

*Reporting was suspended for most of 2020/21 due to the Covid-19 pandemic
**The 'FFT' question was changed in 2020/21 so our data for this year is not comparable to previous performance

We believe our performance reflects that:

- we have maintained high standards of care for our patients despite the pressures of the last year, as evidenced by the overall rating of care
- our staff deliver consistently good care. This is a positive reflection of strong local leadership and support.

We intend to take the following actions to improve/maintain this score, and so the quality of our services, by:

- continuing to work to be more user focused, with patient feedback central to our plans. See 'our improvement priorities' section for more information.

Responsiveness to inpatients' personal needs

We take part in the national survey patient experience programme that is coordinated by the Care Quality Commission (CQC). The results from these surveys are published on the CQC website (https://www.cqc.org.uk/). The surveys are conducted on a one-to-two-year cycle, and include: maternity survey, emergency survey, inpatient survey, children's and young people survey and national cancer survey.

The table below shows our performance with a key selection of questions from the national inpatient survey which show our responsiveness to inpatients' personal needs, compared to peers as well as our previous performance.

	National performance 2022/23			Trust performance			
	Mean	Best	Worst	2021/22	2020/21	2019/20*	2018/19
Score	72.6	87	63	73	70.8	N/A	65.2

*There was no national inpatient survey published in 2019/20
**The most recent data is from the national survey which was published in September 2022 for data from 2021

Our performance reflects that:

- this data is drawn from the nationally reported results of the national inpatient survey, which was published in September 2022 for data collected from patients who were in hospital in November 2022. You can view the full report on our website
- the score is based on the average of the following questions within the CQC inpatient survey:
  - to what extent did staff looking after you involve you in decisions about your care and treatment?
  - did you feel able to talk to members of hospital staff about your worries and fears?
  - were you given enough privacy when being examined or treated?
  - thinking about any medicine you were to take at home, were you given any of the following?
  - did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
- we are performing above the national mean and our performance has improved compared to previous years.

We intend to take the following actions to improve/maintain this score, and so the quality of our services, by:

- continuing to work to be more user focused, with patient feedback central to our plans. See 'our improvement priorities' section for more information.

Venous thromboembolism

Venous thromboembolism (VTE) includes deep vein thrombosis (DVT) and pulmonary embolism (PE) both of which are blood clots within a vein obstructing or stopping the flow of blood. The risk of hospital acquired VTE can be reduced by assessing patients on admission and applying preventative measures such as early mobilisation, chemoprophylaxis with anticoagulants and mechanical devices such as compression stockings.

We have continued to exceed the national guidance for VTE risk assessment of over 95 per cent of all in patients.

	National performance*			Trust performance			
	Mean	Best	Worst	2022/23**	2021/22	2020/21	2019/20
Percentage of patients risk assessed for VTE	95.47%	100%	71.83%	96.5%	96.4%	96.6%	95.9%

Source: Trust data – suspended reporting to NHS England
*National performance data is currently suspended – figures reflect performance from 2019/20 national data.
**2022/23 includes provisional Q1-Q4 figures based on Trust data.

Our performance reflects that:

- we have monitored VTE risk assessments monthly throughout the year and have exceeded the national target of 95 per cent for all inpatients.

We intend to continue to work to improve this percentage, and so the quality of our services, by:

- working to improve data accuracy affected by issues such as change of ward use and by working with the areas that are below target to support staff to complete the assessment
- initiating audits to ensure compliance with the NICE quality statements and guidance relevant for VTE.

