NHS
Imperial College Healthcare
NHS Trust

Quality Account

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2024–25

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Chief executive's overview

Professor Tim Orchard, chief executive

The financial year 2024-25 has been another challenging one, within the Trust and across the wider NHS, with financial pressures, the demands of our ageing estate, and long waiting lists contributing to pressure on our services and staff.

I am very proud of how our staff are rising to these challenges, while keeping our patients and communities at the heart of what we do, and ensuring patient safety and quality remains paramount. That we continue to provide some of the best outcomes in the country, with mortality rates once again among the lowest in the NHS, is testament to their hard work and dedication. We do not always get it right, which is why ensuring our staff feel comfortable to raise concerns is so important, and why it is positive that our incident reporting rate has been increasing year-on-year since 2021-22.

Person-centred safety

In April 2024 we transitioned to the national Patient Safety Incident Response Framework (PSIRF), which is the new way that the NHS investigates and learns from patient safety incidents, moving to a more considered and proportionate response, focused on understanding how incidents happen and on engaging more deeply with and involving those affected.

Throughout 2024-25 we have continued to adapt how we are embedding the new framework in practice to best suit our staff and patients. This has included providing new training and support for staff and implementing new processes to better support the initial stages of the investigation. This is allowing us to more quickly identify learning and actions needed to improve patient care, and working with patients, families and staff involved to ensure we reflect their experience and views in our learning responses.

In addition to making local improvements in response to patient safety incidents, we regularly review these alongside other insights, such as feedback from patients and staff, clinical audit and mortality review outcomes, to identify cross-cutting themes and systems-issues which need a focused, trust-wide approach to improving patient care. These make up our quality and safety improvement programme priorities.

During 2024-25 we made some really positive progress, including:

- a 38% reduction in "failure to rescue" incidents through a focus on improving how we recognise and respond when patients are deteriorating
- improvements and expansion to our Call for Concern service and implementing all elements of Martha's Rule as one of the pilot sites chosen to help develop an NHS-wide approach to this important patient safety initiative
- improved hand hygiene – vital to preventing hospital acquired infections – with compliance reaching 72% by March 2025 compared to 54% in March 2024
- developed new policies, processes and training to improve care for patients with mental health, swallowing or mobility needs to minimise harm through a focus on evidence-based care plans
- implemented new policies, processes and pathways to provide better support and continuity of care for young patients as they transition to adult services.

Our five patient safety partners, lay partners who are actively involved in the development of safer healthcare, continue to ensure the patient's perspective is central to our plans. They have supported us in multiple ways including in the cancer pathway and outpatient services changes, helped us carry out engagement sessions with staff and our community, and contributed to initiatives to improve equity and inclusion.

Looking ahead

Building on the successes of the last year, we have ambitious plans to deliver our priorities into 2025-26 to ensure we are fully realising the benefits for patients and staff. This will include a new focus on safer invasive line care, implementation of a newly developed guideline to improve how we manage patients who are deteriorating or who have suspected sepsis and improving care for patients who are transferred. We have a new mental health plan in place to further support patients when they come to our hospitals and we will also continue to embed our approach to end-of-life care through our new strategy.

We are also focusing on new areas for improvement: endorsement and management of diagnostic results, medication safety during discharge and for time critical medications, pain management, and patient fasting times before procedures. Our work will continue to be underpinned by our maturing approach to person-centred safety and the use of user insights to drive change.

We will also work with our partners across the North West London Acute Provider Collaborative to implement a joint new quality and safety reporting and risk management system, which will help us to standardise reporting and metrics, and ensure we are more accurately capturing and identifying areas of risk and learning across our hospitals.

Our quality account provides just a snapshot of some of the amazing work which goes on across our hospitals every day to keep our patients safe and ensure they get the best possible care. We know we have a lot more to do, but hopefully this document demonstrates our commitment to continually learning and improving.

Thank you to everyone who has helped us put this quality account together including Healthwatch, our integrated care board and local authorities, and to our staff, who are so committed to providing 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 – supports this work.

In 2024-25, 1,043 members of staff participated in improvement training, ranging from basic to advanced courses. We now have 2,959 current members of staff trained in improvement methodology (17%, compared with 13% in 2023-24 and 9% in 2022-23).

In 2024-25, we launched our 'Improvement for All' programme, which has been co-designed with our staff to ensure we fully embed a culture of continuous improvement into every aspect of our organisation. One of the core elements of the programme is the development of a distinct improvement plan for each area of the organisation. These plans collate improvement priorities across quality, safety, operations, finance and workforce to ensure that improvement methodology is applied effectively in all areas. We worked with nine pathfinder wards to develop their improvement plans over the last year. In 2025-26, we are expanding this approach to directorate level as well as to additional wards.

2025-26 improvement priorities

This section of the quality account focuses on the quality and safety improvement programme. The other strategic priorities are included in our annual report.

Our priority improvement areas for quality and safety for 2025-26 are set out 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
- national and acute provider collaborative priorities.

Collectively, they aim to support the Trust's strategic objective to improve outcomes for patients and local communities.

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, focused on the areas of greatest risk of harm. 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 for quality. Following review of our quality insights and data, and progress with our previous priorities, we have agreed nine priority areas for the safety improvement programme in 2025-26. Some of these were priorities in 2024-25 and have been extended so that we can continue to make improvements and build on the progress made. This includes: • infection prevention standards focused on hand hygiene and in addition invasive line care • identification and management of patients with dysphagia • safe transfers of care • implement the new guideline for patient deteriorating and sepsis • invasive procedure safety by implementing NatSSIPs 2 (national safety standards for invasive procedures). Four new areas of risk have been identified and are included in our work plan for 2025-26: **Endorsement and management of results** When the results of a diagnostic test are reported it is important that these are reviewed ('endorsed') quickly by a consultant so that the results can be shared with the patient and any further treatment can be agreed and arranged as soon as possible. Our data shows that we have room to improve, with 59.7% of radiology tests ordered between October 2024 and the end of March 2025 not currently endorsed in our electronic patient record. This is also a theme from some of our recent delayed diagnosis incidents. We are currently setting up a task and finish group which will focus on identifying the issues that are making this difficult for staff and on implementing changes to deliver sustained improvement. **Medication safety on discharge and for time critical medications** Through regular review of incidents, our medicines safety group has identified two key areas of risk for patients: • ensuring patients receive the critical medication they need on time – we will aim to reduce the time between prescribed and actual administration to no more than 30 minutes for the 10 highest-risk medications • reducing the risk of medication errors on discharge by focusing on the screening of medications and the checking process at the point of discharge. The group will review our current processes and identify interventions we can make to reduce errors and delays in these areas.

Assessment and management of patients with pain

Experiencing prolonged pain not only impacts on our patients' immediate experience in hospital, but it can lead to other adverse effects including respiratory issues, clot formation, urinary tract infections and pressure sores, and can result in pain that persists long after our patients have left hospital.

We have a pain team in place who have been training staff and auditing how well pain is managed in our adult inpatient population since 2004, with some really good progress made. This includes an increase in the percentage of patients who had been asked to score their pain in the past 24 hours from 3% in 2004 to 81% in 2024 and a reduction in the percentage of patients who had experienced moderate or severe pain in the previous 24 hours from 73% to 37% in 2024. Although these improvements are positive, the audits do demonstrate that we have more to do to make sure pain is documented, managed and medicated as well as possible – this will be our focus in 2025-26.

Fasting time for patients undergoing an invasive procedure

For many surgical procedures, patients are told not to eat or drink beforehand to reduce the risk of them vomiting while under anaesthetic, which can be dangerous. Historically, policies for patients due for operations stated no food for six hours before surgery, clear fluids until two hours before and then 'nil by mouth' (NBM) until their operation. In practice, it can be difficult to predict when the operation will start, so some patients are kept NBM for hours. This can cause dehydration and discomfort and make it harder to recover from the procedure. During 2025-26 we will develop and implement an improvement plan, incorporating learning from the 'SipTilSend' initiative which allows patients to sip small volumes of water until they are sent for to have their operation.

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 area of risk.
Focus area	**Develop and embed our approach to the use of user insights to drive improvement**
Rationale for selection	We are committed to becoming more 'user-focused' – to better understand and incorporate the needs, views and preferences of our diverse patients, staff, local communities and partners to influence everything we do. We already gather a huge amount of information from – and about – our patients and other 'users'. We created a small, central insight and experience team in 2023 to support the whole organisation in using this information more effectively, including connecting insights to inform and shape our strategy and improvement priorities. The central team also commissions service evaluations to meet specific gaps in understanding, leads on patient and public involvement, and is working to build insight and co-design skills across the organisation. This remains a priority for 2025-26 as we continue to build on the progress made in the last two years.
Key metrics	• improvements in patient feedback and survey responses • improved response rate to complaints within agreed timescales • improved satisfaction with complaint responses
Focus area	**Embed the NHS patient safety strategy: Focus on person-centred safety and insights through the rollout of the new reporting system across the North West London Acute Provider Collaborative**
Rationale for selection	The NHS patient safety strategy focuses on how we can continuously improve safety by building on two foundations: a patient safety culture and a patient safety system. It focuses on establishing a culture of psychological safety, sharing safety insight and empowering people – patients and staff – with the skills, confidence and mechanisms to improve safety. It sets out three strategic aims for the NHS as a whole (insight, involve, improve) with actions under each of these aims. Since it was published, we have been working to implement the main elements of the strategy, which included: • transition to the Patient Safety Incident Response Framework (PSIRF) in April 2024 • transition to the new national way of reporting incidents called Learn from Patient Safety Events (LFPSE) in April 2024 • local implementation of the patient safety syllabus, which provides training for all staff across the NHS. Over 95% of all our staff have now completed level one training • development of the patient safety partner role (lay partners who are actively involved in the development of safer healthcare), and recruitment of five such partners who have been instrumental in developing our local strategy for involving patients in patient safety. Throughout 2025-26, we will continue our work to embed the national strategy, focusing on the following workstreams under two of the main aims. The third aim – improve – is delivered via our safety improvement programme, described above. **Involve** To achieve our person-centred safety goals we must ensure patients, their families and our communities are involved in designing safer healthcare from the outset, that they know how to stay safe when they visit hospital and that we compassionately engage with them when something goes wrong. We have made good progress with implementing our local strategy for involving patients in patient safety as set out in the next section. This will remain a focus while we work to embed cultural change so that patients, service users, families and carers are empowered partners in safety. A key element of this will be delivery of our approach to Martha's Rule, a national initiative providing patients and families with a way to seek an urgent review if their or their loved one's condition deteriorates, and they are concerned this is not being responded to. **Insight** One of our main sources of insight to improve patient safety is the incidents which our staff report. We are proud of our increasing incident

	reporting rate, which demonstrates a culture where staff feel supported to speak up, however we know that we could be reporting more. During 2024-25 we completed the procurement process for a new incident and risk management system with our partners across the acute provider collaborative. This will enable us to standardise reporting and metrics across the four trusts, making improvement and comparison increasingly robust. It will also reduce the administrative burden for our staff and allow automated reporting from the electronic patient record which will ensure we are more accurately capturing and learning from incidents of potential harm. In 2025-26 we will focus on designing the content of and implementation of the new system so that it is as user-friendly as possible for staff. We will also continue our work to embed PSIRF, making sure those affected by incidents (patients, families, staff) are compassionately and effectively involved in our learning responses and improvements.
Key metrics	Improvements in the: • % of patient safety partners and project teams that say they are functioning at the 'empowering' end of the involvement spectrum • % of patients, families and carers that are satisfied with the learning response process and outcome • % of staff that agree they feel safe to speak up about anything that concerns them in the organisation • % of staff that agree the organisation acts on concerns raised by patients / service users • sustained increase in our incident reporting rate. • % of patients, families and carers that are satisfied with the learning response process and outcome
Focus area	**Improve the support and management 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 continues to rise. Managing mental health presentations remains challenging, partly because we do not always have the right environment or enough trained staff to provide the required level of care. Over the last two years we have been working on implementing our strategy for improving mental health care in the Trust and have made good progress (see following section for details). This remains a priority in 2025-26, with a new mental health plan in place until 2027 to support patients of all ages presenting with such needs in our acute hospitals.
Key metrics	• number of medically optimised patients awaiting transfer to a mental health bed • % of healthcare support workers who have completed ENHANCED training • % of staff who have completed rapid tranquilisation training • reduction in significant mental health related events

