NHS
Imperial College Healthcare
NHS Trust

Quality account

2019/20

Our quality account for 2019/20 is dedicated to the commitment and expertise of all of our people who are playing a vital role in the UK's on-going response to COVID-19. We pay special recognition to our colleagues who have died during the pandemic to date and celebrate their lives and contribution to the NHS:

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Chief executive's overview

Welcome to the quality account for Imperial College Healthcare NHS Trust for 2019/20. We are just a couple of weeks past the peak of coronavirus infections in London – not an easy time to reflect on 2019/20. In the last month of the year everything changed and saw us more than double our intensive care capacity, redeploy hundreds of staff into new roles and learn all there was to know about how best to treat a new disease causing huge suffering across the world. At the same time, we did all we could to continue care for all our patients, including transferring planned surgery and treatments to other NHS providers and private hospitals less impacted by COVID-19, and transforming our outpatient appointments into telephone and video consultations.

Despite the challenges we have faced this year, we have made great progress in improving our services for our patients and local communities. I am proud of just how much our staff have achieved and hope this report serves as an open and honest account of where we have moved forward, and where we still have further improvements to make.

We began our commitment to quality improvement in 2015, introducing an organisation-wide improvement methodology and a central support function. Over the past four years, nearly 7,000 staff have been trained on quality improvement and more than 200 have become local improvement coaches. We currently have 130 active quality improvement projects and our Flow Coaching Academy established an additional nine major clinical pathway improvement initiatives.

In July 2019, we received a further boost as the CQC improved their quality ratings for a range of services inspected across four of our hospitals in February 2019, including awarding the first 'outstanding' rating for a maternity unit in London – at both Queen Charlotte's & Chelsea and St Mary's hospitals. All eight services inspected received at least a 'good' rating, representing improvements for most. The Trust's overall CQC rating remains 'requires improvement'.

We have made good progress across our safety work streams and continue to have some of the lowest mortality rates in the country. In 2019/20, highlights included introducing our 'helping our teams transform' simulation and coaching programme to support safer surgery; improving hand hygiene compliance, achieving a 25 per cent reduction in falls in wards piloting an initiative to help patients mobilise safely; and reducing incidents involving high-risk medicines such as anti-coagulants and insulin. One of the main areas where we need to improve in the coming year is increasing incident reporting. Our rate of reporting is variable, we want to focus on learning from things that go well, not just when they go wrong but we can only do that if we hear from our staff and patients.

An initiative central to improving the way we work has been our 'keeping care flowing' programme, a whole range of initiatives led by staff across the organisation with the aim of providing the care our patients need as quickly and as smoothly as possible, from before their first contact, through every stage of their care with us and after they leave. This means our specialist care can be targeted where it will be most effective.

Thank you to everyone who has helped us put this quality account together including Healthwatch, our commissioners and our local authorities, and to our staff who continue to work tirelessly to provide our patients with the highest quality of care.

Professor Tim Orchard
Chief executive

22 June 2020

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.

We are proud of our long-standing commitment to patient safety and continue to focus on improving the quality of care that we provide. We know that embedding our values enables our staff to demonstrate key behaviours that leads to safer care; listening to colleagues and patients, responding proactively where there are concerns, and being caring and supportive when things do go wrong. We will continue to focus on these actions to achieve demonstrable impact.

Our improvement methodology

We have a dedicated improvement team whose aim is to support us to embed a culture of continuous improvement in the Trust. The team continues to ensure the rigorous application of the Institute for Healthcare Improvement's methodology across the organisation by coaching individuals and teams in their area of work; for example, through our Coaching and Leading for Improvement Programme (CLIP) and our Imperial Flow Coaching Academy (FCA) which uses big rooms to engage a variety of diverse stakeholders in improvement work across patient pathways. We are also supporting the development of local capacity through a variety of novel education and training offerings aligned to a refreshed organisational 'dosing' model based on evidence that describes how to embed improvement in an organisation at scale and pace. Actively involving patients, relatives and carers remains central to our improvement approach; with patients as key participants in our big rooms and our lay partners as central to the success of our safety improvement programme.

Our 2020/21 improvement priorities

Each year we arve required to define a number of quality priorities. This year, the Trust has undertaken a new approach – the Imperial Way Model – to ensure the successful delivery of our strategic goals and objectives set out in the wider Trust strategy. This method comprises annual objective setting, business planning and a management system (the Imperial Management and Improvement System (IMIS)). This business planning approach – which includes engagement with staff at all levels and across different groups – identifies a small number of key Trust-level focused improvements, designed to have a direct impact on our strategic goals or objectives within the course of a year. We have therefore aligned our 2020/21 improvement priorities with the six Trust-level focused improvements.

Priorities from this year that are not on this list will be transitioned to business as usual.

Our 2020/21 improvement priorities are listed below:

1. To improve the Friends and Family Test (FFT) response rate
2. To improve the percentage of staff who feel they are able to make improvements in their area
3. To improve incident reporting rates
4. To reduce temporary staffing spend
5. To reduce the number of patients with a length of stay of 21 days or more
6. To reduce avoidable harm to our patients

These priorities will be monitored through the integrated quality and performance reports.

Further information on these priorities and how we will measure our progress is included in the table below.

Improvement priority	Rationale for selection	Progress metrics
1. To improve the FFT response rate	Improving the quality of feedback provided in the FFT responses to feed the natural language processing tool will allow us to better understand the positive and negative experiences of patients.	• FFT response rates
2. To improve the percentage of staff who feel they are able to make improvements in their area	By understanding the primary drivers preventing staff from feeling able to make improvements in their area, we can better address engagement and target capabilities in key improvement initiatives.	• % of staff who feel they are able to make improvements in their area
3. To imprve incident reporting rates	High rates of incident reporting is a strong indicator that staff value safety, feel able to raise safety concerns and can learn to continuously improve services.	• Incident reporting rates
4. To reduce temporary staffing spend	Targeting areas with high temporary staffing spend will help us to create a safe and sustainable workforce.	• Temporary staffing spend
5. To reduce the number of patients with a length of stay (LOS) of 21 days or more	Reducing the number of medically fit patients with a length of stay of 21 days, meaning patients are more likely to be cared for in the right place at the right time.	• Patient stays with LOS > 21 days
6. To reduce avoidable harm to our patients	Reducing avoidable harm will underpin our evolving Safety Improvement Programme, developed through a review and refinement of our current safety streams.	• % of moderate/major harm incidents (TBC)

It is important to note that these improvement priorities were defined and agreed prior to the outbreak of COVID-19 in the UK. In 2020/21 we will continue to deliver against these priorities wherever and whenever we can; however our primary focus will be our organisational, regional and national response to the COVID-19 pandemic.

Progress against our 2019/20 improvement priorities

Last year, we identified eight priority improvement areas based on analysis of progress with our previous goals, feedback from our listening campaign and Care Quality Commission (CQC) inspections, and a review of our operational objectives. The table on the next page provides an overview of our progress.

Improvement priority	What did we achieve?
1. To reduce avoidable harm to patients	Overall our harm profile is good, with some of the lowest mortality rates in the country. Our incident reporting rate remains above the national average. However, national comparison data is published six months in arrears, and if the national reporting rate also continues to increase we may fall below our target when the data is refreshed (this happened in 2018/19). Therefore we continue to focus on further increasing incident reporting, with an improvement programme addressing some of the recognised barriers whilst continuing to promote an open and supportive reporting culture across the organisation. The percentage of moderate and above incidents we have reported so far this year is below national average (1.6% compared to 2%). We have declared 266 serious incidents in 2019/20, with the highest reported category being 'treatment delay (availability of downstream mental health beds)'. Commissioners can raise queries with the Trust regarding submitted reports. To measure improvements in the quality of serious incidents, we aimed for a reduction in the number of reports returned from the commissioners with queries. In the past six months we have seen a decrease in the number of requests. This is due to a focus on reviewing and quality assuring these reports centrally before they get to panel and final submission. We have nine safety streams in place to focus on reducing harm in the most frequently reported serious incidents. Progress this year includes: **Improving hand hygiene** Significant sustained improvement in compliance with hand hygiene; for example, in phase II of the Hand Hygiene Improvement Programme, the 12 focus wards increased their mean compliance scores in the trust-wide IPC audit from 38% to 64%. We have maintained and increased our focus on hand hygiene as part of our response to COVID-19. There have been times where the supply and demand of hand washing materials has been challenging, but we have been able to maintain adequate supplies of soap or alcohol gel in our clinical areas at all times. **Reducing fall with harm** The new Falls Steering Group chaired by the director of nursing has been established, overseeing a 25% reduction in falls with harm in wards piloting falls reduction interventions such as the introduction of a falls care bundle. **Safer medicines** We have seen a reduction in incidents involving high risk medicines such as anti-coagulants and insulin, as well as a novel collaboration with partners in the Patient Safety Translational Research Centre that improves prescribing by providing real-time feedback to prescribers. **Responding to the deteriorating patient** We have sustained a reduction in cardiac arrests taking place outside of our intensive care units across the Trust. **Improving care for patients with mental health problems in the Emergency Department (ED)** This safety stream is focusing on alternatives to admission, reducing environmental risk for patients in the ED and better support, training and development for specialist staff caring for these patients. The work is closely aligned to the mental health 'big room' improving flow across the pathway as part of the Imperial Flow Coaching Academy. In responding to this safety stream we have continued to work closely with our colleagues in our local mental health services. However we continue to face challenges with the timely transfer of care for patients with mental health needs to more appropriate settings. We will continue to work collaboratively to improve our responsiveness to this potentially vulnerable group of patients. **Positive patient identification** Work has focused on defining policy as well as on reducing the number of incidents related to blood testing. In response we have seen a reduction in the number of wrong blood in tube incidents. We have undertaken a pilot of the use of technology during medicines administration. We anticipate once this pilot rolls out that it will reduce harm related to misidentification during medicines administration. **Improving fetal monitoring** The introduction of 'Fetalink' and 'fresh eyes (a second check of fetal monitoring) alongside staff education and strengthened governance to learn from incidents has resulted in a significant reduction in the number of incidents resulting in harm. **Endorsement of abnormal results** We have seen success in improving the time it takes to endorse results as part of a pilot in gynaecology (with endorsement within 30 days increasing from <30% to >90%). Due to the scale of the pilot this has not translated to a reduction in incidents at Trust level; therefore work continues to understand the locations, themes and level of risk associated with clinical incidents related to a delay in reviewing and acting upon test results. **Safer surgery** The successful roll-out of the Helping Our Teams transform (HOTT) for teams undertaking invasive procedures, which includes human factors training, simulation and in-situ coaching. In 2019/20 over 1000 staff have participated in the programme. With our partners, we marked the inaugural World Patient Safety day in September 2019 and hosted our first Imperial Patient Safety Conference in February 2020, providing a dedicated forum to reflect on our safety priorities and actions.