Clostridium difficile

Trust performance

	National performance*			Trust performance			
	Mean	Best	Worst	2022/23**	2021/22	2020/21	2019/20***
Rate of Clostridium difficile per 100,000 bed days	29.7	0	115.1	27.7	25.3	16.5	28.6
Number of cases				90	71	59	101

*National performance figures are based on UK Health Security Agency (UKHSA) epidemiological data for the period April through February financial year 2022/23. The complete financial year 2022/23 data will be available in May 2023.
** Based on April through March financial year 2022/23 cases.
***Change to Public Health England *C.diff* definitions

Our performance reflects that:

- our submissions to UKHSA's data collection system are carried out monthly and signed off by the chief executive's office
- incidence and rates of *C.difficile* infection are routinely monitored at bi-weekly meetings with our clinical divisions and reported monthly to the Trust-wide *C.difficile* infection forum
- the infection prevention and control team provide assurance via quarterly reports to quality committee that infection rates are monitored, interpreted and strategies are developed and implemented to drive improvement
- In 2022/23, we reported 90 cases of *C.difficile* attributed to the Trust. This is above the allocated threshold of 67 cases. Despite the increase in cases, we have had no lapses in care so far this financial year; an improvement for the Trust when compared with the two lapses in care reported in 2021/22.

We intend to take the following actions to improve in this area:

- continuing to work on reducing the use of anti-infectives (antibiotics) and improving our hand hygiene rates and personal protective equipment (PPE) use to reduce the incidence and transmission of infection.

Patient safety incidents

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.

	National performance*			Trust performance			
	Mean	Best	Worst	2022/23**	2021/22	2020/21***	2019/20
Patient safety incident reporting rate per 1,000 bed days	54.9	205.5	23.7	56.8	56.6	52.1	Apr-Sep 19: 50.7 Oct 19 – March 20: 50.4

*National performance data is as of 2021/22.
**2022/23 Trust data is provisional (April 2022-March 2023).
***From 2020/21 onwards data has been reported nationally on an annual basis, rather than every six months.

We believe our performance reflects that:

- we utilise the nationally reported and verified data from the national reporting and learning system (NRLS)
- our individual incident reporting data is made available by the NRLS annually (previously every six months)
- we monitor our incident reporting rates internally on a monthly basis.

We intend to take the following actions to improve reporting rates, and therefore the quality of our services, by:

- improving how we report, manage, and learn from incidents through the implementation of the Patient Safety Incident Response Framework (PSIRF) and LFPSE, included as part of our quality and safety improvement programme.

Percentage of patient safety incidents reported that resulted in severe/major harm or extreme harm/death

We investigate all patient safety incidents, which are reported on our incident reporting system, Datix. Those graded at moderate harm and above are reviewed at a weekly panel chaired by the medical director. Incidents that are deemed to be serious incidents or never events then undergo an investigation which involves root cause analysis (a systematic investigation that looks beyond the people concerned to try and understand the underlying causes and environmental context in which the incident happened).

	National performance*			Trust performance			
	Mean	Best	Worst	2022/23**	2021/22	2020/21	2019/20***
Percentage of severe/ major harm incidents (# of incidents)	0.26%	0.00%	1.10%	0.12% (24)	0.10% (19)	0.12% (18)	Apr-Sep 19: 0.03% (2) Oct19-Mar20: 0.04% (3)
Percentage of extreme harm/ death incidents (# of incidents)	0.14%	0.00%	0.90%	0.04% (9)	0.03% (6)	0.06% (9)	Apr-Sep 19: 0.06% (5) Oct 19 – Mar 20: 0.06% (5)

*National performance data is as of 2021/22.
**2022/23 data is provisional (April 2022-March 2023).
***From 2020/21 onwards data has been reported nationally on an annual basis, rather than every six months.

We believe our performance reflects that:

- we utilise nationally reported and verified data from the NRLS
- we continue to work to improve our incident reporting process and increase the numbers of incidents reported with positive results as described above. This enables us to identify with more accuracy actual or potential harm and investigate appropriately
- between April 2021 and March 2022 (most recent national data available), we reported 0.10 per cent severe/major harm incidents (19 incidents) compared to a national average of 0.3 per cent, and 0.03 per cent extreme/death incidents (six incidents) compared to a national average of 0.1 per cent
- between April 2022 and March 2023, based on our provisional internal data, we reported 0.12 per cent severe/major harm incidents (24 incidents) and 0.05 per cent extreme/death incidents (nine incidents). Eleven of these remain under investigation so the final harm level may change.