Focus area	**Improve end of life care through delivery of our Trust strategy**
Rationale for selection	We are committed to delivering the very best care at the end of life to our patients and those important to them. Our new strategy for 2025 – 2028 will build on the successes of our previous work and ensure we continue to deliver on this commitment. Our new strategy is based on national guidance, local evidence and service user insights, underpinned by our Trust values. This document sets out a clear vision for our work and the strategic commitments which will guide us through the complex landscape of palliative and end of life care over the next three years. Our vision is that every person, and those important to them, approaching the end of their life will receive compassionate and individualised care when and where they need it. Our mission is that all staff and volunteers will understand their responsibility in the delivery of end of life care and will have the necessary skills and confidence to care for those that need it. Our strategic commitments will focus on our patients, staff, organisation and partners. We will deliver these commitments through a detailed work plan, overseen by the end of life steering group.
Key metrics	• staff training compliance rates • feedback from the bereaved, including survey results • performance with the National Audit of Care at the End of Life (NACEL) standards • outcomes of mortality reviews
Focus area	**Ensure young people who move from children's to adults' service have a coordinated transition plan**
Rationale for selection	Transition is defined as a planned process of supporting young people to move from children's to adults' services. It is not a single act so much as a process starting from around age 12 that seeks to involve children and young people in discussions and decisions on all elements of their care management. Transition can be a difficult and anxious time for young people and their families. Without proper support there is a risk of disruptions to care provision during the already vulnerable adolescent period. We know from feedback from our children and young people, their families, their carers and our staff that we have much work to do to ensure developmentally appropriate transition pathways are in place in every specialty and that they meet the needs of the diverse range of patients that we care for. In 2024-25 West London Children's Healthcare (WLCH) identified 'transitioning well to adult services' as a key quality priority and a working group is in place to oversee delivery of a five-year plan, with good progress made as set out in the following section.
Key metrics	We will focus on establishing simple data metrics to enable common and consistent reporting across WLCH.

In addition to our local priorities, we are also working with the other three acute trusts in the North West London acute provider collaborative on a number of priority areas. These are focused on areas where we can work together to make the most difference for our patients and communities and include implementation of the new guideline for management of deterioration and sepsis, and implementation of the new incident and reporting system, which are both local priorities, and work to align clinical pathways to best practice across the collaborative.

Progress against our 2024-25 improvement priorities

This section describes the progress we made with the quality and safety improvement priorities we agreed for 2024-25. These were chosen following a review of quality insights, the NHS patient safety strategy, and in consultation with staff and our partners.

Fully implement and embed the Patient Safety Incident Response Framework (PSIRF) with a focus on experience of and compassionate engagement with those involved

What did we achieve?

In April 2024 we fully transitioned to the PSIRF, which replaced the serious incident framework as the way the NHS investigates and learns from patient safety incidents. This followed a lot of work to change and improve our systems, processes, training and governance to align with the new ways of working set out in the framework.

The framework has four 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
- considered and proportionate responses
- supportive oversight focused on strengthening response system functioning and improvement.

There have been some initial challenges, including delays at all stages of the learning response processes, but we are making progress with the significant cultural and process changes required. We continue to learn and adapt what we are doing to best suit our staff and our patients, but fully embedding the framework will take time and will be an ongoing process over the coming years.

In 2024-25 we:

- developed a workstream with our patient safety partners looking to improve how we involve patients and families in our learning responses. This includes implementing a questionnaire to measure satisfaction with the learning response process and outcome, and working with leads to better understand the challenges to effective compassionate engagement and involvement, with improved guidance and training designed in response
- implemented a new triage process for incidents. This has prioritised rapid review and identification of local actions, meaning we are only taking forward for further investigation those incidents where we have the most to learn. There has been a reduction in the number of 'initial incident reviews' our teams are carrying out as a result, as well as quicker identification of incidents needing more in-depth investigation
- introduced additional training and support for staff following feedback, including drop-in support sessions, training for the learning response leads on development of strong actions which address the systems issues and champion user training for 'after action reviews'
- agreed principles for joint PSIRF learning responses with the other acute provider collaborative trusts to support investigations when more than one organisation is involved, increasing support and improving outcomes for those impacted
- improved compliance with the national patient safety syllabus training. This includes maintaining over 90% compliance with level one training for all staff and improving the percentage of appropriate staff who have completed level two from 26%in March 2024 to 78% by the end of March 2025)
- continued to promote and encourage incident reporting as one of our key tools to identify risk and drive improvement. Our patient safety incident reporting rate per 1,000 bed days is consistently above national average and has steadily increased over the last five years. In 2024-25 it was 64.8, compared to 56.6 in 2021-22. This is a good indication of a culture where staff feel supported to speak up
- completed the procurement process for a new incident reporting system with the other acute provider collaborative trusts. The system should make it easier to report and identify themes and learning from incidents both within the Trust and across the acute provider collaborative.

Fully develop our approach to patient-centred safety with our patient safety partners

What did we achieve?

Our focus this year has been on further developing and delivering our local strategy for involving patients in patient safety, with our patient safety partners. Our strategy has five workstreams:

- improving patient safety partner involvement
- patient and community participation
- involving patients and families in learning responses
- staff engagement and training
- equity, inclusion and patient safety.

In 2024-25 we:

- partnered our patient safety partners with 75% of our safety improvement priorities so that they can bring the patient perspective to our improvement work. Examples of work they have been instrumental to includes the Martha's rule pilot, Call for concern service roll out and bringing a patient focus to the hand hygiene steering group
- gained national recognition for our journey in developing the patient safety partner role, at the patient safety learning network meeting and an online interview, as well as a presentation at a Healthcare Conferences UK event
- promoted the 'Simple steps to keep you safe during your hospital stay' on social media, the community newsletter and screens in patient areas amongst other channels
- delivered seven community engagement sessions, involving 74 people, to help us understand the barriers to speaking up about a safety concern. Issues discussed included how to raise concerns/complaints, concerns about staff behaviours and cultural barriers. We are using the feedback to develop the next steps for the workstream. We are also looking into the possibility of how our reporting system would allow patients to report incidents
- carried out listening sessions with over 80 staff to understand their hopes and concerns about having patients who are more active in safety. Feedback identified worries about the lack of resources to do this properly, the behaviours of some patients and feeling unequipped to help. The feedback is being used to develop our ongoing plans
- involved our patient safety partners in initiatives related to improving equity and inclusion, including the interpreting improvement project and the wider health inequalities programme
- saw an improvement in the percentage of staff responding to the national staff survey who agreed that we act on concerns raised by patients / service users (from 76.7% to 78.2%).

Our work to involve patients and families in learning responses is described under other priorities.

While we are really proud of the progress we are making, feedback from patients, families and staff tells us we have much more to do so this will remain a focus in 2025-26 as part of our priority to embed the NHS patient safety strategy.

Develop and embed our approach to the use of user insights to drive improvement

What did we achieve?

Our user insight, user involvement and experience teams have continued to refine our approach to involving users in the improvement and design of our services.

In 2024-25 we:

- worked with ward teams to review how we collect, interpret and apply user feedback in improvement work. This process has led to the identification of seven recommended projects for 2025-26 which include improvements to the patient survey questions, and to the communication to staff and patients about the importance of the feedback process
- incorporated user insight, including patient interviews and input from our lay partners, into the outpatient improvement programme. This influenced the redesign of the appointment booking process and communication materials, including web content, leaflets, letters, call scripts and more
- conducted a service evaluation study involving patients who have used our cancer services and staff, with an improvement plan developed based on this feedback
- developed a remuneration policy and process to appropriately compensate users/patients who are involved in our work
- continued to implement improved wayfinding across our sites to make them easier to navigate for patients
- completed an in-depth analysis of user feedback for our patient transport services to support their ongoing improvement work
- created guidance and a checklist to assist staff when designing feedback or service evaluation surveys
- began work with maternity services to develop a single user insight improvement plan, collating existing patient feedback, input from the Maternity Voices Partnership, as well as interviews with staff
- continued to improve our complaints processes, successfully reducing the number of complaints which have been open for over 90 days from 15 in November 2024 to 7 in March 2025.