Improvement priority	What did we achieve?
2. To continue to define, develop, implement and evaluate an organisation approach to reducing unwarranted variation	The Trust has established the Imperial Flow Coaching Academy to reduce unwarranted variation by understanding and delivering best practice. We have trained 50 flow coaches supporting teams to deliver improvement across 20 clinical pathways, including: *Sepsis pathway* • A 35% increase in the likelihood of receiving antibiotics within 1 hour of admission with suspected sepsis, a 24% reduction in mortality with a 7% reduction in length of stay (meaning patients get back to their home much sooner). *Vascular elective pathway* • Weekly discharges have increased from a mean of 11 to 16 patients and length of stay has reduced by an average of 2 days; this means patients are more likely to be cared for in the right place at the right time. *Diabetic foot pathway* • Reduction in mean length of stay to 18 days. *Theatres pathway at St Mary's Hospital* • 24 hour stays have been reduced from an average of 17 per month in 2018 to an average of less than six per month in 2019. • Theatre lists are more likely to start on time with over 80% of theatre lists now starting with the patient who has been identified as needing to go first.
3. To improve access to services across the Trust through a focus on increasing capacity and improving energy flow	Our Care Journey and Capacity Collaborative is how we are delivering this priority across four specific areas of the emergency pathway: • Front door – implementing and operationalising urgent and emergency care (UEC) standards; provision of same day emergency services (SDEC); ambulance handovers; and patients in mental health crisis in the emergency department. • Giving the best start – getting inpatients to the right place (time to move and right bed); and timely specialist input. • Perfect ward day – reinforcing the SAFER patient flow bundle. • Discharge – improving patient and family communications around the patient choice policy; and long length of stay reviews. • Performance is monitored through the executive operational performance committee.
4. To improve access for patients waiting for elective surgery	In March 2020, due to the COVID-19 pandemic, all non-urgent elective inpatient procedures were stood down and clinical reviews were completed by the services. Through these review processes, a large number of appointments deemed non-urgent were cancelled or postponed for up to three months. Inevitably this will have a serious effect on the size of our waiting lists and associated performance and data quality metrics. Therefore commentary for this priority focuses on performance up to quarter three (Q3). The Trust over performed against the Referral to Treatment (RTT) target agreed with commissioners, which is throughout Q3 when viewed as a number (63,100). However, we did not meet the percentage target in Q3 which is mostly influenced by winter pressures and patient choice during this time of the year but is being investigated at specialty level to ensure that recovery action plans are in place. Standards set by NHS England state that no patient should wait more than 52-weeks for their treatment to start following referral. In Q3 we have seen a rise in 52 week waiting patients, with 14 patients being reported in the period. The increase is multifactorial and related to capacity; surgeon, theatre and bed availability; patient choice to defer until January 2020 and a high number of cancer patients taking priority over routine elective surgery. Notably, no cases of clinical harm were identified in the quarter due to elective waiting times in the 44+ week cohorts.
5. To improve compliance with the equality and diversity standards	We want to provide a better working environment for our staff, free from all unfair discrimination. The results of our staff survey continue to show we have more work to do to improve equality, diversity and inclusion across the Trust, with performance lower than we would want. We are delivering on our workforce equality, diversity and inclusion work programme with four elements that cover the main protected characteristic groups, including ethnicity, gender and disabilities. This work programme is overseen by a governance structure that includes our Equality, Diversity and Inclusion (EDI) committee chaired by the Trust chief executive. The EDI Committee includes representatives from divisions and staff networks. The committee delivers on its objectives via five staff networks. These networks are anchored by staff leads and cover disability, black, Asian and minority ethnic (BAME), lesbian, gay, bisexual and transgender (LGBT) and gender diversity issues. Executive sponsors give each network's agenda board level visibility. The networks are working with staff and executives to open channels of communication, to agree priorities for our equality, diversity and inclusion agenda and to recognise that everyone has a role to play in delivering it. Our 2018-19 Annual Equality and Diversity (E&D) report was agreed by the board and published on 26 September 2019. The annual report includes the workforce race equality standard (WRES) and workforce disability equality standard (DES) metrics and report, as well as data on our gender pay gap.

Area: Gender Pay Action Plan

Objective	Metric	Baseline annual		2019/20 quarterly			
		17/18	18/19	Q1	Q2	Q3	Q4
Improve female workforce representation at Band 8A+	Increase % of workforce at Band 8A+ (female)	54%	53.42%	53.74%	53.72%	53.47%	54.53%

Area: Disability (WDES action plan)

Objective	Metric	Baseline annual		2019/20 quarterly			
		17/18	18/19	Q1	Q2	Q3	Q4
Improve quality of disability data on ESR	Reduce % of disability data in 'unspecified' category	37.10%	33.20%	32.98%	32.30%	33.40%	30.98%

Area: Race Equality (WRES action plan)

Objective	Metric	Baseline annual		2019/20 quarterly			
		17/18	18/19	Q1	Q2	Q3	Q4
Improve workforce representation of BME people at Band 7+	Increase % of workforce at Band 7+ (BME)	33.57%	34.38%	34.48%	33.68%	34.52%	33.91%

Area: Race Equality (WRES action plan)

Objective	Metric	Annual		
		2017/18	2018/19	2019/20
Reduce the differential in the relative likelihood of BAME and White people receiving D or E ratings in their personal development review (PDR)	Reduce the likelihood of BAME staff receiving D or E ratings (PDR)	1.51	1.45	1.33

Area: Gender pay action plan

Objective	Metric	Gender Pay Gap Report Results		
		March 2017	March 2018	March 2019
Reduce the differentials of bonus pay gap (LCEAs) between female and male	Mean difference	26.60%	28.00%	29.00%
	Median difference	40.00%	46.00%	44.80%

Improvement priority	What did we achieve?
6. To improve the behaviours across the Trust related to safety	Safety culture (or 'the way we do things round here to keep patients and staff safe') has been a focus since 2016, and we have increasingly recognised the importance promoting our values, and ensuring that these translate into the safety behaviours as part of our safety improvement programme. We have seen a year on year improvement in staff survey questions relating to safety culture; for example staff feeling safe to raise concerns. The new national NHS Patient Safety Strategy was launched in July 2019 and the aims of our safety improvement programme were reviewed over the summer of 2019 to ensure that they remain aligned to national policy and our evolving Trust strategy. As part of the review we have established a new safety improvement group (SIG) group to provide strategic oversight of delivery of the safety improvement plan. This is chaired by our medical director and they report exceptions to the executive quality committee. We are delighted to continue to have attendance at the group by our lay partners in safety improvement. *Incident reporting* We concluded a pilot of 90 day improvement cycle to increase incident reporting, which demonstrated an increase in reporting in many of the wards involved. One of the key outcomes of the evaluation was around feedback and learning. Staff in all the pilot wards reported that they did not have regular and easy access to their incident reporting data. Following this programme, a review was established to (a) improve how incident reporting data are presented, (b) to work to make it meaningful to clinical teams, and (c) to improve how incident reporting data is presented and disseminated to staff. A proposal has also been agreed for a pilot to present data in a more engaging way using existing software. Incident reporting is increasing overall. *Communications* We are working with corporate communications to launch a Trust-wide communications campaign in 2020/21 to improve incident reporting, and to raise the profile of the Freedom to Speak Up guardians and speaking up more generally. In addition we continue with our bi-monthly safety briefings and safety alerts. *Learning from Excellence* We have asked our staff to use Datix, our electronic incident reporting system, to record Learning from Excellence. We have now conducted a review into our use of Learning from Excellence comparing the use of Datix with other models, including those used in other trusts. It was proposed to move away from Datix in a future pilot, therefore the next phase of this work will explore alternative software options for Learning from Excellence. This pilot would be cross site and would involve lay-partners in co-production.
7. To improve staffing levels for permanent nurses and non-consultant doctors	By the end of 2019/20, we had achieved our overall vacancy rate targets for all staff and for nursing and midwifery staff. We have ensured staffing meets planned safe levels. Where shifts were not filled, staffing arrangements were optimised and any risk to safe care minimised by the senior nurses taking the following actions: • Using the workforce flexibly across floors and clinical areas • The nurse or midwife in charge of the area working clinically and taking a case load • Specialist staff working clinically during the shift to support their ward based colleagues We are also achieving our vacancy rate targets for career grade and trust grade doctors. Other highlights include: • We have secured 90% of our student nurses who have trained with us and qualified this autumn. • The international nurse recruitment work was on track to realise 160 nurses by the end of March 2020 however, the COVID-19 pandemic has led to delays. • The nursing associate apprenticeship recruitment and development and graduate nurse apprentice numbers are increasing and the schemes are gathering momentum. We are also running recruitment and retention campaigns for areas and staff groups with high vacancy rates, including cardiac physiologists and locally employed doctors.
8. To review our approach to inspection, accreditation and reviews	Our approach has been strengthened over the last twelve months with improvements evidenced by CQC inspections. Our quality ratings have improved for a range of services inspected across four of our hospitals in February 2019. As noted above, these include maternity at Queen Charlotte's Chelsea Hospital and St Mary's Hospital which were the first maternity units in London to be rated as outstanding. Recently the CQC published its report from the inspection of GP services at Hammersmith Hospital and Charing Cross Hospital, with the trust achieving a 'good' rating in all domains. The CQC also completed a re-inspection of Ionising Radiation (Medical Exposure) Regulations (IR(ME)R), following the service of an improvement notice in June 2019. They commended the progress the trust had made in response and were satisfied that we are now compliant with regulatory requirements. The Improving Care Programme Group oversees this work and plans in place with our core services for their inspection preparation.

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 2019/20. 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 2019/20, Imperial College Healthcare NHS Trust provided and/or sub-contracted 104 NHS services.

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

The income generated by the NHS services reviewed in 2019/20 represents 81 per cent of the total income generated from the provision of NHS services by the Trust for 2019/20.

The income generated by patient care services associated with the services above in 2019/20 represents 97 per cent of the total income generated from the provision of services by the Trust for 2019/20.

Participation in clinical audits and national confidential enquiries

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

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

During 2019/20, 49 national clinical audits and two national confidential enquiries covered NHS services that Imperial College Healthcare NHS Trust provides. During that period, we participated in 90 per cent of national clinical audits and 100 per cent of national confidential enquiries in which we were eligible to participate.

The Trust did not participate in four out of the five British Association of Urological Surgeons (BAUS) audits in 19/20 but a benchmarking exercise using alternative data has been conducted to provide assurance. The outcome of this exercise has been reviewed through existing governance arrangements and assurance provided. The Executive Quality Committee agreed that we would not undertake four of the five BAUS audits. This decision was based on concerns raised by the clinical team regarding the level of assurance available from these audits. The urology team have produced a number of local audits to provide assurance in areas where we do not participate in BAUS work.

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

Participation in national clinical audits and confidential enquiries 2019/20.