We intend to take the following actions to improve this percentage, and so the quality of our services, by:

- continuing to work to eliminate avoidable harm and improve outcomes. See ‘our 2023/24 improvement priorities’ section for more detail.

Part 2:
OTHER INFORMATION AND ANNEXES

This section of the report provides further information on the quality of care we offer, based on our performance against the NHS Improvement Single Oversight Framework indicators, national targets, regulatory requirements, and other metrics we have selected.

Our performance with NHS England's single oversight framework indicators

NHS England uses several national measures to assess services and outcomes. Performance with these indicators acts as a trigger to detect potential governance issues. We report on most of these monthly to our Trust board through our performance scorecards.

Key performance indicators

As anticipated, performance against the operational standards has been impacted because of ongoing effects of Covid-19. Patients are being tracked and managed according to clinical priority and a harm review process in place. All safe options for treating patients have been reinstated as part of recovery planning.

		Performance		Quarterly trend			
		Target	Annual	Q1	Q2	Q3	Q4
Referral to treatment times	**% incomplete pathways less than 18 weeks (in aggregate)**	92%	63.1%	65.4%	62.5%	61.8%	60.4%
Diagnostics	**Maximum six week wait for diagnostic procedures**	1%	9.2%	11.5%	12.1%	6.5%	6.6%
Cancer access initial treatments	**Two-week wait**	93%	86%	77.5%	86.4%	92.5%	87.0%
Cancer access initial treatments	**Breast symptom two week wait**	93%	74%	32.6%	92.2%	88.1%	84.0%
Cancer access initial treatments	**% cancer patients treated within 62 days of urgent GP referral**	94%	61%	57.0%	50.0%	68.1%	69.0%
Cancer access initial treatments	**% patients treated within 62 days from screening referral**	85%	44%	36.6%	45.0%	37.3%	56.0%
Cancer access initial treatments	**% patients treated within 62 days (upgrade standard)**	90%	85%	87.3%	81.1%	88.3%	85.0%
Cancer access initial treatments	**% patients treated within 31 days of decision to treat**	96%	94%	94.9%	91.1%	94.8%	95.0%
Cancer access subsequent treatments	**Surgical treatments within 31 days**	94%	92%	93.0%	89.9%	87.0%	99.0%
Cancer access subsequent treatments	**Chemotherapy treatments within 31 days**	98%	99%	99.5%	99.1%	100.0%	97.0%
Cancer access subsequent treatments	**Radiotherapy treatments within 31 days**	94%	92%	94.5%	84.9%	97.1%	85.0%
Infection control	***C. difficile* acquisitions**	77	90	26	26	20	18

In May 2019, we began testing proposed new A&E standards as one of 14 trusts in England. Like other trusts involved in the testing, figures on the A&E four-hour access target will not be published for the pilot period and are therefore not included above. We will commence formal external reporting of A&E four-hour performance from early April 2023 (for March 2023 data).

ANNEX 1: STATEMENTS FROM COMMISSIONERS, LOCAL HEALTHWATCH ORGANISATIONS AND OVERVIEW AND SCRUTINY COMMITTEES

North West London Integrated Care Board (ICB)

Thank you for sharing your annual Quality Account 2022/23 with the North West London Integrated Care Board for comment on the 5th May 2023. We have reviewed the stated areas of focus for 2022/23 and note;

- Improve: We will develop and support safety improvement programmes that prioritise the most important safety issues and employ consistent measurement and effective improvement methods. We note the Trust's progress against the areas of focus.
- Insight: we will improve our understanding of safety. We acknowledge the overall improvement in incident reporting rates with resultant harm levels remaining low. In relation to investigations, we support work the to improve the timeliness of investigation and the embedding of the use of 'after action review' methodology.
- Involve: we will ensure that patients, staff and our partners have the skills and opportunities to improve patient safety. We note your success at recruiting Trust Patient Safety Partners, in addition, the launch of and uptake of staff completing Patient Safety Syllabus training, we will be interested to see how these will have a positive impact on your patient safety culture and work.