Reduce harm to patients through our safety improvement programme

Focus area	What did we achieve?
Reduce infection transmission by improving basic standards of infection prevention and control practice, especially hand hygiene	Hand hygiene is a key factor in the control of infection. This was one of our priorities throughout the pandemic, which increased the risks associated with hand hygiene further. This has been a priority ever since because incident and audit data showed there was more work needed to improve. Our hand hygiene improvement programme now includes over 60 of our staff, from different professional groups, and two of our patient safety partners, working in five different groups to deliver improvements. In 2024-25 we: • saw a steady improvement in compliance from 54% in March 2024 to 72% in March 2025. We have an ambitious internal target of 75% which we have set following review of the available evidence and research. Although comparison across facilities is challenging due to differences in local audit methodologies, a recent worldwide survey has shown hand hygiene compliance of less than 60% in about half of them. Our nursing staff achieved 75% compliance in March 2025 • designed a ward-based diagnostic tool (adapted from the World Health Organization's hand hygiene self-assessment framework) which helps wards to identify actions they can take to improve hand hygiene and is being tested on four wards • improved our ward-based clinical cleaning scores from 83% at the beginning of the year to 90% in March 2025 following the introduction of a 'clinical cleaning' toolkit in 2024 which supports ward staff with what and how to clean patient-facing clinical equipment • undertook an audit of commodes, followed by practice checks with clinical staff to reinforce the importance of commode cleaning for infectious patients, especially where ensuite facilities are not available. Despite a huge amount of work, we have exceeded our yearly thresholds for four of the five mandatory reportable hospital acquired infections, although we are pleased that we saw a reduction in MRSA blood stream infections, E. coli infections, and Clostridium difficile cases in 2024-25 compared to 2023-24. There has been an increase in infections across the UK. There are also ongoing issues with the age and condition of our hospital estates, including lack of isolation rooms, dated ventilation systems, and water hygiene issues. Significant work programmes are in place to mitigate these where possible. In 2024 we set up a quality review meeting process to review the data in more detail in areas where there were infection prevention and control challenges using our refreshed scorecard, and identify any additional support required. We have now replaced this with deep-dive meetings with our clinical divisions, focused on developing and monitoring improvement plans in response to local areas of risk. As part of this work, we have: • identified improvements in our processes for screening patients for key infections which are now being taken forward • delivered bespoke training in areas which had increases in infections, including face-to-face aseptic non-touch technique training (ANTT), which helps keep patients safe from infection during clinical procedures • completed an audit which found issues with ongoing care and documentation of vascular access devices (lines) and their insertion records. Enhanced local training and practice checks will be delivered during 2025. This will continue to be a safety improvement priority in 2025-26, with an ongoing focus on hand hygiene improvement and now with invasive line care.
Improve the treatment of patients with sepsis and signs of deterioration	This priority was chosen because how we recognise and manage when a patient under our care is deteriorating, including how we communicate with families under these difficult circumstances, was a consistent theme in incidents and in our mortality reviews. One of our main focuses was to further develop our plans to fully implement Martha's Rule. In 2024-25 we: • successfully secured funding from NHS England as one of the pilot sites to support them to develop and agree a standardised approach to all three elements of Martha's Rule across the NHS.

- continued to make improvements to our 'Call for concern' service, implemented in January 2024. This enables patients and families to call for immediate help and advice when they feel concerned that the health care team has not recognised deterioration in someone's clinical condition. Stickers highlighting the service are now on over 1500 of our inpatient beds on over 70 wards
- carried out an equality impact review, including feedback from people who had used the service, which helped us to make improvements to our internal and external communications, and informed an improvement plan which is looking at alternative contact methods to support people for whom a telephone service might present a barrier. Between April 2024 and March 2025, the service received 197 calls. Of these, 102 were non-clinical – mostly concerning communication issues, signposting, and general care concerns – while 95 required clinical review. Reviews, conducted in person, led to interventions such as bedside nursing support, oxygen therapy, pain management, and intravenous fluid or electrolyte support, with no patients requiring transfer to higher-level support such as intensive care
- developed and tested a response to the daily questioning component of Martha's Rule. This element involves the implementation of a structured approach to obtaining information relating to a patient's condition directly from them and their families at least daily. The approach we are testing uses a health equity lens to ensure that Martha's Rule is available for all patients, but particularly those who face additional communication barriers to escalating their concerns. We are currently working with patients and staff to co-design interventions.

We have also further developed plans to improve our response to sepsis. Our data shows that we do not always respond as quickly as we could when a patient is diagnosed with sepsis, with 88.6% receiving antibiotics within one hour against a target of 90%. All patients have been reviewed, with minimal harm identified due to the delays. Feedback from clinical teams led to a review of the electronic alert which prompts clinicians to consider sepsis as a diagnosis. New wording has now been agreed which will support staff to make accurate choices once it is implemented in 2025.

During 2024-25 we also worked with the other collaborative trusts to develop an updated guideline to improve the management of deterioration and suspected sepsis. This is based on the PIER Framework that supports systems to 'Prevent, Identify, Escalate, and Respond' to physical deterioration, and will bring us in line with the most up-to-date national guidance. To fully implement this, we will need to make considerable changes to our workflow, electronic patient record, staff training and education. This will be our focus going into 2025-26.

Although we still have improvements to make, we have seen a positive reduction of 38% in 'failure to rescue' incidents causing harm. Our mortality rates remain amongst the lowest in the NHS, our inpatient cardiac arrest rate is below the national average, and our risk-adjusted survival rate is significantly above other comparable trusts, demonstrating that we are providing safe care for most of our patients.

Reduce harm from inpatient falls

This has been an improvement priority since 2021. Over the last two years our focus has been on improving the completion of a high-quality multifactorial assessment to optimise safe activity and the completion of post fall assessments.

In 2024-25 we:

- introduced an education programme, offering monthly sessions at each site, including flexible training adapted to learning from incidents. 672 staff received face-to-face training, complemented by a bespoke e-learning package. A 'train the trainer' model is now being introduced so that the face-to-face training can be expanded at scale and pace
- launched an updated falls policy, and changes to our electronic record to align with evidence-based practices
- focused on improving the percentage of patients aged over 65 who had their lying and standing blood pressure recorded (important in recognising postural hypotension – low blood pressure when you stand up – which may cause a fall), which resulted in a small but sustained improvement from 21% in March 2024, to 36.2% in March 2025
- targeted interventions and support to high-risk wards, with some key successes. For example, Fraser Gamble ward's initiative on postural hypotension, which increased compliance from 21% to 82.7%
- improved performance with some of the key standards in the National Audit of Inpatient Fractures, with checks for injury before moving a patient rising from 20% to 71%, reflecting better post-falls care
- strengthened links with community falls services, increasing direct referrals and clarifying care accountability during hospital-to-home transitions.

Given the successes achieved and that we now have a robust policy and education framework in place, we plan to step this priority down to business as usual, with monitoring though incident reporting, and the inclusion of additional metrics in our quality scorecard.

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 0.70% (14/1991). Through regular review of our incident data, we identified two specific areas in 2023 where we had an opportunity to improve patient safety: anticoagulant therapy and insulin.

Anticoagulant therapy

In 2024-25 we:

- launched a new discharge pathway clinic for patients discharged on all anticoagulation treatments in September 2024. This has been shortlisted for a national venous thromboembolism (VTE) award, which celebrate outstanding practice across healthcare services working to prevent and embed effective management of VTE
- continued to exceed our target to complete VTE risk assessment for at least 95% of all patients

	• implemented an improvement plan in response to incidents which identified issues with anticoagulation management for patients having surgical procedures. This included an audit to identify all relevant procedures, process mapping of the prescribing issues and contributory factors leading to omissions. Work has now started to develop an alert in the electronic patient record to remind staff to stop/re-start anticoagulation, as applicable. We are now stepping down this priority to business as usual with ongoing work overseen by the thrombosis and anticoagulation committee. **Insulin** In 2024-25 we: • developed and launched a new insulin safety e-learning module which went live in January 2025 • worked with the iCare team from the Patient Safety Research Collaboration to develop an automated dataset linked to the National Diabetes Inpatient Safety Audit metrics. Once fully embedded, this dataset will support targeted improvements based on robust evidence • developed a practical toolkit to support wards in addressing local improvements to the processes for dispensing and storing insulin • introduced insulin practice assurance checks. The initial findings showed good overall compliance, with actions put in place where areas of improvement were found, supported by the toolkit described above. This priority was originally chosen following a small number of insulin-related never events. The actions in response to these have now been completed and we have not reported any insulin-related never events since December 2023. While some of this work is ongoing, we will step this down as a priority and monitor through our regular governance processes.
Reduce the harm caused when undertaking invasive procedures by implementing NatSSIPs 2	This priority was chosen to improve patient and staff safety, processes and outcomes associated with invasive procedures. It was originally chosen in response to a series of never events in 2019-20 related to invasive procedures During 2024-25 we have continued our work to implement the new national safety standards for invasive procedures (NatSIPPs 2). The aim is to standardise and educate across organisations and procedural teams to enable safe, reliable and efficient care for every patient having an invasive procedure. This work is delivered through our invasive procedures committee. In 2024-25, we: • agreed updates to the generic World Health Organization (WHO) checklist to align it to the new national standards across the acute provider collaborative. This will be launched at the end of May • continued to update our existing policies and guidelines to reflect the new standards • started work across the collaborative to standardise and eventually digitise our local safety standards for invasive procedures (LocSSIPs) and implement a new training package

	• developed a plan to improve the digital consent process, with a view to making this the default method of taking consent across the Trust – this will continue to be implemented throughout 2025-26 • further developed plans to launch a safer surgery champion scheme which will support improvements in safety culture through peer review and multidisciplinary observational audits once fully rolled out • set up a learning and sharing network to share approaches and innovation to support NatSSIPs2 implementation. Eleven NHS trust across England are currently participating. We are still seeing incidents where failure to follow key safety checks during invasive procedures is a factor, including two never events declared in 2024-25. We still have much work to do to embed the new standards. This will continue as both a local priority, and as a workstream for the acute provider collaborative.
Improve nutrition and hydration, in particular 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 another 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, we identified some gaps in our assurance around the recommendations of this inquiry and this has been a safety priority for two years now. In 2024-25 we: • agreed funding for a new dysphagia practice educator role which is being recruited to – they will take forward plans to improve education and training for staff • finalised our dysphagia policy with plans for launch in 2025-26 • delivered focused improvement work with staff in key areas to help them identify and make decisions on management of patients with dysphagia. This includes a bespoke diet status sheet which is now in place in our emergency departments and training designed to support bank and agency staff on our stroke wards who might not be so familiar with dysphagia which will now be rolled out trust-wide • secured funding to trial a revised swallow screening tool, developed collaboratively by the speech and language therapists across the acute provider collaborative, on our trauma wards • held events and activities in response to nutritional and hydration month with 150 staff participating. We still have work to do to deliver our improvement plans, in particular changes to our electronic patient record and digital workflows, as well as education and training for staff. We will carry this forward as a priority for 2025-26.
Improve positive patient identification (PPID)	Patients should be correctly identified before any care or treatment to ensure that the right person receives their intended care. This was chosen as an improvement priority for 2024-25 as misidentification during key patient interventions such as blood sampling and administration, was an emerging theme from incidents, including a never event in February 2024 where blood products were transfused to the wrong patient.

	We initially focused on learning about the system issues that were making the PPID process challenging for our staff. We undertook a thematic analysis of incidents and held a series of focus groups with staff. We identified that our policy to support staff to positively identify patients was not as clear as it should be, and this was causing confusion and contributing to errors. Our focus was therefore to create a new policy incorporating what we had learned, as well as good practice in other NHS trusts. Over 80 stakeholders including patient representatives were engaged in the policy review, and this was published in January 2025. To ensure we could successfully translate the policy into practice, the launch of the new policy was accompanied by targeted communications to staff and patients, developed with our patient safety partners and informed by a survey of staff and patients' views. We also designed an improvement toolkit to support local areas to improve PPID for their highest risk tasks on an on-going basis, which is being tested and will be rolled out in early 2025-26. We also worked with some local areas to reduce incidents of blood gas mislabeling, doing so by 66% in critical care. We plan to step this priority down for 2025-26, with ongoing monitoring through incident data and improvements delivered locally using the new toolkit.
Improve safe transfers of care	This priority was chosen for 2024-25 as ongoing reviews of incidents highlighted a risk for patients who are being transferred between wards, other hospitals within our Trust and externally. There had been several cases where transfers have occurred unnecessarily or when the patient was not well enough. Our initial plan was to review our Trust policy and develop a new tool to help staff assess whether patients are well enough to be transferred and that a senior decision maker is involved in the process. A risk assessment tool was drafted, however we realised that to deliver meaningful change we needed to widen the scope and include our colleagues across the acute provider collaborative. This is now underway with the aim of agreeing a series of key principles on which we will base our policy. Developing and implementing this, along with the tools which will support staff to make the right clinical decision for their patient, will be the focus for this priority for 2025-26.