National Clinical Audit and Clinical Outcome Review Programmes	Host Organisation	Participation	% submitted
Assessing cognitive impairment in older people/care in emergency departments	Royal College of Emergency Medicine	✓	120 cases submitted percentage not available
BAUS urology audit – cystectomy	British Association of Urological Surgeons	✗	Did not participate *See commentary above*
BAUS urology audit – female stress incontinence (SUI)	British Association of Urological Surgeons	✓	100 per cent
BAUS urology audit – nephrectomy	British Association of Urological Surgeons	✗	Did not participate *See commentary above*
BAUS urology audit – percutaneous nephrolithotomy (PCNL)	British Association of Urological Surgeons	✗	Did not participate *See commentary above*
BAUS urology audit – radical prostatectomy	British Association of Urological Surgeons	✗	Did not participate *See commentary above*
Care of children in emergency departments	Royal College of Emergency Medicine	✓	Ongoing collection
Case Mix Programme	Intensive Care National Audit and Research Centre	✓	Ongoing collection
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	✓	100 per cent
Elective Surgery (national PROMs programme)	NHS Digital	✓	77.1 per cent

National Clinical Audit and Clinical Outcome Review Programmes	Host Organisation	Participation	% submitted
Endocrine and Thyroid national audit	British Association of Endocrine and thyroid surgeons	✓	Not available
Falls and Fragility Fractures Audit Programme (FFFAP) – fracture liaison service database	Royal College of Physicians London	✓	100 per cent
Inflammatory Bowel Disease Registry – biological therapies audit	Inflammatory Bowel Disease Registry	✓	Ongoing collection
Major trauma audit	Trauma Audit and Research Network	✓	97.6 per cent
Mandatory surveillance of bloodstream Infections and Clostridium Difficile Infection	Public Health England	✓	100 per cent
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRACE-UK	✓	Ongoing Collection
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	✓	100 per cent
Mental Health – care in emergency departments	Royal College of Emergency Medicine	✓	186 cases submitted Percentage not available
National Asthma and COPD Audit Programme	Royal College of Physicians	✓	Ongoing collection
National Audit of Breast Cancer in Older People	Royal College of Surgeons	✓	100 per cent
National Audit of Cardiac Rehabilitation	University of York	✓	773 cases
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	✓	100 per cent
National Audit of Dementia (Care in General Hospitals)	Royal College of Psychiatrists	✓	100 per cent
National Audit of Pulmonary Hypertension	NHS Digital	✓	Ongoing collection
National Audit of Seizure Management in Hospitals	University of Liverpool	✓	100 per cent
National Audit of Seizures and Epilepsies in Children and Young People	Royal College of Paediatrics and Child Health	✓	Not available
National Bariatric Surgery (NBSR)	British Obesity and Metabolic Surgery Society	✓	Ongoing collection
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre	✓	100 per cent from April to December Data to end of March not available until end of May
National Cardiac Audit Programme	Barts Health NHS Trust	✓	Ongoing collection
National Diabetes Audits – adults	NHS Digital	✓	Ongoing collection
National Early Inflammatory Arthritis Audit	British society for Rheumatology	✓	Ongoing collection, 119 records submitted so far
National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists	✓	100 per cent Charing Cross Hospital 74 per cent St Mary's Hospital Ongoing collection
National Gastro-Intestinal Cancer Programme	NHS Digital	✓	Ongoing collection
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership	✓	Ongoing collection
National Lung Cancer Audit (NLCA)	Royal College of Physicians	✓	Ongoing collection
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists	✓	Not yet started
National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health	✓	100 per cent

National Clinical Audit and Clinical Outcome Review Programmes	Host Organisation	Participation	% submitted
National Ophthalmology Audit	Royal College of Ophthalmologists	✓	Ongoing collection
National Paediatric Diabetes Audit (NPDA)	Royal College of Paediatrics and Child Health	✓	Ongoing collection
National Prostate Cancer Audit	Royal College of Surgeons	✓	Ongoing collection
National Smoking Cessation Audit	British Thoracic Society	✓	100 per cent
National Vascular Registry	Royal College of Surgeons	✓	Ongoing collection
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	✓	Ongoing collection
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds / University of Leicester	✓	100 per cent
Perioperative Quality Improvement Programme	Royal College of Anaesthetics	✓	Not available
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Public Health England	✓	Ongoing collection
Sentinel Stroke National Audit Programme (SSN/AP)	King's College London	✓	98.2 per cent up to February 2020 Ongoing collection
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion	✓	Ongoing collection
Society for Acute Medicine's Benchmarking Audit	Society for Acute Medicine	✗	Did not participate
Surgical Site Infection Surveillance Service	Public Health England	✓	100 per cent
UK Parkinson's Audit	Parkinson's UK	✓	100 per cent

National clinical audit

We reviewed the reports of 46 national clinical audits and confidential enquires in 2019/20. These clinical audits linked with our focused improvement work have identified a number of areas of excellent practice as well as opportunities for development and improvement.

Paediatric Intensive Care Audit Network: annual report 2019

We have performed extremely well in all of the key domains of this recurring national audit. The one area for improvement is against the recommended overall ratio of trained nurses to inpatient beds, although this is improving year on year as a result of a focused recruitment programme and staffing review. The unit underwent an extensive redevelopment and refurbishment this year as a result of a generous donations from Imperial Health Charity and Children of St Mary's Intensive Care (COSMIC). The new unit is much larger and provides more space and better facilities for patients, families and staff.

The Learning Disabilities Mortality Review

The Learning Disabilities Mortality Review (LeDeR) programme was established in May 2015 across England to review the deaths of people with a learning disability, to learn from those deaths and to put that learning into practice. The Trust has care pathways for inpatients, outpatients, emergency departments and some specialist services with a full time learning disability coordinator, to support the care and management of patients with learning disabilities. There is also a clear pathway in relation to learning from deaths and the structured judgement review (SJR) process that links with the LeDeR review process. The Trust reported 18 deaths of patients with learning disabilities to the LeDeR programme in the last financial year. The learning disability coordinator routinely reviews the records of all patients with learning disability, which includes do not attempt cardio-pulmonary resuscitation (DNACPR) status. Where there is any doubt on the basis of the decision or where inadequate capacity assessments/best interest decisions have been made this will be followed up with the responsible consultant and investigations undertaken.

National Diabetes Insulin Pump Audit (NDIPA) 2017-2018

This audit collects information on the number and characteristics of people with diabetes using an insulin pump, the reason for going on an insulin pump and the outcomes achieved since starting the pump. The Diabetes Technology Centre was set up earlier this year and since July 2019, all pump starts at the Trust take place here in a dedicated pump initiation clinic run by our type 1 diabetes educators. 19.7 per cent of people with type 1 diabetes being seen at the Trust were receiving insulin pump therapy compared to 17.7 per cent of patients nationally. 91.3 per cent of our pump users had their HbA1c recorded appropriately, which

is on par with the national average (94.9 per cent), but only 43.5 per cent achieved all eight care processes compared to the national average of 52.6 per cent. We have developed a new Type 1 diabetes clinic template to improve data capture and ensure that the key eight care processes are undertaken and recorded.

Royal College of Emergency Medicine Vital Signs in Adults National Report

The Vital Signs Standards were originally developed and published in 2010 through a partnership between the Royal College of Emergency Medicine, the Royal College of Nursing, the Faculty of Emergency Nursing and the Emergency Nurse Consultants Association. This is the second time this audit has been conducted at the Trust. Senior decision maker oversight, and evidence that doctors acknowledged abnormal vitals, were on the whole very good. The Trust, however, is implementing an action plan to improve communication between reception and triage, implement an early warning score action card, and to devise a written escalation policy for triage surges.

National Pregnancy in Diabetes Audit Report 2018

The National Pregnancy in Diabetes (NPID) Audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant. It presents national data that shows that seven out of eight diabetic women were not well prepared for pregnancy. Stillbirth rates and other complications of pregnancy were demonstrably higher for diabetic mothers. The audit presents a challenge to all stakeholders to participate in the challenge to improve pre-gestational diabetic pregnancy outcomes. We have developed a new endocrinology/ diabetes pregnancy clinic to offer specialist care based on the St Mary's Hospital site.

National audit of cardiac rhythm management devices and ablation 2016/2017 – summary report

The National Audit of Cardiac Rhythm Management (CRM) collects information about all implanted cardiac devices and all patients receiving interventional procedures for management of cardiac rhythm disorders in the UK. The Trust is a major national centre for this work and the report reflects this, showing that the unit is performing in line with or better than peer units. In addition, a strong research programme means that patients are often able to benefit from new and developing techniques and technology in advance of formal approval by the National Institute of Clinical Excellence (NICE) as part of collaborative research programmes.

State of the Nation – England report – using national clinical audit to improve the care of people with falls and fragility fractures in England

This national audit has been reported with acceptable risk/reasonable assurance. It represents improvements in performance in most areas but demonstrates that achieving early and timely surgery for patients with hip fractures remains challenging. This has been recognised by the Trust and is the focus of a dedicated multidisciplinary improvement group including orthopaedic surgeons, anaesthetists and ortho-geriatricians. A business case including additional theatre capacity has been made although no decision has yet been made. This will be kept under review through approved governance structures. One area of improvement has been the implementation of a new fracture liaison service since January 2020, which aims to risk assess patients presenting with fragility fractures and to advise and intervene to reduce future fracture risk.

National Paediatric Diabetes Audit Spotlight reports – workforce and structure

The Trust offers a mature and well-developed service that is well ahead of many peers. We are able to offer the recommended four appointments a year for all children and young people with diabetes. We have a well-established Young Adult Transition clinic, where paediatrician, adult physicians and other professionals involved work with young adults and their parents to provide the necessary support for this age group. This audit showed that our specialist staffing is better than other units in London, the South-East and nationally.

National Paediatric Diabetes Audit spotlight reports – diabetes-related technologies

This audit is specifically aimed to determine the prevalence of use of diabetes-related technologies amongst children and young people with Type 1 diabetes across England and Wales. It also aims to establish the type of support children, young people and their families receive when utilising diabetes-related technology. The Trust is well ahead nationally in this area and the audit demonstrated that the paediatric diabetes unit is performing in line with or better than peer units in all key audit domains.

Perinatal Mortality Review Tool – first annual report (2019)

We were able to demonstrate reasonable assurance against the recommendations of this audit; however, there were opportunities for improvement. We have reviewed the processes for our perinatal mortality reviews so that we can learn and improve. Some of the actions we are taking to achieve this include improving our record keeping about who is involved in reviews. We have identified two obstetric leads; a neonatal lead is already in post. We are actively engaging and seeking the views of parents during reviews to make this a more useful process and to ensure that they are given every opportunity to ask questions, feedback and express their views and concerns.

Local clinical audit

Over the year, the Trust has identified a number of areas for targeted audit work across the organisation. These have been selected as areas of potential risk or in order to support a strategic aim. Audits conducted in these areas have been coordinated centrally and reported to the trust audit group and to executive quality committee for oversight and monitoring of actions and to provide assurance. Many of these audits form part of our safety improvement programme, with the results being used to inform specific quality improvement work. In addition, specialties within directorates conduct local audit activity. Over 2019/20 there were 337 local audits registered in the Trust. The report, including any action plans, are reviewed through local audit and risk governance meetings and logged centrally.