The ICB notes the continued impact of Covid-19 on the Trust and its services and acknowledge the work the Trust has implemented to mitigate risk to your patients as a result.

In terms of Trust participation in national audits and confidential enquiries, we note the Trust has identified a number of learning points. We will be interested to see how your implementation of the learning points will show improvements in the care of patients associated to these audit conditions and subsequently the Trust performance next year. In addition to the national audits, we also acknowledge the extensive local audit programme and the recommendations from these to improve the care to your patients.

We support your commitment to the Commissioning for quality and innovation (CQUIN) in 2023/24 as part of the NHS contract. The ICB Quality Team look forward to working with you regarding the schemes and the Trust's achievement against these through the year.

We recognise that maternity services as a whole have been under immense scrutiny and we are aware of the Trusts input into the Local (North West London) Maternity and Neonatal System where maternity standards and compliance are monitored and reviewed. In March 2023 the CQC undertook a review of maternity services as part of their national maternity inspection programme and we anticipate the outcome of this. We understand the CQC has not undertaken any other inspections and the Trust's rating remains unchanged.

We note the work the Trust has undertaken in relation to Learning from Deaths and the changes to how deaths are graded. We also note and agree with the change in how patients who died after a hospital-onset Covid-19 infection are reviewed so they are now reviewed in line with Trust's standard mortality review process. We acknowledge the different, national, process for review of maternity and neonatal deaths and note the Trust process for sharing the learning from these.

The ICB acknowledge and agree with the data statements and reporting against the core indicators within the report.

On behalf of NWL ICB, we can confirm that to the best of our knowledge, the information contained in the report is accurate. The ICB supports the on-going quality priorities for 2023/24 and looks forward to working closely with Imperial in exploring further quality improvement initiatives to build on the provision of safe and effective services for our patients.

I would like to take this opportunity to thank Imperial for its continued focus on quality.

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

On behalf of the London Borough of Hounslow's Health and Adult Care Scrutiny Panel, please find our response statement for inclusion in the Imperial College Healthcare NHS Trust Quality Account 2022-23 report.

Statement

The London Borough of Hounslow's Health and Adults Care Scrutiny Panel (the 'Panel') welcomes the opportunity to provide a response to the Imperial College Healthcare NHS Trust (the 'Trust') Quality Account 2022-23 report. This report provides an update on progress made and identifies future priorities. The Panel would like to thank the Trust and its staff for continuing to provide services, and for preparing the Quality Account for comment.

2022-23 Quality Account

Improvement priorities

Thank you for sharing your improvement priorities, for this and next year. We note the work done on the 2022/23 improvement priorities, and we are pleased to see the Trust continues to improve patient safety, services for staff and patients, alongside the continued clinical research activities.

The Panel commends the Trust and its staff for its commitment to delivering a high standard of care for patients. We are pleased to see the positive steps taken towards ensuring continued compliance and to improving quality of care.

Progress against 2022/23 goals:

1. Improve hand hygiene practice, and the safe use of PPE in our clinical areas
    - We note a new approach to infection prevention and control education, training, and support. However, the decrease in infection control compliance from 65% to 60% raises concerns about maintaining infection prevention within the Trust.
    - We would like to stress the importance of infection prevention and control practice being a priority and hope to see an improvement in compliance rates.
2. Improve how we agree and document appropriate treatment escalation plans for our patients in an individualised, compassionate and inclusive manner
    - We note the implementation of an online training module designed to help staff with cardiopulmonary resuscitation (CPR) treatment. We are pleased to see the Trust continues to improve patient safety through building a strong safety culture, alongside staff education and training.
    - We hope the Trust will continue progress in due course so the 90% target can be met for the next year.
3. Improve how we document that our patients have provided informed consent prior to relevant procedures

- We commend the success of the digital consent process and are pleased with the positive feedback received from both patients and staff.