Improve the support and management of patients with deterioration in their mental health

What did we achieve?

During 2024-25 we continued delivery of our mental health strategy and action plan. This is monitored through a monthly mental health care improvement steering group attended by key internal and external stakeholders.

In 2024-25 we:

- continued to increase staff training levels. Since we started our improvement work in 2022, 1,567 staff have received a form of mental health training. We have now developed a mental health training framework which will include new courses in 2025-26
- launched a new training course for healthcare support workers which focuses on the provision of enhanced care for people with mental health needs, with 235 trained since May 2024. The training was positively received, with staff reporting improved confidence ratings afterwards in recognising psychological deterioration and responding to distress, identifying mental health related risks, developing therapeutic relationships, understanding mental health law and undertaking enhanced care
- developed and launched a rapid tranquilisation e-learning package for registered nurses aligned to the new trust guidelines, which are designed to ensure safe and appropriate prescribing, administration and monitoring of medications used when a patient needs to be sedated due to behavioural issues which may pose a risk to themselves or others
- reduced our reliance on using agency staffing to fill vacant mental health nursing shifts, from 40% of shifts being covered by agency to approximately 23% on average, helping to ensure greater continuity of care. This is due to our well-established mental health team, but also to work to increase the number of trained mental health staff available on the bank, with an additional 80 recruited in-year
- established a strong working relationship across the acute provider collaborative and contributed to workstreams to improve the safety of the environment and introduce new clinical assessment models for patients with mental health needs. In 2025-26 we will help shape the acute provider collaborative mental health strategy and align our key delivery objectives with these
- supported the development of a mental health workflow in the electronic patient record used across the collaborative. This will standardise documentation, ensure processes are clearer for staff and improve monitoring of key metrics so we can more easily identify areas for improvement.

We have developed a new mental health plan for 2025-2027; delivery of this will be a priority during 2025-26.

Improve end of life care with our new Trust strategy

What did we achieve?

End of life care encompasses care given to patients approaching the end of their lives, as well as care after death. End of life care may be delivered on any ward or within any service across the Trust.

In 2024-25 we:

- saw our newly appointed end of life education and transformation team become established and begin development of our strategic approach to the delivery of education and training. To date we have educated over 2,300 staff from eight different staff groups across all areas in the Trust
- completed our service user insights work, funded by Imperial Health Charity, focusing on understanding the experiences of dying in our hospitals and working directly with lived experience representatives to deliver improvements
- launched the 'Purple Butterfly Model of Care' to empower staff to provide excellent, individualised end of life care to patients and those important to them – every time. This has been implemented on eight of our adult wards and the roll out will continue over the next 12 months
- introduced the renewed National Audit for Care at the End of Life (NACEL) including the survey of the bereaved. The outcomes of this will inform future improvements

- continued to work with colleagues across north west London, identifying and collaborating on areas where we can improve care more effectively by working together. An example is digital improvements to the fast-track application process to reduce the time it takes for patients with a rapidly deteriorating condition to be discharged from hospital. This will be implemented in 2025-26.

We have just renewed our end of life strategy taking into account national and regional priorities and guidance as well as local evidence and service user insights. Delivery of this will be our focus between now and 2028.

Develop a robust plan to collect/review data to identify inequalities in all quality metrics

What did we achieve?

We have a key role to play in tackling health inequalities in partnership with other healthcare providers and community services. Our aim is to improve health, wellbeing and equity for our patients and within our local communities, in line with our vision of 'better health for life'. To achieve this, we must focus on improving disparities in health outcomes, especially between people from different ethnic and socioeconomic groups.

We recognise that some groups and communities experience variations in patient safety outcomes and can be disproportionately impacted by patient safety events. Through PSIRF implementation, we are seeking to collate and use data, including our learning responses, to identify health inequalities and make improvements where we can.

In 2024-25 we:

- improved the quality of our ethnicity data for patients who die in the Trust, reducing the percentage of deaths where ethnicity is unknown from 17% to 6%. This data shows that we have lower than expected mortality rates for all ethnic groups. With the support of the health inequalities programme team, we are working to analyse this data from a population health perspective and to understand inequalities in services. This will include additional demographic details, including age, gender, deprivation and primary language
- participated in the work underway to agree priority patient cohorts and digital tools to enable effective identification and monitoring of health inequalities across the acute provider collaborative. An action plan is being developed and the focus for 2025-26 will be on waiting lists, maternity, do not attend lists and patients with sickle cell disease.
- undertook a review of Call for concern focusing on access, needs, harm, and experience. This demonstrated that while service access was generally appropriate and inclusive, disparities remain. Our improvement plan includes initiatives to enhance communication methods and follow-up surveys to capture patient experiences more effectively
- developed an app which allows us to compare demographic data from patient safety incidents to our inpatient population. This will be used to inform future improvement work.

This will not be a standalone priority into 2025-26, instead each of our priorities will include in their project plan how they plan to collect, review and use data related in inequalities.

Ensure young people who move from children's to adults' service have a coordinated transition plan

What did we achieve?

Our transition steering group, which was re-launched in 2024 to include representation from adult services, is focusing on delivering our plans to provide a safe, effective and developmentally appropriate process for transition and transfer (handover) from children's services to adult services for all young people within acute services, and on ensuring young people and/or their carers are equipped with the required knowledge and skills to manage in adult services.

The initial focus has been on ensuring adequate systems and processes for the recording and reporting of activity, training and education and the development of clear policy and guidelines.

In 2024-25 we:

- agreed the adolescent and young adult healthcare transition policy which is now in place across all services
- identified key information available for young people and their families to support the transition process for example, a transition leaflet and 'Own It' information posters
- implemented an admission process for children and young people aged 13 to 17 to clarify decision making for admission to paediatric and adult wards
- agreed a checklist for young adults (aged 18-25) and under 18-year-old admissions to adult wards. The checklist provides guidance around wider issues that impact on young people and young adults (e.g. psychosocial issues) and where to seek specific advice if needed (including seeking paediatric specific professional opinions if required). We are currently piloting this with adult critical care and will work towards embedding this in practice in all adult wards
- developed a service level audit tool for paediatric services to assess themselves against basic standards outlined in key national transition documentation. This is currently being tested and will then be used for a paediatric wide audit. This will define the key performance indicators for this workstream
- worked with the diabetes and asthma specialities as pilot pathways for development and trial of a framework and toolbox for supporting transitions
- established a workshop to finalise core topics for an education module suitable for all clinical staff.

We will continue to build on the progress made so far in 2025-26, with this remaining a quality priority.

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 2024-25. 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 2024-25, the Trust provided and/or sub-contracted 112 NHS 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 2024-25 represents 95% of the total income generated from the provision of Trust services in 2024-25. The income generated by patient care associated with these services in 2024-25 represents 86% of the total income generated from the provision of services by the Trust for 2024-25.

We have good structures in place to provide routine and ongoing monitoring and assurance for quality within the Trust via our executive management board for quality, supported by a range of mechanisms at corporate, divisional, directorate and service level.

When we identify concerns about quality of care which cannot be resolved through our usual governance channels, we arrange a series of quality review meetings. These meetings provide a way for the relevant teams to come together collectively to share and review information, identify actions and provide support.

During 2024-25 we concluded quality review meetings for the following services:

- Cardiac – concerns about timely identification and reporting of incidents, and oversight of outcomes data, with a small increase in incidents causing harm. Improvements were made to the multidisciplinary team meetings (MDTs) and the morbidity and mortality (M&M) review meetings where cases are discussed and learning and actions agreed. There has been an increase in incident reporting which is positive, improvements made to the chest pain pathway and harm levels have reduced.
- Infection prevention and control (IPC) – concerns around performance with key metrics. This supported the development of data-driven IPC improvement plans across the divisions, resulting in improvements in hand hygiene, screening for key infections and IPC training compliance in key areas.
- Emergency departments – concerns regarding escalation of risk and review of clinical harm associated with capacity issues. Staffing has been reviewed with plans underway to add additional nursing staff and registered mental health nurses. A new dashboard is now reporting weekly to our executive including measures for overoccupancy and length of stay, incident numbers and harm, and patient experience. We have seen a recent reduction in incidents causing harm and improvements in 'friends and family test' results despite our departments remaining very busy.

We have two quality review meetings still underway:

- Neurotrauma – concerns regarding governance processes and pathway issues highlighted by incident investigations. An action plan is focusing on clarifying roles and responsibilities within the team.

- Neurosurgery – multiple, complex issues affecting quality, education and operational aspects. These include managing and mitigating a high number of long waiting patients for elective care, with an associated increase in complaints about appointments and long waits, an increase in surgical site infections in the cranial service, issues with consultant engagement and poor feedback from resident doctors about their training, which resulted in the specialty being placed under enhanced monitoring by the General Medical Council. In March 2025, we temporarily paused the neuro-oncology service following an invited review by the Royal College of Surgeons in response to concerns raised internally. An improvement plan and external expert support are in place with regular meetings with the medical director to oversee progress.

A full review of the neurosurgery specialty has been undertaken, with new governance and leadership posts put in place and a business case developed to address staffing and rota issues. Improvements have been made in response to the resident doctor feedback, including changes to clinic templates, theatre allocation and office space. This quality review meeting process will continue for the foreseeable future while we work to resolve these complicated issues.

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 2024-25, 71 national clinical audits covered relevant health services that we provide. During this period, we participated in 93% of national clinical audits and 100% of national confidential enquiries.

The national clinical audits and national confidential enquiries that the Trust was 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 these will be accurate up to February 2025 when host organisations were contacted, but some data collection was still ongoing.

National clinical audit

The Trust reviewed the reports of 55 national clinical audits and confidential enquires in 2024-25. 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.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) 2022 Perinatal Mortality Report

The report covered perinatal deaths from 22 weeks gestational age (including late fetal losses, stillbirths, and neonatal deaths) of babies born between 1 January and 31 December 2022. The audit showed that our stabilised and adjusted mortality rates were lower than those seen across comparable trusts and health boards in the comparator group with a Level 3 neonatal intensive care unit. All cases are investigated using the perinatal mortality review tool, with insights feeding into our improvement plans.

Our maternity and neonatal services focus on a number of national and local schemes to improve patient safety, quality and experience, including the clinical negligence scheme for trusts (CNST) maternity incentive scheme (year six) which we reported full compliance with in February 2024, the national three-year delivery plan, and implementation of the Saving Babies' Lives care bundle (version three). Following review of incidents and complaints three local priority improvement projects have been identified for 2025-26, these include the induction of labour pathway, the maternity day assessment unit/triage pathway, and access to interpreting services.