Some examples of the actions to improve the quality of healthcare provided include:

- **Audit of compliance with the World Health Organization's five steps to safer surgery, including the Trust Count Policy**: Substantial assurance that surgical teams are complying with the five steps to safer surgery with some local variation in practice around the count which is being addressed through the development of a single unified policy as part of the Trust invasive procedure group. The HOTT programme is the key intervention to improve and maintain compliance.
- **Audit of our consent policy (part 4 – specifically for adults who are unable to consent to investigation/ treatment)**: Overall completion of the consent form for patient details, name of procedure and signature of health professional was completed to a satisfactory level. Documentation for assessment of mental capacity and best interests was generally poorer, with a lack of explanation to attempts made and reasoning for failed attempts. Education that includes teaching the importance of using justified reasoning and completing sections fully has commenced.
- **Audit of the chest pain pathway**: carried out by the cardiology team, this audit found that appropriate referrals were being made but that the times for transfer were found to be longer than the trust target but this data was collected during a time of high bed pressure. Improvements are being made to the pathway to the heart attack centre (HAC) and to downstream beds.
- A**udit of compliance of documentation of operative notes after hip replacement surgery against newly released 'getting it right first time' (GIRFT) guidance**: carried out by the trauma and orthopaedic team, this audit demonstrated good compliance which could be further improved by the introduction of a standardised operation note template in the electronic patient record which is being taken forward.
- **Re-audit of the assessment for delirium and cognitive impairment in adult general surgical patients over 65 years admitted to the Trust**: carried out by the general surgical team, this audit has shown an improvement demonstrating that of the 85 per cent of patients with a positive indicator for delirium, 74 per cent received a formal assessment for delirium or cognitive test and of those with clinically suspected delirium, 82 per cent of patients received a formal assessment.

Our participation in clinical research

We continue to contribute to world-leading programmes of clinical research, partnering closely with Imperial College London through the Imperial College Academic Health Science Centre (AHSC). In collaboration with industry, the charity sector and government, this partnership drives our biomedical and clinical research strategy. It ensures we remain at the forefront of scientific discovery and can apply these new advances to benefit of our patients and the wider population.

Through the AHSC we also work closely with the Royal Brompton & Harefield NHS Foundation Trust and the Royal Marsden NHS Foundation Trust to coordinate our efforts and align our priorities across North West London.

Much of our innovative clinical and biomedical research is made possible because of significant infrastructure funding, awarded through open competition by the National Institute of Health Research (NIHR). This includes our NIHR Biomedical Research Centre (BRC), Clinical Research Facility (CRF), Patient Safety Translational Research Centre (PSTRC), Experimental Cancer Medicine Centre (ECMC) and MedTech & In Vitro Diagnostics Cooperative (M&IC). Funding from our own Imperial Health Charity ensures this work not only benefits our NHS patients, but also provides career development opportunities for our staff.

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2019/20 that were recruited to participate in research approved by a research ethics committee was 13,801. 11,760 patients were recruited into 402 NIHR portfolio studies in 2019/20. This included 757 patients within 89 studies sponsored by commercial clinical research and development organisations.

More detail on our translational research work can be found on the NIHR Imperial Biomedical Research Centre website: https://imperialbrc.nihr.ac.uk/research/.

Our CQUIN performance

Commissioning for Quality and Innovation (CQUIN) is a quality framework that allows commissioners to agree payments to hospitals based on the number of schemes implemented and a proportion of our income is conditional on achieving goals through the framework. We signed up to a total of ten CQUIN schemes for 2019-20, five Clinical Commissioning Groups (CCGs) schemes and five NHSE schemes with a proportion of our income in 2019/20 being conditional on achieving quarterly scheme targets. The total value

of the schemes we signed up to is 1.55 per cent of the contract value for NHS acute healthcare services as agreed with NHS England and 1.25 per cent of the contract value for agreed CCG schemes.

Submissions have been made for Q1-3 and we are on track for our Q4 end of year submission in April 2020. All ten schemes had strong clinical and service leadership engagement with the aim to bring as many schemes into business as usual at the end of the financial year. Our CQUIN goals for 2020/21 have not yet been agreed, however they are likely to focus on similar issues to our current goals.

Statements from the Care Quality Commission (CQC)

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

The Trust's overall CQC rating remains requires improvement.

All trusts participate in CQC patient surveys; the outcomes of three surveys carried out during 2018 were published during 2019/20. Overall, the Trust's performance in the surveys was relatively unchanged and was "about the same" when compared to other trusts.

- The outcomes of the adult inpatient survey showed no significant change. The Trust performed better than other trusts in relation to patients being asked to give their views on the quality of care.
- The outcomes of the urgent and emergency care survey identified dissatisfaction with the availability of food; however, there was significant improvement in relation to privacy, cleanliness, waiting times and knowing who to contact for advice after discharge.
- The outcomes of the children and young people survey showed no significant change; parents raised concerns about the availability of hot drinks, the quality of food and cleanliness of the environment.

We did not participate in any special reviews carried by the CQC during 2019/20, nor were any reviews published that the Trust participated in which were carried out in previous years.

The CQC inspected four core services at the Trust in February 2019:

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

The outcomes of the inspections were published in July 2019 and we are very proud of our performance overall. In summary:

- Maternity at St Mary's Hospital and QCCH were the first maternity services in London to be rated "Outstanding" overall.
- Services generally improved to good, or maintained existing good ratings, for both domains and overall.
- Three ratings remained Requires Improvement:
  - The safe domain in services for children and young people at St Mary's Hospital.
  - The well-led domain for services for children and young people at Hammersmith Hospital (the David Harvey Unit).
  - The well-led domain for critical care at Hammersmith Hospital.
- The overall ratings for St Mary's, Charing Cross and Hammersmith hospitals remained requires improvement, although some of these issues, such as poor physical estate, are largely outside our control. We will need more services to be inspected and improve to influence our overall ratings at these sites.
- The Trust's overall CQC rating following these inspections remains requires improvement.
- The overall rating for Queen Charlotte's & Chelsea Hospital improved to outstanding.

Following the CQC's inspection of well-led at Trust level domain in April 2019, the Trust level rating for well-led improved to good.

Compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) in the imaging department at St Mary's Hospital was inspected by the CQC in June 2019. Following this inspection the CQC took enforcement action against the Trust in the form of an improvement notice, which required that the Trust address the areas of non-compliance identified during the inspection which in the main related to our overarching governance structures, procedures and policies related to IR(ME)R. The CQC re-inspected in August 2019 and confirmed the imaging department at St Mary's Hospital had become fully compliant with IR(ME)R.

The GP practice operated by the Trust, Hammersmith & Fulham Centres for Health, is located at Charing Cross and Hammersmith hospitals. The practice was inspected by the CQC at both sites in July 2019; this was the first ever inspection of the practice. The outcomes of the inspection were published in September 2019; all domains and the practice overall at both sites, were rated good.

Routine CQC inspections have been suspended during the COVID-19 pandemic however, an unplanned (focused) inspection of any service could be carried out in response to changes in CQC intelligence, where serious concerns are identified. When routine inspection recommences we will expect the Trust's next round of core service inspections and the inspection of well-led at Trust level. We look forward to this opportunity to have our other services re-inspected and our ratings updated.

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 our trust and essential to our mission.

NHS number and general medical practice code validity

The Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data, which included the patient's valid NHS number, was:

- 97.7 per cent for admitted patient care;
- 99.3 per cent for outpatient care; and
- 93.2 per cent for accident and emergency care.

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

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

Data security and protection toolkit

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

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

Clinical coding quality

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

The Trust was not subject to the payment by results clinical coding audit by NHS Improvement during 2019/20 by the Audit Commission.

Data quality

We continued to focus on improving the quality of our performance data via the Data Quality Improvement Programme (DQIP). The aim of the DQIP is to prioritise areas for improvement and provide intensive support within these areas for a period of time, before returning metrics to business as usual internal frameworks. The Data Quality Steering Group (DQSG) oversee progress with the DQIP, reporting to the Executive Operational Performance Committee (ExOp) on a monthly basis and to Audit Risk and Governance Committee (ARG) bi-annually.

In 2019/20, we chose 20 data quality indicators (DQIs) identified as key priorities for improvement across waiting times (10) and income/activity (10). Highlights and achievements for 2019/20 include:

- Four out of the five waiting time audits have continuously reported within the agreed five per cent threshold recommended by NHS Improvement.
- The average RTT error rate has improved to eight per cent for 2019/20, as compared to ten per cent for 2018/19.
- Of the ten priority waiting time DQIs, five have shown sustained improvement when compared to baseline.
- Outpatient check-in and outpatient check-out waiting times DQIs have shown a 42 per cent improvement against baselines, after operational teams implemented a targeted action plan across the year.

In March 2020, due to the COVID-19 pandemic immediate changes were put in place for the provision of outpatient services across the Trust. To reduce the number of face-face contacts in the outpatient departments, clinically appropriate services were transferred to telephone or video consultations. For inpatient procedures, all non-urgent elective treatments were stood down and clinical reviews were completed by the services. Through these review processes, a large number of appointments deemed non-urgent were cancelled or postponed for up to three months. This change will affect the waiting lists and associated performance and data quality metrics.

With the normal processes affected due to the current situation, a clear governance process is required to provide assurance across the Trust for the management of our elective care waiting lists. The Trust is developing a five-step 'COVID-19 waiting list data quality framework'. This will replace the business as usual Data Quality Improvement Programme. A number of measures and mitigation reports are being implemented to track data quality throughout the Trust's COVID-19 response; this includes six key priority data quality indicators.

The COVID-19 waiting list data quality framework will be proposed to the executive team in mid-April and work on the implementation will begin after this, with a dedicated scorecard reported on a routine basis. When the Trust returns to business as usual, the expectation is to return to the Data Quality Improvement Programme and continue as per the original plan.

Learning from deaths

We comply with all elements of the national learning from deaths process with a policy that sets out standards and measures reported up to Trust Board. Through this process, 75 per cent of deaths which occurred at the Trust between April 2019 and March 2020 have been reviewed so far. Of these, 198 have gone forward for structured judgement review (SJR). This is a validated methodology and involves trained clinicians reviewing medical records in a critical manner to comment on phases of care and determine whether the death may have been due to problems with the care the patient received.

In 2019/20 we implemented our medical examiner (ME) service in line with national guidance; we are pleased to say that our service was fully operational before the 1 April 2020 deadline. The ME service has fundamentally changed how we learn from deaths. Our ME service now identify cases where a SJR should be conducted, this is based on a review of clinical notes and most importantly a conversation with the bereaved. Our ME service now reviews every death that occurs in our hospitals and: a) ensures that the proposed cause of death is accurate, b) the bereaved understand the cause of death and have an opportunity to raise any concerns and c) identify any cases that should be referred for SJR.