4. Reduce avoidable harm and improve performance and outcomes associated with invasive procedures

- We note the achievements of the invasive procedures group, however we stress the importance of reducing operation and procedure incidents to ensure patient safety and care.

5. Reduce the number of patient falls and associated harm levels

- We note the work on falls prevention, but also note that the Trust has observed an increase in patient falls. This raises concerns about patient safety, and we ask for improvements in the fall prevention strategy and implementation.

6. Improve the checking of blood components prior to transfusion

- The Panel notes the implementation of digital training and rigorous pre-administration checklists and ask that this continues to be a priority.
- The Panel is pleased to see the Trust has not experienced a never event related to blood transfusion since August 2021.

7. Improve the identification and management of adult patients with dysphagia

- We note the organisation faced challenges in addressing this priority and stress the importance of continued work to address the importance of patient safety.
- The Panel asks clear targets and milestones should be set to track progress and successful implementation of training and improvements.

8. Improving fetal monitoring during labour

- We commend the Trust's 93% compliance with "fresh eyes" and are pleased to see a commitment to providing high-quality care to patients.

9. Improving follow up of abnormal urine results in maternity

- The Panel notes the progress the Trust has made to ensure patient safety and that the Trust will make efforts to implement a standardised safety protocol.
- We note that this is an area of improvement, and we ask the Trust reports the outcome of implementing the electronic system.

Statements of assurance from the board

- We are pleased to see an increase in the participation of national audits, and the number of local clinical audits.
- We note that the Trust's CQC rating is 'Requires improvement' which is of concern and ask that this continues to be a priority.
- The Panel notes the work on data quality and look forward to the plan for data quality improvement.

Reporting against core indicators

- The Panel notes the low mortality ratios across the Trust. We note the collaboration with North West London Acute Provider Collaborative to share knowledge and data to make evidence-based improvements.

- We commend the Trust for prioritising patient care and note the percentage of staff stating that the care of patients is the top priority increased to 82%, in comparison to other acute trusts who observed a decrease.
- The Panel notes the commitment towards monitoring progress and reporting equality diversity and inclusion.

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

Health and Social Care Select Committee at the London Borough of Hillingdon

The Health and Social Care Select Committee welcomes the opportunity to comment on the Trust's 2022/2023 Quality Report.

Members note that the following priorities have been set for 2023/2024:

1. Reduce harm to patients through our safety improvement programme;

2. Implement the NHS patient safety strategy with a focus on the Patient Safety Incident Response Framework (PSIRF) and Learn from Patient Safety Events (LFPSE); including the launch of our new incident reporting / risk management system;

3. Improve the treatment of patients with deterioration in their mental health;

4. User insights and focus; and

5. Embed our ward accreditation programme as an enabler for Pathway to Excellence.

Good progress appears to have been made by the Trust in relation to its 2022/2023 quality priorities.

Members are pleased to note the activity undertaken in relation to Covid-19 vaccinations and positive improvements put in place to address the disruption caused by hospital-associated infection. They are also impressed by the Trust's awareness that there is still room for improvement. The Trust's commitment to improving the uptake of vaccinations in staff and patients, and initiatives such as the roaming vaccination service, have resulted in more than 99k Covid-19 vaccinations being administered. This performance should be commended.

In terms of the staff survey results, it is noted that the percentage of staff who would recommend the Trust to friends and family needing care has been going down over the last three years but is still ahead of the national average (62%) at 73%. Performance against the percentage of staff who would recommend the Trust as a place to work was also good, achieving 66% compared to the national average of 57%. It is pleasing that this performance has been achieved during particularly challenging times and the Committee looks forward to hearing about the priority people programmes that are put in place to further improve the performance.