We continue to see increasing pressure and activity in our maternity services due to the high demand for our CQC-rated 'outstanding' maternity services. While our staff are working hard to keep patients safe, and we have not had a deterioration in our key safety metrics, the insights from users (including patients and staff) are showing the impact this is having. In response, we implemented a demand management plan and additional resource is in place to support the teams.

National Audit of Inpatient Falls (NAIF) Annual Report 2024

NAIF is a clinically led, web-based audit of inpatient falls prevention care and post fall management in acute, mental health, community and specialist trusts in England and Wales. NAIF aims to improve inpatient falls prevention and post fall care through audit and quality improvement.

We saw some really positive improvements in our performance, including:

- The percentage of patients who had their lying and standing blood pressure taken increased from 18.2% in December 2023 to 41.5% in December 2024.
- Cases where patients were checked for injury before being moved improved from 15% in 2023 to 71% in 2024.
- Cases that received a medical assessment within 30 minutes of a fall improved from 77% in 2023 to 86% in 2024, against a national average of 65%.

From 1 January 2025, NAIF has expanded to collect information from patients over the age of 60 who sustained any fracture, spinal or head injury because of an inpatient fall. We are working to ensure we can accurately capture all relevant patients for the expanded audit.

The Sentinel Stroke National Audit Programme (SSNAP): Together with a therapy spotlight report

A state of the nation report from 2024 found that nationally there has been a continued increase in stroke onset to hospital arrival time. We are working collaboratively with the regional Hyper acute stroke units (HASUs) and London Ambulance Service to improve the speed of pre-hospital transfer to our HASU at Charing Cross Hospital. This includes joining the north central London pre-hospital video triage improvement programme which is helping ensure patients are transferred to the right place to receive the right care.

In 2024, we performed a total of 287 thrombectomy procedures, an increase year-on-year, and we have broadened our treatment criteria for mechanical thrombectomy according to national and international clinical guidelines. We have focused improvement efforts on ensuring patients who do need to go to HASU are transferred within four hours of arrival at A&E, with action plans including training and education, and working closely with A&E to improve the transfer process with the help of the thrombolysis nurse.

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. Some examples are included in the table below.

Audit title	Audit findings
Management of oropharyngeal dysphagia in inpatients with Parkinson's disease	This audit reviewed the quality of dysphagia care provided to patients with Parkinson's disease who were admitted to hospital when acutely unwell and assessed the Trust's compliance with national guidelines set out in the NCEPOD 'Hard to Swallow' report from 2021. We found that all patients who were identified as dysphagic during their admission screening were referred to speech and language therapy. The audit did identify some areas for improvement, including the screening of patients for dysphagia at admission, nutrition screening and discharge documentation. The audit results have been used to help shape our improvement priority plan for 2025-26.
Deteriorating patients audit	This audit was undertaken to establish a baseline audit of our response to deterioration to support our on-going improvement plans. It identified issues around timeliness and accuracy of documentation. While all cases had their NEWS 2 score and time of deterioration recorded in Cerner, only 48% of cases had all the required documentation completed and therefore met all of the audit standards. The audit results are being used to help develop our plans to implement our new deteriorating patient guideline.
Consultant ward round audit – Grand Union ward and Great Western ward	A retrospective audit was carried out on patients admitted to Great Western and Grand Union wards in September 2024. The audit focused on the proportion of daily ward rounds with documented evidence that a consultant was present to assess the level of care received by patients. Combined audit results for both wards demonstrate a reasonable assurance at 82%. In some cases, consultants were present on the ward round, but this is not explicitly documented in the notes. Also, a lack of capacity has been identified for all necessary patients on the general paediatric ward round to be seen by a consultant in busier periods. Additional general paediatric consultant provision was extended from 24 weeks to 30 weeks per year to meet increased demand outside of the normal busy winter period.
Audit of recording food and /or drug allergies on Cerner electronic patient records	This audit was conducted in response to a serious incident. Findings show that food allergies are not routinely recorded in the correct place in the electronic patient record. This poses a patient safety risk and may lead to unintended exposure to food allergens and anaphylaxis in hospitalised patients. As a result, actions are underway to update Cerner to include allergen codes to ensure all common allergens are captured and make this easily searchable and embed allergy coding in teaching / induction to raise awareness.

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 2024-25 there were 266 local audits registered. Local audit reports, including any action plans, are reviewed through local audit and risk governance meetings and logged centrally.

Our participation in clinical research

In collaboration with Imperial College London, 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.

Much of our innovative research is enabled through significant infrastructure funding, awarded through open competition by the National Institute of Health and Care 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 Healthtech Research Centre (HRC). The NIHR Imperial HRC has recently been awarded funding (£3m) for a further five years from 2024 onwards. We were also awarded £4.5m of capital funding for NIHR to provide essential equipment to support our early-phase clinical research.

NIHR infrastructure support, our partnership with Imperial College, and many other industry, charity and government partners, 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.

The NIHR Imperial BRC, the largest in the country, 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: the discovery of a rare genetic variant which can cause severe inflammatory conditions in some children following COVID-19 infection; a study demonstrating that the risk of rejection in kidney transplant patients can be reduced by more specific matching of blood transfusions; and the first patients treated with a new experimental mRNA cancer vaccine in partnership with industry.

We continue to invest in the analysis of large, interlinked datasets and to develop new artificial intelligence (AI) tools to assist in clinical decision-making, including using echocardiogram (ECG) data to predict cardiovascular risks later in life, examining brain scans to pinpoint exactly when strokes happened (which then informs the appropriate patient treatment) and the deployment of AI-enabled smart stethoscopes to 100 primary care practices to assist clinicians in their evaluation of heart failure.

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. The last year saw the launch of the Imperial Health Knowledge Bank, a secure biomedical repository of data and blood samples from Imperial College Healthcare patients which can be used in future research studies. Over 40,000 patients have already consented to participation in this project.

We continue to work in close partnership with Imperial Health Charity to complement the research we undertake, particularly 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 2024-25 that were recruited to participate in research approved by a research ethics committee was 39,100. These patients were recruited into 410 studies in 2024-25 – this includes 574 patients recruited into 118 studies sponsored by commercial clinical research and development organisations.

Statements from the Care Quality Commission (CQC)

We are required to register with the CQC for all of our sites. We were compliant with the requirements of our CQC registration during 2024-25 and our current registration status is 'registered without conditions'.

We were not subject to any inspections in 2024-25. We were not subject to any enforcement action this year. Our overall CQC rating remains 'requires improvement.'

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 2024-25 to the Commissioning Data Sets (CDS) Dashboard (formerly the secondary uses service) for inclusion in the hospital episode statistics. The percentage of records in the published data (current to February 2025), which included the patient's valid NHS number, was:

1. 98.2% for admitted patient care
2. 99.4% for outpatient care
3. 94.8% for accident and emergency care.

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

1. 100% for admitted patient care
2. 100% for outpatient care
3. 100% 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.

For the 2023-24 submission, we met all the mandatory standards of the toolkit and therefore produced a 'satisfactory' return.

The outcome of the 2024-25 submission will be confirmed in June 2025 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 2024-25.

Data quality

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

We perform consistently well compared to other NHS trusts on the overall Data Quality Maturity Index (DQMI). The DQMI, published by NHS England, is a national measure of data quality that monitors coverage, consistency, completeness, and validity across several datasets. We have continued to meet this benchmark.

However, broader operational challenges in recent years have impacted the quality of waiting list data, which can impact delivery of care. We actively manage this risk and prioritise improvement through our waiting list data quality and reporting framework. In 2024-25, we designed processes with staff to improve data quality and reduce errors and implemented models of care dashboards to aid staff in managing waiting lists in Cerner. We conducted several waiting list audits throughout the year to identify root causes of data inconsistencies and used these results to inform education and training sessions.

Learning from deaths

We fully adhere to the national *Learning from Deaths* process, with a policy that outlines our standards and measures. Compliance is regularly reported internally to our quality committee and subsequently to the acute provider collaborative board-in-common.

All patient deaths within the Trust are reviewed by the medical examiner. This process includes an examination of clinical notes and, crucially, a discussion with the bereaved for all deaths occurring in our hospitals. Through this approach, we ensure that a) the proposed cause of death is accurate, b) referrals to the coroner are appropriate and consistent, c) the bereaved understand the cause of death and have the opportunity to raise any concerns, and d) cases meeting the criteria are referred for a structured judgement review (SJR).

Structured judgement review is a validated methodology in which trained clinicians systematically assess medical records, evaluating and scoring different phases of care throughout the patient's journey. This process helps identify any potential issues with the care provided. Cases undergo further review, and if concerns are identified, they may be subject to a more in-depth investigation through our incident management processes to highlight areas for learning and improvement. In addition, a regular death review panel examines complex cases or those where care concerns have been raised, bringing together all associated investigations for a comprehensive review.

Patient deaths: 1 April 2024 to 31 March 2025

	Q1	Q2	Q3	Q4	Total
Number of patients who died – based on date of death	432	379	512	518	1,841
Number of deaths referred for SJR – based on date of death	52	48	46	58	203

Deaths which occurred in 2024/25

Of the 1,841 deaths which occurred in 2024-25, all deaths were subject to medical examiner review, and 206 were referred for structured judgement review. Of the 196 deaths which have had these reviews completed, there were 13 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; these are included in our quality and safety improvement priorities. We also completed SJRs in 2024-25 for 8 deaths which occurred in 2023-24, 1 of which identified issues in the overall care delivered.

Of the 13 cases which occurred in 2024-25, the death review panel has reviewed three so far and concluded poor care did not contribute to the deaths. During 2024-25, the panel also reviewed four deaths that occurred in 2023-24, confirming poor care in one of them. The panel concluded that the poor care did contribute 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.

There were 78 perinatal mortality reviews reported to MBRRACE-UK in 2024-25 for babies who died in the year, of which 51 reviews were completed. Ten had care or service delivery issues identified that may have changed the outcome.

Learning from these cases has led to a number of changes to improve care, including improvements to our bereavement care and facilities, the opportunity to speak with the medical examiner regarding the cause of death, and ongoing work to improve access to interpreters, which has been identified as a key priority for our maternity services in 2025-26.

The outcomes of these reviews are shared with clinical teams for evaluation and action planning during their specialty mortality and morbidity meetings. Work continues to further improve the consistency and documentation of these meetings so that we can more effectively capture their outputs and use them to identify further learning.

On 9 September 2024, new statutory reforms to the death certification process were implemented in England and Wales, which included the requirement for all deaths not referred to a coroner to be reviewed by the medical examiner, not just those which occur in the hospital setting. Ahead of this, we had already expanded the deaths reviewed by our medical examiner service to include those which occurred in the community within the London Borough of Hammersmith & Fulham and the City of Westminster. Throughout the last year we have been working to engage with our community partners to ensure we can effectively embed the new ways of working across the system, which has resulted in a 40% increase in the number of deaths referred to us for review.