We have changed our SJR process to ensure that it is aligned with our other clinical governance process, as part of this we have moved away from an SJR declaring a death avoidable or unavoidable. Rather the SJR now focusses on identifying learning and care/service delivery issues. Where care/service delivery issues are identified these are reviewed via our serious incident framework and are subject to more in depth investigation as appropriate.

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

Patient deaths, April 2019-March 2020

	Q1	Q2	Q3	Q4	Total
Number of patients who died *Based on date of death*	442	441	436	598	1917
Number of deaths subjected to case review or investigation *Based on date of death*	59	69	56	14	198
Estimate of the number of deaths where some level of care concerns were identified but were still deemed to be unavoidable	7	1	5	0	13

Our rate of referral to SJR reduced in Q4, and our rate of death increased significantly because of COVID-19. We believe that the reduction in cases referred to SJR is representative of the fact that the ME service started reviewing all deaths in Q4. This means that family concerns are dealt with quickly and transparently, and other issues are explored and understood at the point of death, rather than referring cases to SJR for further review as would have happened previously. In order to assure ourselves that the correct cases have been referred to SJR we will audit all cases in Q4 in order to provide further assurance that the correct cases have been referred.

Deaths which occurred in 2019/20

Of the 1917 deaths that occurred during 2019/20, 1440 were subject of case record reviews, 164 SJRs and 18 serious incident investigations. Of those reviewed, 13 of the deaths were identified with level of care concerns. Which represents 0.67 per cent of the deaths that occurred during that financial year.

In six of these cases, the issues were not found to have contributed to the outcome and the deaths were deemed to be totally unavoidable. The themes for these were poor documentation of clinical decision making and records of discussions with patients and/or their families when the prognosis of their current condition was poor.

In seven cases some opportunities for learning were identified but none were deemed to be avoidable deaths. The potential learning from these have been fed into two of our safety streams: 'responding to the deteriorating patient' and 'fetal monitoring'. An additional theme was not following the recommendations in the Trust guidelines of referring patients with a history of multiple miscarriages and foetal concerns to an obstetrician-led antenatal clinic. Cases are shared with the safety stream leads to ensure the improvement work covers the findings of the SJRs.

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

- Review of pathways of care for head injury patients in the trauma service
- Raise awareness of the guidelines for referral to consultant led antenatal clinics
- Carry out an audit on a representative sample of patients of the documentation of National Early Warning Score (NEWS) and escalation of triggers in line with Recognising the Deteriorating Patient – Management and Escalation of Adult Patients and implement the appropriate actions in response to the findings

We expect that the impact of these actions will be improvements in the overall quality and safety of care provided to our patients. On a trustwide level, we have seen a reduction in avoidable deaths compared to last year.

Seven day hospital services

The seven day services programme is designed to reduce the discrepancy in care quality provided by Trusts to patients admitted during the week or those admitted during the weekend. We are currently meeting three of the four priority standards, those numbered: (5) seven-day access to diagnostic services; (6) 24 hour, 7 day a week access to consultant directed interventions; and (8) twice daily consultant review for patients with high dependency needs.

We continue to fall below the target in Standard 2 that 'all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital'. Given the way we organise our specialist services, we continue to have confidence that our medical model provides appropriate expertise should patients require it. We are clear that the forecasted recurrent cost of delivering such rotas (circa £2million) would not make significant enough impact on improving care quality to justify this spending. This approach has previously been well understood by our CCGs and NHS Improvement.

Although not formally audited as priority standards, we continue to make good progress in improving the areas of care that relate to the experience, safety and flow of patients through our services (which are represented by the non-priority standards 1,3,4,7,9 and 10).

Speaking up

Freedom to Speak Up (FTSU) promotes and encourages the raising of concerns from NHS workers, sub-contractors and volunteers to ensure patient safety is maintained at all times and to make the health service a better place to work. We are committed to embedding an open and transparent culture in which staff members and volunteers feel empowered to raise concerns, with confidence that these concerns will be acted upon and without fear of detriment for speaking up. To this end, we have enhanced our processes and structures to support speaking up and ensure that all staff members demonstrate the values and behaviours required to deliver this in practice.

At present we have five FTSU guardians in the Trust, with one vacancy. They are all volunteers and from a broad range of backgrounds. They perform their guardian role in conjunction with their primary employment, with protected time of 0.1 whole time equivalent (WTE) for their FTSU role. A 0.5 WTE guardian was recruited in 2019 to lead on the strategic direction for the Trust, freeing other guardians to focus on raising awareness and casework.

Responsibility for FTSU has moved from the people and organisational development directorate to the corporate governance team, part of the CEO's office. A non-executive director and the director of corporate governance & Trust secretary actively support the FTSU agenda, and the guardians have direct access to all of them.

FTSU is introduced at Trust induction and is included in the 'active bystander' training package.

A FTSU strategy was passed by the Trust Board in January 2020, giving direction to the service for this year. One aim is to deliver a more 'joined up' way of working across the Trust.

We also have a raising concerns policy, which details the different ways in which staff can speak up, including through their immediate management team (most concerns are resolved this way), HR, and our FTSU guardians. This is being reviewed at present to ensure it represents our current offer and best practice.

Rota gaps

We have 785 doctors in training working at the Trust, with 50 gaps on the rota. Twenty-five of these gaps have been filled by locally employed doctors. We have 14 unfilled posts, 11 of which are being recruited to. The remaining 11 are going through the approval to recruit process. In addition to recruiting, we take action each month to make sure that the rotas are filled, including proactive engagement with Health Education England so we can accurately plan targeted campaigns for hard to recruit specialties and the use of locums where necessary.

1.3 Reporting against core indicators

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

Mortality

As part of our drive to deliver good outcomes for our patients we closely monitor our mortality rates. We do this by using two measurement methods: SHMI (Summary Hospital-level Mortality Indicator) and HSMR (Hospital Standardised Mortality Ratio). Both of these data sets allow us to understand our mortality rate when compared to our peers. However, the two measures differ slightly in methodology. SHMI measures all deaths that occur in England, including those that occur within 30-days of discharge from hospital and is the official mortality measure for England. HSMR measures more variables than SHMI, such as patients receiving palliative care, deprivation and whether the patient has been transferred between providers. We believe using both measures gives us the best picture of our mortality rate across our hospitals:

SHMI

	National performance 19/20*			Trust performance			
	Mean	Best	Worst	2019/20*	2018/19	2017/18	2016/17
SHMI	100	69.09	119.57	69.09	73.21	74.13	75.54
Banding**	-	-	-	3	3	3	3
% deaths with palliative care coding	36.79%	N/A	N/A	57.86%	57.7%	56.7%	54.9%

*Most recent available data range 01 Dec 2018 to 30 Nov 2019; next update available 14 May
**SHMI Banding 3 = mortality rate is lower than expected
Source: NHS Digital

HSMR

	Trust performance*		
	2017/18	2018/19	2019/20
HSMR	67.37	64.0	66.97
National performance	2nd lowest HSMR of all acute non-specialist providers	Lowest HSMR of all acute non-specialist providers	Lowest HSMR of all acute non-specialist providers

*Dates cover January-December performance
Source: Dr. Foster

We believe the reasons for these results are as follows:

It is drawn from nationally reported data

- We have reported a lower than expected SHMI ratio for the last three years.
- We have the lowest SHMI ratio of all acute non-specialist providers in England, across the last available year of data (1 Nov 2018-31 Oct 2019).
- We have the lowest HSMR of all acute non-specialist providers across the last available year of data (66.97 from January – December 2019).

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

- Continuing to work to eliminate avoidable harm and improve outcomes.
- Reviewing every death which occurs in our Trust and implementing learning as a result, as described above in the 'Learning from Deaths' section.

Patient reported outcome measures (PROMs)

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

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

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 NHSE.

	National performance*			Trust performance		
	Mean	Best	Worst	2018/19*	2017/18	2016/17
Hip replacement surgery (EQ-5D)	0.457	0.546	0.348	0.480	0.464	0.443
Knee replacement surgery (EQ-5D)	0.337	0.406	0.262	0.310	0.298	0.276

*2018/19 data is latest full year of data available
Source: NHS Digital

We believe that our performance reflects fact that:

- we have a process in place to collect, collate and calculate this information on a monthly basis, which is then sent to NHS Digital.
- data is compared to peers, highest and lowest performers, and our own previous performance.
- we are preforming above the mean for hip replacement surgery, and slightly below the mean for knee replacement surgery; however we have continued to improve our performance in this area year-on-year since 2016/17. We will continue to focus on improving our performance in these areas.

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

- We now have a dedicated nurse in post to oversee the process and continue to put patient experience and improvement at the top of our quality agenda.

28 day readmissions

	National mean	2019/20*	2018/19	2017/18	2016/17
28-day readmission rate (Patients aged 0-15)	9.87%	4.72%	4.88%	4.92%	5.15%
28-day readmission rate (Patients aged 16+)	8.87%	7.43%	6.75%	6.92%	6.64%

*Last full year of data available (November 2018 – October 2019)

We believe our performance reflects that:

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

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

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

Patient experience

One way in which we measure patient experience is by collating the results of a selection of questions from the national inpatient survey focusing on the responsiveness to personal needs. Our performance, compared to peers as well as our previous performance, is listed in the table below.

	National performance 19/20*			Trust performance				
	Mean	Best	Worst	2018/19	2017/18	2016/17	2015/16	2014/15
Score	67.2	85	58.9	65.2	68.8	67.3	67.6	68

*Latest data available from NHS Digital.

We believe our performance reflects that:

- we have systems and processes in place to collect this data
- we are performing slightly below the national mean drawn from the nationally reported data from the National Inpatient Survey, which was published in August 2019.

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

- Increasing the FFT response rate is one of our key priorities for this year
- Improving response rates will allow us to better understand the experiences of patients and to identify areas for improvement
- Better utilizing our Patient Led Assessments of the Care Environment (PLACE) data, including creating a formal action plan for 2020.

Staff recommendation to friends and family

The extent to which our staff would recommend the Trust as a place to be treated is another way to measure the standard of care we provide. Our performance, compared to our peers and our previous performance, is listed in the table below.

	National performance			Trust performance			
	Mean	Best	Worst	2019/20	2018/19	2017/18	2016/17
Percentage of staff who would recommend the provider to friends and family needing care	70.5%	87.4%	39.7%	75.8%	71.7%	73%	70%

We believe our performance reflects that:

- We utilise nationally reported and validated data from the national staff survey.
- Our results are slightly above average for acute trusts.

The 2019 staff survey saw our biggest ever response rate with 52 per cent (5659) of staff participating. This is over 2000 more responses than any previous survey we have run. Our overall engagement score increased from 7.0 to 7.2 which is above average and was the most improved engagement score in London. The score for all ten themes within the survey have improved since 2019.