The Trust's performance in relation to participation in the A&E friends and family test has reduced year on year since 2017/2018. Although this seems to have been a national trend, the Trust's performance in 2023/23 (82%) is still above the national average of 76% and compares favourably to the best national performance of 85%.

Looking forward, there are areas where the Trust continues to express a commitment to make improvements, and the Committee notes that there are a number of areas where further improvements are still required. Members look forward to being provided with more detail, on the progress of the implementation of priorities, but more importantly on the achievement of objectives outlined in the Quality Report and improved outcomes over the course of 2023/2024.

ANNEX 2: STATEMENT OF DIRECTORS' RESPONSIBILITIES FOR THE QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

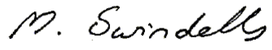
NHS England has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report. In line with national guidelines, we moved to adopt the same requirements for NHS foundation trust boards beginning in 2019/20 and have continued this year.

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

- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2019/20* and supporting guidance *Detailed requirements for quality reports 2019/20*
- the content of the quality report is not inconsistent with internal and external sources of information including:
  1. board minutes and papers for the period April 2022 to May 2023
  2. papers relating to quality reported to the board over the period April 2022 to May 2023
  3. feedback from clinical commissioning groups
  4. the annual governance statement May 2023
  5. feedback from local Healthwatch and local authority overview and scrutiny committees
  6. the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  7. the national staff survey 2022
  8. the head of internal audit's annual opinion of the Trust's control environment May 2023
  9. mortality rates provided by external agencies (NHS Digital and Telstra Health).
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, 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 report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report. The quality account was reviewed at our audit, risk and governance committee held in June 2023, where the authority of signing the final quality accounts document was delegated to the chief executive officer and chair.

By order of the board



Matthew Swindells, Chairman
29 June 2023

Professor Tim Orchard, Chief executive
29 June 2023

ANNEX 3:
PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES 2022/23

Details of the eligible audits applicable to Imperial College Healthcare NHS Trust and compliance of the mandatory audit programme during 2022-2023 are listed in the table below:

Name of Project	Host Organisation	Did we participate?	Stage / submission details
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)			
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	Yes	Ongoing
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	Yes	Ongoing
Breast and Cosmetic Implant Registry	NHS Digital	Yes	5 cases
Case Mix Programme	Intensive Care National Audit and Research Centre	Yes	Ongoing
Elective Surgery: National PROMs Programme	NHS Digital	Yes	100%
Emergency Medicine QIPs – 551 cases in total			
a. Pain in children	Royal College of Emergency Medicine (RCEM)	Yes	49 cases
b. Infection Control	Royal College of Emergency Medicine (RCEM)	Yes	330 cases
c. Consultant sign-off	Royal College of Emergency Medicine (RCEM)	Yes	172 cases
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People[1]	Royal College of Paediatrics and Child Health	Yes	100%
Falls and Fragility Fracture Audit Programme			
a. Fracture Liaison Service Database	Royal College of Physicians	Yes	Ongoing
b. National Audit of Inpatient Falls	Royal College of Physicians	Yes	Ongoing
c. National Hip Fracture Database	Royal College of Physicians	Yes	Ongoing
Gastro-intestinal Cancer Audit Programme			
a. National Bowel Cancer Audit	NHS Digital	Yes	184 cases
b. National Oesophago-gastric Cancer	NHS Digital	Yes	155 cases
Inflammatory Bowel Disease Audit	IBD Registry	Yes	Ongoing
Muscle Invasive Bladder Cancer Audit	The British Association of Urological Surgeons	No	
National Adult Diabetes Audit			
a. National Diabetes Core Audit	NHS Digital	Yes	Ongoing
b. National Diabetes Foot Care Audit	NHS Digital	Yes	Ongoing