We also continue to improve our internal processes to make the service more effective for bereaved families. This includes introduction of a seven-day medical examiner service with a weekend on call rota to ensure urgent scrutiny for deaths for those whose faith means burial should happen within 24 hours for both in-hospital and community referrals.

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. Our compliance with the four key standards is:

- **standard two – early consultant review:** partial compliance
- **standard five – access to diagnostic services:** full compliance
- **standard six – access to interventions:** full compliance
- **standard eight – ongoing review:** partial compliance.

While we have access to diagnostic services 24/7 if necessary, feedback from staff and evidence from incidents has shown that the pathways are not as clear as they could be. We are now developing a guide setting out clearly what investigations are available, and how and when to access these. This will involve a review of cardiology provision, including access to echocardiography.

Although our policies and procedures fully support delivery of standards two and eight, and this is the expected standard of care here in the Trust, our audit and incident data demonstrate that we do not consistently achieve this across all areas. In 2024 we reviewed the arrangements for each specialty and confirmed that there are mitigations in place where the standards are not always able to be met. There are plans to review service provision in key areas to increase consultant presence where possible. We also carried out a review of quality insights in these areas which showed that patient safety was being maintained.

Rota gaps

We have 828 resident doctors working at the Trust, with 43 gaps on the rota. Thirty-seven of these gaps have been filled by locally employed doctors. We have six unfilled posts, two 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 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, Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI), which enable us to compare ourselves with our peers. 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 deprivation and whether the patient has been transferred between providers. The methodology for HSMR changed nationally in December 2024, which resulted in the removal of the adjustment for palliative care coding and changes in the diagnostic groupings which make up the ratio. We believe using both measures gives us the best picture of our mortality rate across our hospitals:

SHMI

National performance 24/25*				Trust performance*				
	Mean	Lowest	Highest	2024-25	2023-24	2022-23	2021-22	2020-21
SHMI	100	70.16	128.49	70.16	73.32	76.25	72.73	77.02
Banding**	2	3	1	3	3	3	3	3
% deaths with palliative care coding	44.00%	17.00%	66.00%	65.00%	64.00%	64.00%	61.00%	56.00%

*National and Trust position currently rolling 12 months from December 2023 to November 2024
**SHMI Banding 3 = mortality rate is lower than expected
Source: NHS Digital/Telstra Health

HSMR

Trust performance*					
	2024-25*	2023-24	2022-23	2021-22	2020-21
HSMR	76	70.1	77.8	68.03	75.9
National performance	5th lowest HSMR of all acute non-specialist providers	5th lowest HSMR of all acute non-specialist providers	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

*National and Trust position currently rolling 12 months from January 2024 to December 2024
Source: Telstra Health

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

- our mortality rates remain consistently lower than expected and amongst the lowest of all acute non-specialist providers in England (lowest SHMI, fifth lowest HSMR)
- our palliative care coding rates are high, and we are confident that they are accurate with a clinical coding review process in place.

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.

Patient reported outcome measures (PROMs)

Patient reported outcome measures assess 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. Analysis of any differences between the first and second questionnaires is used to calculate the overall health gain.

The below 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 2023-24*				Trust performance			
	Mean	Best	Worst	2023-24*	2022-23	2021-22	2020-21
Hip replacement surgery (EQ-5D)	0.453	0.708	0.105	0.678	0.515	0.666	0.535
Knee replacement surgery (EQ-5D)	0.323	0.679	-0.126	0.359	0.313	0.523	0.316

Source: NHS Digital
*2023-24 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
- we are performing above the mean for both hip and knee replacement surgery.

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

- continuing to monitor performance monthly and introduce improvements where necessary.

28-day readmissions

	National mean*	2024-25	2023-24	2022-23	2021-22
28-day readmission rate (Patients aged 0-15)	10.29%	5.54%	5.65%	5.30%	5.35%
28-day readmission rate (Patients aged 16+)	8.12%	6.18%	6.35%	6.01%	6.32%

*Most recently available data covers the period of October 2023 to September 2024

We believe our performance reflects that:

- 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:

- ensuring we treat and discharge patients appropriately so that they do not require unplanned readmission
- working to tackle long-standing pressures around demand, capacity, and patient flow.

Staff recommendation to friends and family

The extent to which our staff would be happy with the standard of care provided by the Trust if a friend or relative needed treatment is measured by the national staff survey and is another way to measure the standard of care we provide. We are above the acute trust average for this question, and also 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 (82.98% of respondents in 2024, compared to 79.81% in 2021).

National performance				Trust performance			
	Mean	Best	Worst	2024	2023	2022	2021
Percentage of staff who would recommend the trust to family and friends needing care	61.54%	89.59%	39.72%	74.53%	74.23%	73.31%	74.22%

Another key measure in the NHS Staff Survey is the overall measure of engagement and morale. Overall engagement measures motivation, involvement and advocacy. In 2024, our overall score for engagement was 7.11, increased from 7.08 last year and above the average for acute trusts in 2024 (6.84). The same trend is seen in the overall score for morale (6.08), where we are above the average for acute trusts (5.93) and have improved since 2021.

This is our fourth consecutive year of improvement, with our results topping last year's best ever scores and bucking the trend nationally on many questions. These results show that we are making progress in a number of areas, despite incredibly challenging demands on our staff. This includes increased scores for all questions at Trust level about team working, line management and compassionate leadership that show the impact of our 'improvement through people management programme'.

We have also seen improvement in equality, diversity and inclusion; retention; we are safe and healthy; and we are always learning. These map to the areas where we have implemented a range of improvement programmes.

However, we remain below the national average for flexible working. This will remain a priority in 2024-25, although we have improved in this area from 5.88 in 2021 to 6.21 in 2024.

We will continue to use these survey results to identify areas for improvement at Trust, divisional, directorate, and department level, and to incorporate these findings into our 2025-26 people priorities.

Patient feedback and experience

We continue to strive to become a more user focused organisation – to better understand, measure, and improve our responsiveness to the needs, views, and preferences of our diverse patient population.

Since 2015, we've used the national friends and family test (FFT) question as a tool to collect patient feedback across all our clinical areas, including A&E, children's and young people, inpatients, maternity, outpatients, and patient transport. Since 2020 the question has asked: '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 2024-25 A&E and inpatient services below. The rating is based on the percentage of people who describe the service as very good or good.

Additionally, we take part in the NHS patient survey programme that is coordinated by the 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 results are used to inform our improvement plans.

A&E friends and family test

National performance*				Trust performance			
	Mean	Best	Worst	2024-25	2023-24	2022-23	2021-22
Score	79%	89%	72%	83%	84%	82%	84%

*National data current to January 2025 only

The average participation rate in 2024-25 was 6.15%. This is slightly lower than 2023-24 which was 6.7%.

We believe our performance reflects that:

- at a time of competing demands and extended winter pressures we have tried to maintain a high standard of care. This is reflected in our continued positive results, which are above national average.

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

- improving our approach to violence and aggression across all of our hospitals to ensure the safety of our patients and staff. Some staff now wear small body cameras, which help to deter aggressive behaviour. We are also expanding our staff training and resources to help avoid and 'de-escalate' conflict
- refurbishing the urgent treatment centre at St Mary's Hospital to improve the facilities and environment for our patients
- refurbishing our cafe and restaurant facilities at St Mary's Hospital to improve the experiences of all patients, including those who are using our urgent and emergency services.

Inpatient friends and family test and responsiveness to inpatients' personal needs

Friends and family test

National performance*				Trust performance			
	Mean	Best	Worst	2024-25	2023-24	2022-23	2021-22
Score	95%	97%	92%	96%	96%	96%	95%

*National data current to January 2025 only

The average participation rate over the past year has been 35.30%, which is consistent with last year's rate.

Responsiveness to inpatient's personal needs

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.

National performance 2023-24*				Trust performance			
	Mean	Best	Worst	2023-24*	2022-23	2021-22	2020-21
Score	72	87	63	73	72	73	70.8

*The most recent data is from the national survey which was published in August 2024 for data from 2023

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 these scores:

- continuing to work to be more user-focused. This includes our user insight and improvement programme for wards, which helps us to more effectively collect and utilise patient feedback.

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.

National performance*				Trust performance			
	Mean	Best	Worst	2024-25	2023-24	2022-23	2021-22
Percentage of patients risk assessed for VTE	90.57%	N/A	N/A	97.38%	97.10%	96.50%	96.40%

Source: Trust data
*National figures reflect performance in quarter three of 2024-25 (latest available)

Our performance reflects that:

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

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

- working with the areas that are below target to support staff to complete the assessment.

Clostridium difficile

National performance*				Trust performance				
	Mean	Best	Worst	2024-25	2023-24	2022-23	2021-22	2020-21
Rate of Clostridium difficile per 100,000 bed days	32.6	0	92.3	23.5	24.1	27.7	25.3	16.5
Number of cases	-	-	-	83	85	90	71	59

*National performance figures are based on UK Health Security Agency (UKHSA) epidemiological data for the period April 2024 through March 2025

Our performance reflects that:

- we reported 83 cases of *C.difficile* attributed to the Trust. This is just above the threshold allocated to us by NHS England of 81 cases for financial year 2024-25. Our rate is below the national mean. We had no lapses in care in 2024-25 and none in the previous two financial years.

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

- reducing the use of anti-infectives (antibiotics) and improving our hand hygiene rates to reduce the incidence and transmission of infection
- continuing to analyse cases through multi-disciplinary team meetings and *C.difficile* monthly meetings
- monitoring the impact of our recently re-written and improved *C.difficile* policy
- continuing to work with the acute provider collaborative to address *C.difficile* 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	2024-25	2023-24	2022-23	2021-22
Patient safety incident reporting rate per 1,000 bed days	53.9	205.5	23.7	64.8	63.5	57.1	56.6

*National performance data is as of 2021-22 (latest published by the National Reporting and Learning System)

We believe our performance reflects that:

- our incident reporting rates have been improving year-on-year and are now consistently above national average which is a positive reflection of our safety culture and the willingness of our teams to raise issues
- where issues are identified, incident reporting is encouraged to inform improvement planning.

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

- continuing to highlight the importance of reporting incidents and ensure we feedback to our staff, and patients, the improvements we have made as a result of the incidents they report
- making it even easier for our staff to report incidents through procurement of a new incident reporting system with the other trusts in the acute provider collaborative, which will be implemented in 2025.

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. Those graded at moderate harm and above, and those which represent a significant learning opportunity, or which are set out in our Patient Safety Incident Response Plan (PSIRP) as needing further investigation, are reviewed at a weekly meeting chaired by one of our hospital medical directors. This allows us to identify any emerging safety risks and opportunities for learning and improvement as soon as the incident is reported. At this meeting, we also agree what type of learning response is needed to ensure we can fully understand the reasons the incident occurred, identify themes, learning and actions to improve and provide answers to any questions the patient or their family may have.