The Trust launched its people strategy in 2019 where we introduced a number of significant initiatives to improve staff experience including:

- The launch of our Living our Values culture programme.
- Almost 3,000 staff involved in the development of the Trust's behavioural framework – designed by our people, for our people.
- People processes such as corporate welcome (induction) and PDR (appraisal) have been redesigned to support the Living our Values programme and the behavioural framework.
- Over 1,300 staff have experienced the Living our Values programme (which has at the core of it a one-hour workshop) with a commitment that all our #ImperialPeople will be touched by the programme by the end of the year.
- The launch of the active bystander programme (we are the first NHS trust to run this) which supports staff to challenge negative behaviours in the workplace.
- A reverse mentoring scheme for BAME nurses and midwives and the executive team.
- New staff networks launched including BAME, LGBT, Women's and disabilities.
- New leadership development programmes for junior doctors, consultants and general managers launched in 2019.
- Two major wellbeing initiatives launched; mental health first aid for managers and a fast track physio service.
- An impact maintenance fund where staff can apply for funding to improve the state of our estate.

In 2020/2021, we intend to take the following actions to improve this percentage, and so the quality of our services, by:

- Consolidating these initiatives, while continuing to pay attention to priority areas of the staff survey: bullying and harassment and health and wellbeing.
- Implementing a programme of pulse surveys to monitor staff experience and engagement in major Trust-wide initiatives or campaigns.

Patient recommendation to friends and family

The Friends and Family Test (FFT) is a key indicator of patient satisfaction which asks patients whether they would be happy to recommend our Trust to friends and family if they needed similar treatment.

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

A&E Friends & Family Test

	Trust performance			
	2019/20	2018/19	2017/18	2016/17
% would recommend	93%	94.26%	94%	95%

We believe our performance reflects that:

- We utilise nationally reported and validated data
- We have actively monitored our performance throughout the year.
- We have almost met our target for the percentage who would recommend our A&E services (average 93 per cent) and met our target for the response rate of 15 per cent.
- We are better than the national average for our A&E response rates and similar for our likely to recommend score.

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

- Continuing to take steps to improve and ensure that waiting and delays are kept to a minimum and, where they are unavoidable, patients are kept informed.
- Continuing to improve our environment with improvements made to our Charing Cross Hospital A&E services in the past year.
- Reviewing how we support patients to access food and drinks when waiting in our A&E departments by setting up a working group. We will focus in St Mary's Hospital A&E in the first instance.

Inpatient Friends and Family Test

	Trust performance			
	2019/20	2018/19	2017/18	2016/17
% would recommend	97%	97.42%	97%	97%

We believe our performance reflects that:

- We utilise nationally reported and validated data
- We have actively monitored our performance throughout the year.
- Our average inpatient FFT likely to recommend rate was 97 per cent, above our 94 per cent target and similar to last year's performance.

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

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

- Continuing to improve our volunteering service building on the successful introduction of patient support volunteers (kindly sponsored by Imperial Health Charity).
- Continuing our improvement project called 'eat and drink, move and sleep' (MOVE) which was launched in 2018/19 in response to patients telling us that noise at night and the quality of our food is a problem. In response, we will implement a malnutrition screening tool in our patient electronic records and introducing 'sleep easy' boxes across 18 wards as part of the 'sleep' element of the project. Over the next year we will focus on implementing the 'Time to Eat' guidelines across the inpatient areas and have begum bespoke projects in areas such as paediatrics. We have seen improvements in patient activity with more patients sitting out of bed as part of the 'move' element of the work. This has also helped to promote the 'eat' element as we encourage patients to sit out for meals.
- Increasing deaf awareness by introducing the use of blue deaf awareness bands for patients and the use of deaf awareness cards. This project is driven by feedback from one of our patients who suggested the use of blue bands.
- Improving how we use patient experience data. Work is continuing to develop the natural language processing tool. This helps us to learn how to extract comments and themes from patient feedback so we can use this to continue to make improvements across our services.
- Our Learning Disability and Autism Policy has been updated and will be published in April 2020. We have incorporated our new learning disability 'purple pathways' that include learning from incidents to highlight the risk of aspiration pneumonia and constipation to staff.
- Working to improve care for young people moving from paediatric to adult services. We have introduced the HEADSS Risk Assessment tool (home; education, employment, eating and exercise; activities and peer relationships, social media; drug use, including prescribed medications cigarettes, alcohol and other drugs; sexuality and gender; Suicide and depression (including mood and possible psychiatric symptoms), spirituality and safety. This gives a structured approach to understanding young people's needs, enabling the clinical teams to provide appropriate support.
- We have held two adolescent transition clinics to date and expect to expand upon this next year. The clinics have been well-received by young people and their parents.
- The patient affairs and bereavement services have relocated to the nursing directorate. We are looking at how we can improve our end of life care across the Trust with the new end of life big room starting this year and an end of life nursing lead being developed.
- The Patient Experience Network (PEN) has been launched. This provides a forum whereby staff can meet to share best practice and ideas.

Venous thromboembolism

Venous thromboembolism (VTE) is a blood clot within a blood vessel that blocks a vein, obstructing or stopping the flow of blood. The risk of hospital acquired VTE can be reduced by assessing patients on admission.

	National performance*			Trust performance			
	Mean	Best	Worst	2019/20*	2018/19	2017/18	2016/17
Percentage of patients risk assessed for VTE	95.47%	100%	71.83%	96.27%	95.39%	93.87%	95.33%

Source: NHS Improvement; 2019/20 includes only Q1-Q3; Q4 unavailable (published on 4 June).

We believe our performance reflects that:

- We utilise nationally reported and validated data published quarterly by NHS England.
- We have monitored VTE risk assessments on a monthly basis throughout the year. While we did not meet the 95 percent target during the first quarter, our improved performance across the second and third quarter contributed to an average compliance across the year of 96.27 per cent.

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;
- Reviewing our compliance with national guidance and are developing reports which will allow us to better monitor the percentage of patients who received appropriate prophylaxis and the outcomes of root cause analysis into VTE cases.
- Continuing to take part in the Getting it Right the First Time (GIRFT) thrombosis survey.

Clostridium difficile

For 2019/20, Public Health England changed the surveillance definitions for Clostridium difficile. From April 2019, any cases of C. difficile within 48 hours of admission have been classed as hospital acquired (previously this was 72 hours). This means we are unable to compare our performance in 2019/20 with the previous year. It also means that our target for C. difficile was increased accordingly from 68 to 77.

	National performance*			Trust performance			
	Mean	Best	Worst	2019/20	2018/19	2017/18	2016/17
Rate of Clostridium difficile per 100,000 bed days	48 cases	0 cases	147 cases	19.6 (72 cases)	14.3 (51 cases)	17.6 (63 cases)	18.03 (63 cases)

*National performance does not include March 2020

We believe our performance reflects that:

- We utilise nationally reported and validated data
- We monitor performance regularly through our Trust Infection Control Committee and weekly taskforce meeting.
- In 2019/20, we reported 101 cases of C. difficile attributed to the Trust; 72 of these cases were hospital onset, and 29 were community onset. This is above our target of 77.1 of these cases were related to lapses in care, compared to 11 last year.

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

- continuing to work on reducing the use of anti-infectives (antibiotics) and improving our hand hygiene rates (as described above).

Patient safety incidents

An important measure of an organisation's safety 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	2019/20	2018/19	2017/18	2016/17
Patient safety incident reporting rate per 1,000 bed days	Apr-Sep 19: 49.8	Apr-Sep 19: 103.8	Apr-Sep 19: 26.3	Apr-Sep 19: 50.7 Oct 19 – March 20: 50.4	Apr-Sep 18: 50.4 Oct 18 – March 19: 45.8	Apr-Sep 17: 47.96 Oct 17 – March 18: 51.26	Apr – Sep 16: 42.3 Oct 16 – Mar 17; 46.82

*Latest data available from NRLS reports

We believe our performance reflects that:

- We utilise the nationally reported and verified data from the National Reporting and Learning System (NRLS).
- The data shows all incidents reported by us for the period April – September 2019: our incident reporting rate for this period was 50.7 against a median peer reporting rate of 49.8.
- Our individual incident reporting data is made available by the NRLS every six months, and we have performed slightly better than the national mean during both six-month reporting periods.

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

- improving how we report, manage and learn from incidents. See further detail outlined in our 2020/21 improvement priorities.

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

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

	National performance*			Trust performance			
	Mean	Best	Worst	2019/20	2018/19	2017/18	2016/17
Percentage of severe/ major harm incidents	Apr-Sep 19: 0.23%	Apr-Sep 19: 0.00%	Apr-Sep 19: 1.22%	Apr-Sep 19: 0.03%	Apr-Sep 18: 0.05%	Apr – Sep 17: 0.06%	Apr – Sep 16: 0.08%
(#of incidents)	(15)	(0)	(17)	(2) Oct 19 – Mar 20: 0.04%	(4) Oct 18 – Mar 19: 0.04%	(5) Oct 17 – Mar 18: 0.12%	(6) Oct 16 – Mar 17: 0.06%
				(3)	(3)	(9)	(5)
Percentage of extreme harm/death incidents	Apr-Sep 19: 0.08%	Apr-Sep 19: 0.00%	Apr-Sep 19: 0.7%	Apr-Sep 19: 0.06%	Apr-Sep 18: 0.05%	Apr – Sep 17: 0.09%	Apr – Sep 16: 0.03%
(# of incidents)	(5)	(0)	(24)	(5) Oct 19 – Mar 20: 0.06%	(4) Oct 18 – Mar 19: 0.01%	(7) Oct 17 – Mar 18: 0.05%	(2) Oct 16 – Mar 17: 0.12%
				(5)	(1)	(4)	(9)

*Latest data available from NRLS reports

We believe our performance reflects that:

- We utilise nationally reported and verified data from the NRLS
- Between April and September 2019 (most recent national data available), we reported 0.03 per cent severe/major harm incidents (two incidents) compared to a national average of 0.23 per cent and 0.06 per cent extreme/death incidents (5 incidents) compared to a national average of 0.08 per cent.

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 2020/21 Improvement Priorities" section for more detail.

Part 2: Other information and annexes

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

Our performance with NHS Improvement single oversight framework indicators

NHS Improvement uses a number of national measures to assess services and outcomes. Performance with these indicators acts as a trigger to detect potential governance issues. We report on most of these monthly to our Trust Board through our integrated quality and performance report (IQPR).