c. National Diabetes Inpatient Safety Audit	NHS Digital	Yes	Ongoing
d. National Pregnancy in Diabetes Audit	NHS Digital	Yes	Ongoing
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme			
a. Adult Asthma Secondary Care	Royal College of Physicians	Yes	Ongoing
b. Chronic Obstructive Pulmonary Disease Secondary Care	Royal College of Physicians	Yes	Ongoing
c. Paediatric Asthma Secondary Care	Royal College of Physicians	Yes	117 Cases
d. Pulmonary Rehabilitation Organisational and Clinical Audit	Royal College of Physicians	Yes	Ongoing
National Audit of Breast Cancer in Older Patients	Royal College of Surgeons	Yes	Ongoing
National Audit of Cardiac Rehabilitation	University of York	Yes	Ongoing
National Audit of Care at the End of Life	NHS Benchmarking Network	Yes	Ongoing
National Audit of Dementia	Royal College of Psychiatrists	Yes	Ongoing
National Audit of Pulmonary Hypertension	NHS Digital	Yes	Ongoing
National Bariatric Surgery Registry	British Obesity and Metabolic Surgery Society	Yes	Ongoing
National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre	Yes	Ongoing
National Cardiac Audit Programme			
a. Myocardial Ischaemia National Audit Project	Barts Health NHS Trust	Yes	Ongoing
b. National Adult Cardiac Surgery Audit	Barts Health NHS Trust	Yes	1,522 cases
c. National Audit of Cardiac Rhythm Management	Barts Health NHS Trust	Yes	Ongoing
d. National Audit of Percutaneous Coronary Interventions	Barts Health NHS Trust	Yes	Ongoing
e. National Heart Failure Audit	Barts Health NHS Trust	Yes	Ongoing
National Child Mortality Database	University of Bristol	Yes	Ongoing
LeDeR – learning from lives and deaths of people with a learning disability and autistic people	NHS England and NHS Improvement	Yes	Ongoing
National Early Inflammatory Arthritis Audit	British Society of Rheumatology	Yes	Ongoing
National Emergency Laparotomy Audit	Royal College of Anaesthetists	Yes	120 cases
National Joint Registry	Healthcare Quality Improvement Partnership	Yes	Ongoing
National Lung Cancer Audit	Royal College of Surgeons	Yes	Ongoing
National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology	Yes	Ongoing
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	Yes	Ongoing
National Ophthalmology Database Audit	The Royal College of Ophthalmologists	Yes	Ongoing
National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	Yes	140 cases
National Perinatal Mortality Review Tool	University of Oxford / MBRRACE- UK collaborative	Yes	Ongoing
National Prostate Cancer Audit	Royal College of Surgeons (RCS)	Yes	Ongoing
National Vascular Registry	Royal College of Surgeons (RCS)	Yes	Ongoing
Neurosurgical National Audit Programme	Society of British Neurosurgeons	Yes	100%
Paediatric Intensive Care Audit[1]	University of Leeds / University of Leicester	Yes	Ongoing
Perioperative Quality Improvement Programme	Royal College of Anaesthetists	Yes	27 cases
Renal Audits			
a. National Acute Kidney Injury Audit	UK Kidney Association	Yes	Ongoing
b. UK Renal Registry Chronic Kidney Disease Audit	UK Kidney Association	Yes	Ongoing
Respiratory Audits			
a. Adult Respiratory Support Audit	British Thoracic Society	Yes	Ongoing
b. Smoking Cessation Audit – Maternity and Mental Health Services	British Thoracic Society	N/A	On hold nationally
Sentinel Stroke National Audit Programme	King's College London (KCL)	Yes	Ongoing
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Serious Hazards of Transfusion	Yes	Ongoing
Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	No	Trust is using other ways to measure the service
Trauma Audit and Research Network	Trauma Audit and Research Network	Yes	Ongoing
UK Parkinson's Audit	Parkinson's UK	Yes	100%

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