National performance*				Trust performance			
	Mean	Best	Worst	2024-25	2023-24	2022-23	2021-22
Percentage of severe/ major harm incidents	0.26%	0.02%	1.06%	0.10%	0.09%	0.13%	0.10%
(Number of incidents)				*24*	*21*	*26*	*19*
Percentage of extreme harm/ death incidents	0.14%	0.00%	0.90%	0.08%	0.05%	0.05%	0.03%
(Number of incidents)				*20*	*12*	*10*	*6*

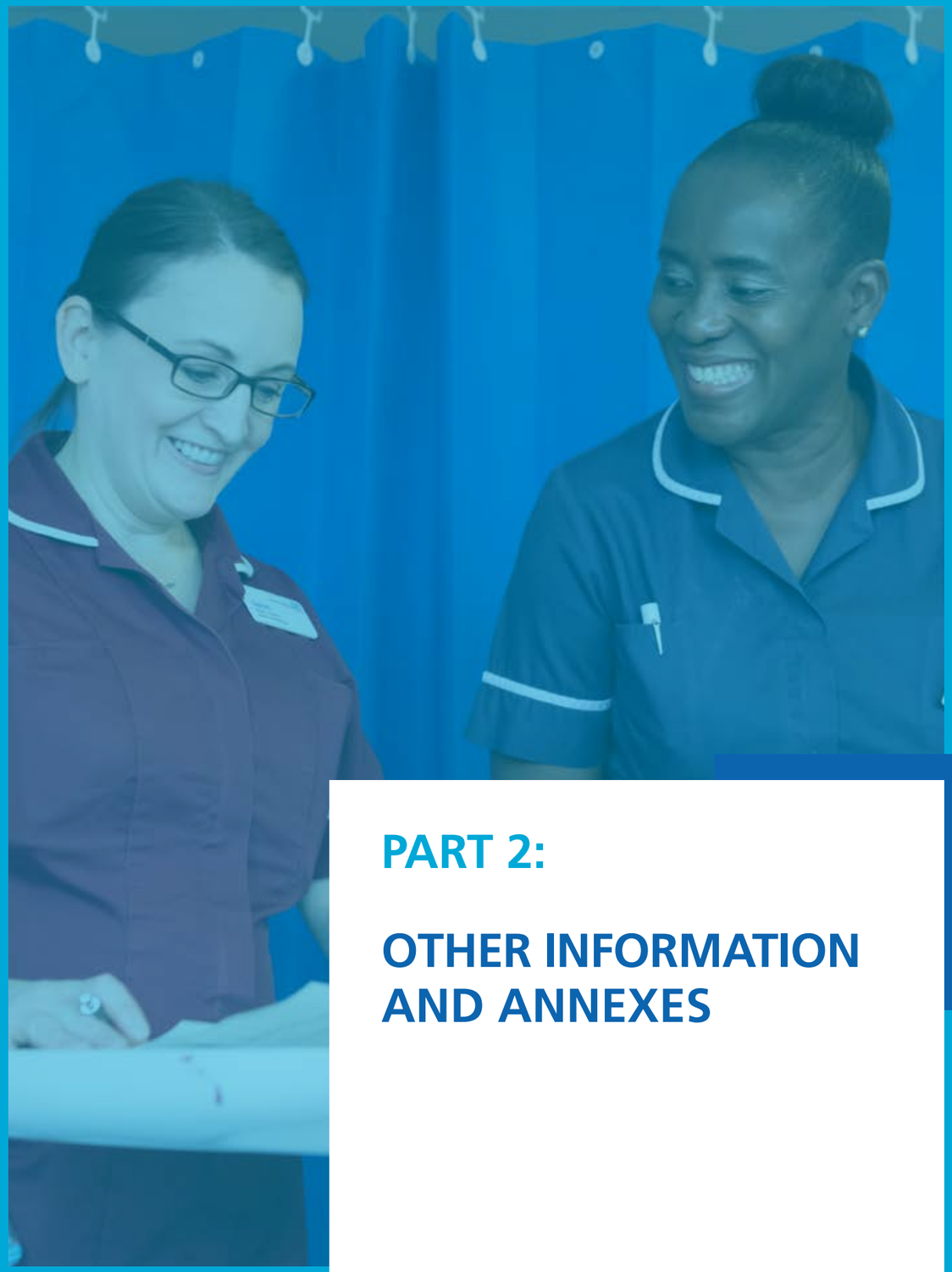
*National performance data is as of 2021-22 (latest published by the National Reporting and Learning System)

We believe our performance reflects that:

- between April 2024 and March 2025, we reported 0.10% severe/major harm incidents (24 incidents) and 0.08% extreme harm/death incidents (20 incidents). Twenty-three of these remain under investigation so the final harm level may change
- our percentages of incidents causing harm remain below national average (compared to most recently available national data).

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 2025-26 Improvement Priorities' section for more detail
- working to embed PSIRF and continually improve how we investigate and learn from patient safety incidents.



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 and regulatory requirements.

Our performance with NHS Improvement Single Oversight Framework indicators

NHS Improvement 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 through our performance scorecards and to the board-in-common via the acute provider collaborative operational performance dashboard.

Key performance indicators

Performance against the operational standards continues to be impacted by the length of our waiting lists. Patients are being tracked and managed according to clinical priority and a harm review process in place.

		Performance		Quarterly trend			
		Target	Annual	Q1	Q2	Q3	Q4
Emergency care waits	% patients waiting over four hours in urgent and emergency care	76%	76.7%*	76.7%	78.2%	76.4%	75.1%
Referral to treatment times	% incomplete pathways less than 18 weeks (in aggregate)	92%	58.04%	57.4%	57.9%	58.3%	58.8%
Diagnostics	Maximum six week wait for diagnostic procedures	1%	14.3%	14.7%	18.1%	13.8%	10.2%
28 day general faster diagnosis standard	A diagnosis or ruling out of cancer within 28 days of referral	75%	82.5%	81.8%	82.3%	82.5%	83.3%
31 day general treatment standard	Commence treatment within 31 days of a decision to treat	96%	95.8%	92.2%	96.8%	97.5%	96.8%
62 day general treatment standard	Commence treatment within 62 days of being referred	70%	71.9%	73.0%	72.5%	69.5%	72.6%
Infection control	C. difficile acquisitions	81	83	22	31	19	11

Annex 1: Statements from the Integrated Care Board, local Healthwatch organisations and overview and scrutiny committees

NHS North West London Integrated Care Board (ICB)

NHS North West London Integrated Care Board (NWL ICB) has welcomed the opportunity to respond to the ICHT Quality Account for 2024/25 which we received on 8th May 2025.

The ICB notes the Quality Account 2024/25 focusing on quality improvement priorities, patient safety, and assurance statements from the board. We acknowledge that in this year's report, the Trust describes the launch of the 'Improvement for All' programme which has integrated an improvement plan for each area of focus. Compared to 2023/24, there is a significant increase in staff training participation in improvement methods, rising to 17% of staff, compared to 13% in 2023-24 and 9% in 2022-23.

The Trust has extended infection prevention, patient transfers and dysphagia management priorities which the ICB supports and we note the new areas of focus for 2025/26 which include;

- Endorsement and management of diagnostic results (addressing delays in consultant review).
- Medication safety during discharge & time-critical medications (reducing administration delays).
- Pain management in inpatients (building on a 37% reduction in moderate/severe pain cases in 2024).
- Patient fasting times before procedures (trailing 'SipTilSend' to reduce discomfort).

The ICB has enjoyed working with the Trust during its implementation of the Patient Safety Incident Response Framework and we endorse the open culture the Trust has in sharing patient safety events and investigation findings with the ICB. We are supportive of the procurement of a new incident reporting system which will be across the four acute providers within North West London, this will support the identification of cross provider areas of learning.

The ICB has worked with the Trust to understand the challenges seen in neurosurgery with the temporary pause of the neuro-oncology service. We accept the immediate actions taken by the Trust and will work with you as you continue to review the service.

We note the rising demand for mental health support in acute hospital settings and acknowledge the challenges in managing mental health presentations, particularly due to staffing constraints and unsuitable environments for some patients. The Trust has set out key improvements and actions during 2024-25 which include; staff training expansion and reducing agency mental health nurses by expanding your bank workforce.

You have also developed mental health workflows in electronic patient records, standardised documentation and improved monitoring of key patient outcomes. The ICB acknowledges the work to date and the creation of your new Mental Health Plan for 2025 to 2027 which will expand on staff training, implementing standard risk assessments for mental health patients and refining the acute provider collaborative mental health strategy.

The ICB are in support of the Trust's End-of-life care strategy (2025-2028) which aims for better training compliance and bereavement service enhancements, using the insights from your new user-led experience evaluation. We note the work the Trust has done to improve data collection in terms of recording the ethnicity of the deceased and that you've seen a reduction of cases classified as 'unknown' from 17% to 6%. We also acknowledge the expansion of the medical examiner review of cases beyond the deaths that occurred within the Trust to community deaths from two boroughs. We welcome this expansion and would like to work together to understand the learning from the death reviews to share with the wider system.

Overall, the ICB acknowledges your Quality Account for 2024/25 noting it builds upon previous years but demonstrates deeper data integration, cross-organisational collaboration, and expanded patient safety measures, particularly incident learning frameworks and improved governance transparency.

The ICB is satisfied that the overall content of the quality account meets the required mandated elements.

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 2025/26 and looks forward to working closely with the Trust 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 the Trust for its continued focus on quality.

Healthwatch Hammersmith and Fulham

Healthwatch Hammersmith and Fulham welcomes the opportunity to comment on the Imperial College Healthcare NHS Trust's 2024/25 Quality Account. We value our ongoing relationship with the Trust and appreciate its continued commitment to involving Healthwatch, patients, and local communities in shaping quality improvement across services.

Over the past year, we have seen how staff across the Trust have worked hard to provide compassionate, high-quality care, even while facing significant pressures and rising demand. Their dedication is reflected in the feedback we receive from patients and carers, and we recognise and commend their ongoing efforts.

Informed by our local engagement and patient experience data, we are pleased to see progress in the following areas of the Trust's improvement priorities for 2024/25:

- **Improving inclusion in clinical research**: We welcome the Trust's work to broaden access to research for underrepresented communities. Better collection of demographic data is a positive step towards more inclusive and representative studies that reflect the Trust's diverse patient population.
- **Listening to patient voices:** The Trust gathered over 10,000 responses through the Friends and Family Test, with positive themes mirroring our own findings. Our data shows a strong level of satisfaction with treatment and staff interactions, averaging 4.5 out of 5 stars.
- **Strengthening Equality, Diversity and Inclusion (EDI):** We are encouraged by the continued investment in EDI initiatives, including the Calibre Leadership Programme and the increased representation of BAME staff in senior roles. The visible presence of BAME ambassadors is helping to create more culturally sensitive environments for both staff and patients.
- **Maintaining safety standards**: Patients continue to tell us that hygiene practices and infection control measures are consistently strong across the Trust. Feedback highlights this as a clear area of confidence and reassurance.