Key performance indicators

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

		Performance		Quarterly trend			
		Target	Annual	Q1	Q2	Q3	Q4
Referral to treatment times	% incomplete pathways less than 18 weeks (in aggregate)	92%	82.01%	85.45%	83.67%	80.4%	77.74%
Diagnostics	Maximum six week wait for diagnostic procedures	1%	1.53%	0.88%	0.81%	1.17%	3.27%
Cancer access initial treatments	Two week wait	93%	89.0%	91.97%	84.40%	90.13%	89.85%
Cancer access initial treatments	Breast symptom two week wait	93%	93.6%	93.83%	94.80%	94.37%	90.5%
Cancer access initial treatments	% cancer patients treated within 62 days of urgent GP referral	85%	85.8%	88.7%	86.83%	86.73%	78.05%
Cancer access initial treatments	% patients treated within 62 days from screening referral	90%	78.8%	81.47%	81.07%	79.87%	69.8%
Cancer access initial treatments	% patients treated within 62 days (upgrade standard)	85%	84.5%	87.20%	87.67%	82.13%	79.4%
Cancer access initial treatments	% patients treated within 31 days of decision to treat	96%	97.1%	97.67%	97.17%	96.97%	96.55%
Cancer access subsequent treatments	Surgical treatments within 31 days	94%	96.9%	97.69%	97.90%	95.70%	95.9%
Cancer access subsequent treatments	Chemotherapy treatments within 31 days	98%	99.9%	100%	99.60%	100%	100%
Cancer access subsequent treatments	Radiotherapy treatments within 31 days	94%	97.9%	97.17%	100%	96.77%	97.6%
Infection control	C. difficile acquisitions	77	101	25	28	27	21

In May 2019, the Trust began testing proposed new A&E standards as one of 14 hospital trusts in England. Like other trusts involved in the testing, figures on the A&E four-hour access will not be published for the pilot period and are therefore not included above.

Our performance in other key areas

In addition to our core 2019/20 improvement priorities described above, we have made progress in a number of other quality areas and initiatives. We have included this information as it represents a broad spectrum of our quality activity across various parts of our organisation; the below include patient led initiatives such as PLACE, as well as developments in our clinical services and our on-going clinical information technology programme.

Pressure ulcers

A pressure ulcer is a type of injury that affects areas of the skin and underlying tissue. They are caused when the skin is placed under too much pressure. They can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. We reported twenty one category three and un-stageable Trust acquired pressure ulcers in 2019/20, which is one less than last year. We have not reported a Trust acquired category four, the most serious of pressure ulcers, since March 2014. We have nominated skin champions in each of our clinical areas and we run quarterly study days for our staff in the prevention of pressure ulcers and wound care.

PLACE

All patients should be cared for with compassion and dignity in a clean, safe environment. PLACE began in 2013 as an annual patient-led initiative to monitor and score the environment based on six criteria. The assessments provide a clear message, from patients, about how the environment or services might be enhanced. PLACE focuses entirely on the care environment and does not cover clinical care provision or how well staff are carrying out their roles.

In 2019, we introduced a number of changes to PLACE, including: changing when we complete the assessment to later in the year; the questions asked; and the scoring/weighting mechanisms. As such, results are not directly comparable with previous years.

This year's assessment still contained the six areas listed below, and the Trust performance is summarised against each:

- Cleanliness – all hospitals scored above national average.
- Food and hydration – Trust scored above average, with only one site slightly below.
- Privacy, dignity and wellbeing – each hospital was below average, as a Trust <three per cent below national average score.
- Condition, appearance and maintenance – all scores were above national average.
- Dementia – all sites scored above national average.
- Disability – Trust scored above average, with only one site slightly below.

It is difficult to compare to last years' standings due to changes in the PLACE system in 2019. However, advances in wayfinding and a steady improvement programme, including small impact works, have contributed to a generally good picture. The PLACE Steering Group is now taking this work forward with a formal action plan for the 2020 round of assessments.

Genomic medicine service

The NHS genomic medicine service went live in April 2020 and is available as a routine test, in the right circumstances, to our patients. The service includes single gene testing, whole genome sequencing (WGS), gene sequencing and personalised treatment plans and has the potential to change the way we deliver health care by providing consistent and equitable care to patients. As a new service we will operate to common national standards, specifications and protocols using a single national testing directory and building up a national genomic knowledge base to inform academic and industry research to help new drug discovery. Consolidating existing services such as lab testing, genetics and multi-disciplinary meetings and improving access to these tests will continue to transform how the NHS will diagnose, treat and care for patients.

'Streams' results viewing

We have partnered with Google Health to implement Streams, an app which allows Imperial clinicians to view patient's blood results, radiology results and observation data securely on their own mobile device. This will allow better access to key clinical data at the bedside or while on-call and should reduce time taken to take clinical decisions should a patient's condition change. Implementation across the Trust will continue in 2020.

App developments for 2020/21 include displaying deteriorating patient flags (National Early Warning Score, acute kidney injury and sepsis) and clinical documentation. The partnership will also explore the practical implementation of A.I. and machine learning into clinical services, such as breast screening.

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

The following organisations were invited to provide statement on our quality account:

North West London Collaboration of Clinical Commissioning Groups

NHS Brent CCG
NHS Central London CCG
NHS Ealing CCG
NHS Hillingdon CCG
NHS Harrow CCG
NHS Hounslow CCG

Central and West London Healthwatch
Brent Healthwatch
Ealing Healthwatch
Barnet Healthwatch
Hounslow Healthwatch
Hillingdon Healthwatch

City of Westminster
London Borough of Hammersmith and Fulham
London Borough of Ealing
London Borough of Brent
Royal Borough of Kensington and Chelsea
London Borough of Harrow
London Borough of Hillingdon
London Borough of Hounslow

Due to the COVID-19 pandemic the draft quality account was shared with stakeholders electronically and staff from the Trust were not available to attend meetings or overview and scrutiny committees to answer questions in person. Stakeholders were invited to share any questions via email with a named individual from the Trust. The Trust received the following written responses:

Hammersmith and Fulham response Health and Social Care Policy and Accountability Committee response to Imperial Health Care Trust Quality Account 2019-2020

1 Introduction

1.1 We thank Professor Tim Orchard and his staff for their continuing dedication and compassion, performing so well during the COVID crisis and send our condolences for those Trust staff who have died. This has been an unprecedented time and the Trust's staff at all levels have shown great leadership and commitment to supporting local people and engaging with partners. We are impressed by much in the report especially:

- Those areas where the Trust is performing above average against national indicators [paediatrics, cardiac care];
- The achievement of good outcomes on all the services audited by CQC this year; and
- the achievement of outstanding ratings in the recent CQC audits.

1.2 There are also several areas that we have highlighted which we believe would benefit from further attention and some that we would like to review as part of HISPAC's work next year

2 Improvement methodology

2.1 The Improvement Team

The Trust has a dedicated quality and improvement team, implementing Institute for Health Care Improvement methodologies. A new Imperial Management and Improvement System has identified this year's priorities. There is a significant culture change programme in place, that should itself be a focus, as it provides impetus for a Trust wide organisational change

2.2 Benchmarking

We expect Imperial to be a leader in this area and the significant investment in quality improvement reflects this. It would be useful to benchmark the team itself against best practice elsewhere, including the level of resourcing.

2.3 Programmes

The report summarises several innovative improvement initiatives. Going forward the scope and effectiveness of the such key programmes as the Living our Values, the Imperial Flow Coaching Academy, Improving Care Programme Group as well as more targeted initiatives such as HOTT (Helping Our Teams Transform), the Falls Bundle, Connecting Care for Children, Connecting Care for Adults, would all benefit from being highlighted in detail.

2.4 Reporting

A clearer view of the overall work programme and its objectives would be more effective. An understanding and evaluation of results is integral to informing the Trust's culture change programme.

Overall a different form of reporting is required. Whilst we appreciate that the Quality Account is

written according to a specific remit and is meant to be a summary, we feel that its format could be improved for next year to be more user friendly. Suggestions would be to allow greater consistency year on year with the format of the tables to enable clearer comparisons, extended timelines for the Committee to provide input, and clarification about protected data.

3 This year's programmes

3.1 COVID-19 impact

Clearly the Trust's attention has been focused on the COVID-19 crisis and it has made a massive commitment to manage the new situation. Going forward it will impact on Trust performance at every level and it may be worth revisiting the improvement targets and consider adjustments.

Potential refinement of several key areas will need to be addressed

- Treatment backlog

The backlog of planned non-COVID 19 treatment is likely to put pressure on the system as it attempts to return to normality. It would be helpful if plans could be shared when they are available [see also below].

- Staff exhaustion

Staff have worked remarkably hard, under enormous pressure facing a serious and uncompromising threat to their own health and that of their families, friends and neighbours. When the pandemic finally retreats, staff who may already be physically and nervously exhausted, will face an enormous deferred treatment backlog. The trust will need to develop a support programme for very tired staff.

- Learning from the crisis

Assessing lessons learned will need a critical view point to distinguish improvements that can be mainstreamed, for example, a significant improvement in collaborative working and faster decision making, from improvements that are the product of significant extra resources combined with a significant reduction in demand.

3.2 Patient engagement involvement

the Trust as well as the Local Authority are developing their engagement with the public to improve services. The engagement with patients is visible across the Quality Audit but should also be highlighted in its own right. In addition, there has been an upsurge of volunteering across the public sector which represents a unique opportunity for a step change in public engagement and co-production.

3.3 Improvement Priorities for 2020/2021

- **COVID-19 impact**

Clearly the Trust's attention has been focused on the COVID-19 crisis and it has made a massive commitment to manage the new situation.

Across the board targets will be impacted by COVID 19 which will distort staff and patient responses, and impact on activity at all levels.

There will be a need to review the improvement targets altogether

- **Five Improvement Targets**

The current five key improvement targets have the advantage of addressing areas that staff across the trust can contribute to. Family and friends' response rates; rates for staff feeling able to make improvements and improved incident reporting rates are enablers for change; reducing agency costs is a key staffing measure. Patients waiting over 21 days is an index of flow effectiveness, and therefore of partnership working

Flow issues have received a lot of attention within the COVID guidance and there will be a significant opportunity for stakeholders across the system to contribute to improved performance

- **Older people**

This is not an area addressed in the report. Covid-19 has demonstrated the particular vulnerability of older people to such epidemics which may recur.

We would appreciate some detail on the performance of older people's services in the Trust, and in particular a discussion about possibilities for deeper planning for this age cohort. We note, for example, that delays to hip and knee replacement continues to be a concern. These conditions disproportionally effect older people and delays may have serious consequences for that group's ability to participate in the life of their community, undertake caring commitments, result in increased social isolation and the risk of further deterioration. A designated action plan is required, and the Committee would welcome further engagement in developing this. Its production presents major opportunities for public engagement and co-production.

- **Capital programmes and use of resources**

Use of resources is now one of the CQC priorities and made the difference in the Trust being able to achieve a Good rating overall. The physical environment also impacts significantly on patient and staff's assessment of the service, both in A&E and in the hospital overall and is a particular quality issue for Imperial given its significant maintenance backlog, which should also be focused on going forward. Given the significant backlog repairs and modernisation work the Committee would like the Trust to share an action plan which addresses the impact of the

physical infrastructure limitations and how this would affect the CQC rating.

4 Progress against last year's priorities

4.1 Reduce avoidable harm

In general, there has been considerable work against last year's priorities, but a number of areas suggest that further follow up work may be required, and we would like to highlight the following:

It would be helpful to have areas where incidents have occurred tabulated to clearly emphasise their relative significance. Improvements are not quantified in several areas [safer medicines, deteriorating patient mental health in ED patient, fetal monitoring]. It would perhaps be helpful to have a dashboard against this priority.

Particular issues are:

- **Incident reporting**

The Trust reports that incident reporting rates are below national average, and this remains a priority in 2020/2021. It would be helpful to have better tabulation of the causes of reported incidents going forward.

- **Improving hand hygiene**

Compliance has increased but this is in one of the areas that we would expect to improve radically following COVID-19 requirements.

- **Reducing falls with harm**

This is a key programme that would benefit from further highlighting particularly on the scope objectives and effectiveness of the new Falls Bundle

- **Responding to the deteriorating patients with mental health problems in the emergency department**

This pathway continues to face challenges, and this is an area of concern which suggests that further work with the mental health trust, local authority and commissioners to manage flow outside the hospital is required. This would be a useful area for the Committee to scrutinise.

On page 6, the target "reduce harm to patients" mentions "treatment delay (availability of downstream mental health beds)." This needs considerably more detail given the importance of mental health in our community which leads the Committee to ask the following questions:

1. **What are the numbers of patients affected or involved?**
2. **Does the lack of beds mean that beds were simply not available locally or across London? This is important as there** is much evidence of patients being sent to beds far from their families and communities.
3. **Is the lack of suitably the qualified mental health staff a factor?**
4. **Do we have detail on the social background, age groups and gender of the affected patients?**
5. **What liaison is there on this matter (Q4) with local authorities?**
6. **Most important, if this situation is not "one off" what mitigations are planned for what may be an ongoing situation.**
7. **The Committee would like to know what work the Trust is doing on this area with local mental health trusts (West London Mental Health Trust).**

It is encouraging to hear that the Flow coaching academy is focusing on mental health including in ED and this may provide the opportunity to address this in more detail.

4.2 Reducing unwarranted variation

This is a significant area of work with 50 flow coaches supporting 20 clinical pathways of which four are highlighted. A consistent measure of variation is not used. It would be helpful to have a dashboard to get an understanding of the overall programme and an assessment of its effectiveness. 4.3 Improving access to services across the Trust through a focus on increasing capacity and improving emergency flow.

London Borough of Brent Community and Wellbeing Scrutiny Committee's response to the draft Quality Accounts for 2019/20

Imperial College Healthcare Trust: Quality Accounts 2019/2020

The scrutiny committee again welcomes the publishing of the Trust's Quality Accounts because of the transparency and public accountability they provide. Overall, the Accounts have helped the committee to understand the Trust's focus on quality improvement in 2019/2020 and the Trust's ambitions to deliver better outcomes for its patients in the year ahead.

The Quality Accounts clearly set out the six areas for improvement in the next year. However, it is not clear why reducing temporary staffing spend is one of the priorities and we would have liked for the relationship between temporary staffing and improvements in quality to have been more clearly set out. In addition, the table setting out the six areas does not identify clear metrics for improvement, which would help us to better understand the scale of your ambitions for the next year. For example, while we welcome the inclusion of the Family and Friends Test it could be made clearer what target for progress metrics you aspire to in 2020/2021; and how performance will be monitored by the Board. It would also be useful to

have benchmarking on such a measure, against other comparable Trusts or national statistical averages.

We also welcome that the Trust has identified a key priority for improvement as the percentage of staff who feel they are able to make improvements in their area. Engaging with the views of staff is very important and helps to deliver high-quality care. It is also right for the Trust to emphasise values and behaviours and for the Trust to promote these values at all levels of the organisation. The Quality Accounts make it clear that the leadership and the Board are committed to an open organisational culture in which staff feel they can raise concerns and we note the commitment to the Freedom to Speak Up initiative and a Raising Concerns policy. However, the scrutiny committee would have liked to have seen more evidence of how these initiatives and policies have led to learning and quality improvements in the last year, by citing examples.

Views of the Care Quality Commission as the regulator of the Trust are very important. The Quality Accounts consider that last year there was the publication of the outcome of three CQC surveys of patients: Adult Inpatient Survey, Urgent and Emergency Care Survey, and the Children and Young People Survey. However, while it's a good practice that areas of dissatisfaction or negative experiences are recorded; they are not described in great detail, and it's not clear from the Accounts how these will be areas for improvement or what improvements were made in these areas. The Quality Accounts identify the results of four inspections and highlight where it has been rated Good, but it would also be useful for the purpose of the Quality Accounts to focus on the areas which were identified as Requires Improvement, and how this will be taken forward next year.

Over the eight core quality indicators it is very welcome that the Quality Accounts have applied the rigour of stating the Trust's performance over a period of time, and also giving the benchmarking information of national averages, using averages from the best to the worst, using data where it is available. We can clearly see how the Trust ranks against others, and how performance has changed over time across these important indicators, or in other words 'the direction of travel'. It is also clear from the Quality Accounts how the Trust intends to improve on its targets in the next year and what actions it will put in place – and it is a good practice that these are clearly listed under each of the core indicators.

More generally, the committee welcomes the Trust's commitment to using high-calibre data. It is not enough to say that an organisation is committed to data quality in principle. The committee appreciates that the Quality Accounts set out how the Board and leadership have sought assurance that the data they work with is robust and fit for purpose through the Data Quality Improvement Programme (DQIP), and reporting of any improvements or areas of concern to the Audit, Risk and Governance Committee.

Last year a priority for improvement in the Quality Accounts was to improve compliance with the equality and diversity standards, and metrics were set out. We would expect all healthcare Trusts to be committed to reducing inequalities in access to care and outcomes of care. This is especially so for the Trust's patients who live in the London Borough of Brent which has one of the most diverse populations in London and one of the highest percentages of Black and Minority Ethnic (BAME) groups of any London borough.

Increasingly, many of these communities are experiencing widening health inequalities, and early evidence suggests this has been a factor in the Covid-19 pandemic. The Quality Accounts for 2019/20 do make reference to Covid-19 throughout the document and the committee would like to see how this area of inequalities and BAME populations will be taken forward in the next year in more detail.

Finally, the scrutiny committee would like to thank formally all the staff at Imperial College Healthcare Trust for the care they have provided to many people in the London Borough of Brent in the last year and especially in their response to the Covid-19 pandemic which has placed great pressures on staff and healthcare services at the Trust.

Cllr Ketan Sheth, Chair

Brent Council Community and Wellbeing Scrutiny Committee

Response from the Westminster Adult's and Children's Services Policy and Scrutiny Committee

Introduction

The Westminster Adult's and Children's Services Policy and Scrutiny Committee welcomes the opportunity to comment on the Imperial College Healthcare NHS Trust Quality Account 2019/20.

Quality progress 2019/20

We are pleased to see progress in reducing avoidable harm to patients. We note that the Trust incident reporting rate is above the national average. We welcome its continued commitment to identifying barriers to reporting and promoting a supportive reporting culture. This was also an area of success for the Trust in 2018/19, and we commend the continued focus in this area.

We note that there have been 266 serious incidents, with the highest category being the result of treatment delay due to availability of downstream mental health beds. While we are pleased that the percentage of moderate and above incidents is below the national average, we encourage the Trust to continue to review and learn from its serious incidents, particularly those resulting from treatment delay, to help reduce the numbers in future.

Improving care for patients with mental health problems in the Emergency Department was a focus for the Trust during 2019/20. We note that the Trust continues to face challenges with the timely transfer of these patients to more appropriate settings. We are pleased the Trust is committed to working collaboratively with colleagues in mental health services to improve in this area and we hope that this work leads to a more responsive service.

We are pleased that significant progress was made in 2019/20 towards improving hand hygiene, especially as this will continue to be an important area of focus during the COVID-19 pandemic. This was also an area of improvement in 2018/19 and we commend the Trust for maintaining improvements in this area.

The Imperial Flow Coaching Academy was established to reduce unwarranted variation and promote best practice. We are pleased about the improvements this has led to across different clinical pathways; for example, in the Sepsis Pathway a 24% reduction in mortality and a 7% reduction in length of stay.

Improving access to patients waiting for elective surgery was an area of focus for the Trust in 2019/20. We acknowledge that the COVID-19 pandemic has affected the size of waiting lists due to all non-urgent elective inpatient procedures being stood down in March 2020. We are pleased to see that in Q3 the Trust overperformed against the RTT target agreed with commissioners. However, we do note that the Trust did not meet its percentage target and encourage continued investigation of this at a specialty level.

Standards set by NHS England state that no patient should wait more than 52-weeks for their treatment to start following referral. We are concerned that in Q3 there was a rise in 52 week waiting patients, with 14 patients being reported in the period.

We are concerned that the Trust's staff survey results indicate that more needs to be done to improve equality and diversity. We encourage the Trust to continue to do work in this area and to ensure that staff at all levels are engaged with about this.

In 2018/19 the previous committee noted the Trust had not achieved its 4 hour wait target for A&E. We note that in 2019 the Trust was one of 14 hospitals to test new A&E standards. We will be interested to see the results of this test.

We were pleased to see that the Trust's quality ratings from the CQC have improved for a range of services inspected across its hospitals in February 2019.

Priorities for 2020/21

We note that for 2020/21 a new model (The Imperial Way Model) has been established to drive the delivery of strategic goals and objectives set out in the Trust's wider strategy. We are pleased to see this new approach includes engagement with staff at all levels. The model has identified six priority areas for improvement. However, since these priorities were identified, the Trust's primary focus has moved to responding to the COVID-19 pandemic. While the COVID-19 response is now the Trust's central focus it is still important that the Trust continues to look for ways to drive improvements in its service and that it keeps patient safety and quality service at the centre of its decisions.

Conclusion

Overall, the progress that the Trust has made over the last year is welcomed. We appreciate the Trust's collaborative approach towards engaging with the committee, in particular the regular meetings between Committee Chair and the Chief Executive to keep abreast of issues that are affecting the Trust. We hope to continue to work closely with the Trust in 2020/21. Lastly, we want to offer our sincere thanks and appreciation to the Trust and its staff for their continued work as part of the COVID-19 response.

Councillor Iain Bott

Chairman Adult's and Children's Services Policy and Scrutiny Committee.

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 2010 (as amended) 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. While we are not an NHS foundation trust in line with guidance from NHS Improvement we are following the NHS foundation trust regulations in relation to quality accounts.

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:
  - board minutes and papers for the period April 2019 to May 2020
  - papers relating to quality reported to the board over the period April 2019 to May 2020
  - feedback from Clinical Commissioning Groups
  - the annual governance statement May 2020
  - feedback from local Healthwatch and local authority overview and scrutiny committees
  - the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - the national inpatient survey 2019
  - the national staff survey 2019
  - the Head of Internal Audit's annual opinion of the trust's control environment May 2020
  - CQC inspection report dated July 2019
  - The General Medical Council's National Training Survey 2019;
  - Mortality rates provided by external agencies (NHS Digital and Dr Foster).
- the quality report presents a balanced picture of the 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 Audit, Risk and Governance Committee held in May 2020, where the authority of signing the final quality accounts document was delegated to the chief executive officer and chair.

By order of the board

Date: 22 June 2020

Paula Vennells CBE
Chair

Date: 22 June 2020

Tim Orchard
Chief executive

NHS
Imperial College Healthcare
NHS Trust

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