Between April 2024 and March 2025, Healthwatch Hammersmith and Fulham gathered 1,522 pieces of patient feedback, with 83% of comments rated positive, 11% neutral, and 6% negative. Patients spoke highly of the quality of care and the professionalism of staff, with an average overall rating of 4.1 out of 5. However, we continue to hear concerns about long waiting times and challenges accessing appointments, issues that are consistently raised across our borough. In our feedback, 49% of comments related to waiting times were negative, as were 48% about appointment availability. These concerns reflect wider system pressures, and we support efforts to address them as part of the Trust's forward-looking quality priorities.

We are pleased to see the Trust's proposed 2025/26 priorities reflect some of these key themes, particularly around improving communication, reducing delays, and strengthening access. We encourage the Trust to continue working closely with us to improve independent feedback mechanisms, including expanding our community visits and patient engagement workstreams, to ensure that local voices continue to influence service design and delivery.

From our 2024/25 Enter and View visits to Charing Cross and Hammersmith Hospitals, we have identified several practical steps that could support ongoing improvements:

- Signage and accessibility: Clearer, larger signage and reliable accessibility features (such as working escalators and better visibility of blue badge parking information) would significantly improve the patient experience on site.
- Appointment communication: Patients would benefit from streamlined admin systems, more timely appointment letters, and better promotion of digital communication options.
- Waiting environment: We recommend introducing digital queuing systems that provide real-time updates to reduce uncertainty and anxiety in waiting areas.
- Supporting staff wellbeing: Staff are key to sustaining high-quality care. We suggest building on existing wellbeing offers through increased access to counselling, peer support, and regular opportunities for open dialogue via staff forums.

We are grateful for the continued partnership with Imperial College Healthcare NHS Trust and look forward to working together in 2025/26 to support meaningful, inclusive improvements in patient care across Hammersmith and Fulham.

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 Improvement 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 2024 to May 2025
  2. papers relating to quality reported to the board over the period April 2024 to May 2025
  3. feedback from the integrated care board
  4. the annual governance statement May 2025
  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 2024
  8. the head of internal audit's annual opinion of the trust's control environment May 2025
  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 quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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 quality committee held in May 2025 and also at our audit, risk and governance committee held in June 2025, 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, Chair
27 June 2025

Professor Tim Orchard, Chief executive
27 June 2025

Annex 3: Participation in national clinical audits and confidential enquiries 2024-25

Details of the eligible audits applicable to Imperial College Healthcare NHS Trust and compliance of the mandatory audit programme during 2024-25 are listed in the table below:

National clinical audits 2024-25

Name of project	Host organisation	Did we participate?	Stage / submission details
BAUS DATA & AUDIT PROGRAMME The British Association of Urological Surgeons (BAUS)			
BAUS Penile Fracture Audit	The British Association of Urological Surgeons (BAUS)	Yes	Ongoing
BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	The British Association of Urological Surgeons (BAUS)	Yes	CXH – 30 cases
Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	The British Association of Urological Surgeons (BAUS)	Yes	100%
Breast and Cosmetic Implant Registry	NHS England (formerly NHS Digital)	Yes	Ongoing
British Hernia Society Registry	British Hernia Society	No	Ongoing, there is a plan to submit data to the registry
Case Mix Programme	Intensive Care National Audit & Research Centre (ICNARC)	Yes	Ongoing
Child Health Clinical Outcome Review Programme [1]	National Confidential Enquiry into Patient Outcome and Death	Yes	Ongoing
Cleft Registry and Audit NEtwork (CRANE) Database	Royal College of Surgeons of England (RCS)	N/A	N/A
Adolescent Mental Health	Royal College of Emergency Medicine	Yes	100%
Care of Older People	Royal College of Emergency Medicine	Yes	100%
Time Critical Medications	Royal College of Emergency Medicine	Yes	100%
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health	Yes	106/106 (100%)
Falls and Fragility Fracture Audit Programme (FFFAP): Royal College of Physicians			
a. Fracture Liaison Service Database (FLS-DB)	Royal College of Physicians	Yes	837 cases
b. National Audit of Inpatient Falls (NAIF)	Royal College of Physicians	Yes	Ongoing
c. National Hip Fracture Database (NHFD)	Royal College of Physicians	Yes	209 cases
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	NHS England	Yes	Ongoing
Maternal and Newborn Infant Clinical Outcome Review Programme	University of Oxford / MBRRACE-UK collaborative	Yes	Ongoing
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	Yes	Ongoing
National Diabetes Core Audit.	NHS England (formerly NHS Digital)	Yes	Ongoing
National Diabetes Footcare Audit (NDFA)	NHS England (formerly NHS Digital)	Yes	Ongoing
National Diabetes Inpatient Safety Audit (NDISA)	NHS England (formerly NHS Digital)	Yes	SMH, HH, CXH and St Charles Hospital – Ongoing
National Pregnancy in Diabetes Audit (NPID)	NHS England (formerly NHS Digital)	Yes	SMH – Ongoing
National Audit of Cardiac Rehabilitation	University of York		Ongoing – Awaiting response
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	Yes	444 cases
National Audit of Dementia (NAD)	Royal College of Psychiatrists	Yes	SMH – 100%
National Bariatric Surgery Registry	British Obesity & Metabolic Surgery Society	Yes	SMH – 100%

Name of project	Host organisation	Did we participate?	Stage / submission details
National Audit of Metastatic Breast Cancer (NAoMe)	Royal College of Surgeons of England (RCS)	Yes	108 cases
National Audit of Primary Breast Cancer (NAoPri)	Royal College of Surgeons of England (RCS)	Yes	1536 cases
National Bowel Cancer Audit (NBOCA)	Royal College of Surgeons of England (RCS)	Yes	245 cases (85%)
National Kidney Cancer Audit (NKCA)	Royal College of Surgeons of England (RCS)	Yes	353 (88%)
National Lung Cancer Audit (NLCA)	Royal College of Surgeons of England (RCS)	Yes	296 cases
National Non-Hodgkin Lymphoma Audit (NNHLA)	Royal College of Surgeons of England (RCS)	Yes	215 cases
National Oesophago-Gastric Cancer Audit (NOGCA)	Royal College of Surgeons of England (RCS)	Yes	164 cases
National Ovarian Cancer Audit (NOCA)	Royal College of Surgeons of England (RCS)	Yes	132 cases
National Pancreatic Cancer Audit (NPaCA)	Royal College of Surgeons of England (RCS)	Yes	188 cases
National Prostate Cancer Audit (NPCA)	Royal College of Surgeons of England (RCS)	Yes	335 cases
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit & Research Centre (ICNARC)	Yes	100%
National Adult Cardiac Surgery Audit (NACSA)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	457 cases
National Congenital Heart Disease (NCHDA)	National Institute for Cardiovascular Outcomes Research (NICOR)	N/A	N/A – Trust sites are currently not performing procedures for congenital heart disease
National Heart Failure Audit (NHFA)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	SMH – 269 cases CXH – 280 cases HH – 229 cases Trust Total – 778 cases
National Audit of Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	100%
National Audit of Percutaneous Coronary Interventions (NAPCI)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	HH – 1148
Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	29
UK Transcatheter Aortic Valve Implantation (TAVI) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	288
Left Atrial Appendage Occlusion (LAAO) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	No	Plans in place for future submission
Patent Foramen Ovale Closure (PFOC) Registry	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	Ongoing
National Child Mortality Database	University of Bristol	Yes	Ongoing
2023 Audit of Blood Transfusion against NICE Quality Standard 138	NHS Blood and Transplant	Yes	100%
b) 2023 Bedside Transfusion Audit	NHS Blood and Transplant	Yes	100%
National Early Inflammatory Arthritis Audit (NEIAA)	British Society of Rheumatology	Yes	46
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	Yes	100%
National Joint Registry	Healthcare Quality Improvement Partnership (HQIP)	Yes	CXH – 100% SMH – 100%
National Major Trauma Registry	NHS England	Yes	1426 cases
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetrics and Gynaecology	Yes	Ongoing

Name of project	Host organisation	Did we participate?	Stage / submission details
National Neonatal Audit Programme (NNPA)	Royal College of Paediatrics and Child Health	Yes	CXH – 100% SMH – 100%
National Obesity Audit (NOA)	NHS Digital	Yes	100%
National Ophthalmology Database Audit: Cataract Audit	The Royal College of Ophthalmologists	Yes	2779 – 100%
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	Yes	SMH – 160 cases
National Perinatal Mortality Review Tool	University of Oxford / MBRRACEUK collaborative	Yes	Ongoing
National Pulmonary Hypertension Audit	NHS England (formerly NHS Digital)	Yes	993 cases
COPD Secondary Care	Royal College of Physicians	Yes	100%
Pulmonary Rehabilitation	Royal College of Physicians	Yes	100%
Adult Asthma Secondary Care	Royal College of Physicians	Yes	100%
Children and Young People's Asthma Secondary Care	Royal College of Physicians	Yes	100%
National Vascular Registry (NVR)	Royal College of Surgeons of England (RCS)	Yes	>85%
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds / University of Leicester	Yes	100%
Perioperative Quality Improvement Programme	Royal College of Anaesthetists	No	Trust did not participate during 24-25, work is currently underway to address this.
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oral and Dentoalveolar Surgery	British Association of Oral and Maxillofacial Surgeons (BAOMS)	No	Trust did not participate during 24-25, work is currently underway to address this.
Sentinel Stroke National Audit Programme	King's College London (KCL)	Yes	Ongoing
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT)	Yes	Ongoing
Society for Acute Medicine Benchmarking Audit (SAMBA)	Society for Acute Medicine	No	Trust is using other ways to measure the service
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	N/A	Not applicable
UK Renal Registry Chronic Kidney Disease Audit	UK Kidney Association	Yes	100%
UK Renal Registry National Acute Kidney Injury Audit	UK Kidney Association	Yes	Partial submission

National Confidential Enquiries into Patient Outcome and Death (NCEPOD) 2024-25

The table below show the list of ICHT eligible NCEPOD studies in 2024-25, in which hospital sites participated and the number of clinical and organisational questionnaire completed.

NCEPOD Studies 2024/25	Trust Participation	Clinical Questionnaire Completed	Organisational Questionnaire Completed
NCEPOD Blood Sodium Study	Yes	Hypernatraemia Questionnaire – 4/4 (100%) Hyponatraemia Questionnaire – 6/6 (100%)	HH – 100% CXH – 100%
NCEPOD Emergency (non-elective) procedures in children and young people study	Yes	Surgical Questionnaire – 6/8 (75%) Anaesthetic Questionnaire – 7/8 (88%)	SMH – 100% CXH – 100%
NCEPOD Acute Limb Ischaemia Study	Yes – ongoing	7/9 (78%)	SMH – 100% CXH – 100%
NCEPOD Acute Illness in people with a Learning Disability study	Yes (requested data has been provided to NCEPOD)	New study – not yet assigned to Trust	New study – not yet assigned to Trust

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