Imperial College Healthcare NHS
NHS Trust

Quality Account 2014/15

Contents

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Statement on quality from the chief executive

Tracey Batten
Chief executive

These are undeniably challenging times for healthcare, with NHS services under increased pressure due to our ageing population. However with these challenges, we have an exciting opportunity when it comes to improving healthcare quality. Events at Mid-Staffordshire have helped to generate a sector-wide commitment to quality, with quality improvement now seen as everybody's business. As we gain more understanding of the different ways we can improve, we are in a better position than ever before to look critically at what we can do better, and test and apply improvements.

At Imperial College Healthcare NHS Trust, we are working to harness these new opportunities in order to provide safe, high quality, patient-centred care for all our patients. This is our commitment as an organisation – but we also want it to become a personal commitment for each of our staff members, from surgeon to receptionist. To achieve this, we will be rolling out a centralised programme of quality improvement training and support to build an organisation-wide culture of continuous improvement. At the same time, patients have a stronger voice than ever before, and we have begun working more closely with the people and communities we serve to make sure that the care they receive is centred on their needs.

2014/15 – an overview

We have seen some inspiring work across our five hospital sites over the past year. We have made significant improvements in patient experience and our mortality rates are amongst the lowest nationally, reflecting the excellent clinical outcomes achieved for many of our patients. However, in some ways, 2014/15 has been a challenging year for us as a Trust. Like many hospitals, we saw unprecedented demand on our A&E departments over winter, which put increased pressure on all our services. 2014 also saw the closure of our A&E department at Hammersmith Hospital, leading to significant changes to the way we provide services for unplanned care. Our Trust was also inspected by the Care Quality Commission (CQC) in September 2014 who gave us an overall rating of 'requires improvement' in their final report. We have put a comprehensive action plan in place to deal with the issues they found. While we have many examples of excellent work and high quality care, we recognise we have much to do to achieve our ambitions.

A focus on quality

In 2013 we launched our first quality strategy, which outlined our aim to put quality at the forefront of everything we do. In 2015 we have worked to develop these ideas further in a second strategy which will be launched in the summer. This strategy is designed to bring our plans in line with the CQC framework and ensure sustainable and continuous improvement across our services. Through this strategy, we want to achieve a rating of 'good' in our next CQC inspection, while striving for 'outstanding' where we can be across our sites and services by the end of 2017.

We will also use it to strengthen confidence and pride in the services we provide. We want patients to be confident that Imperial is among the best in the world – safe, effective, caring, well led, and responsive to our patient's needs. We want people working within and alongside Imperial to know that they are providing the best service they can, and that what they do is important and valued.

Through our annual quality account, we will report progress with delivery of our strategy in future years and will outline priorities for the following year as agreed by our board, following consultation with our internal and external stakeholders and partners.

About this report

Quality accounts were introduced in 2009 to make healthcare organisations more accountable when it comes to quality of care. They are designed to report on how we have performed against the targets we set for ourselves last year, and to share our targets for next year, which we developed after consulting with stakeholders and staff. In these pages you will find some successes of which we are very proud; however there have been disappointments too. Where things have not gone to plan, we show what we believe went wrong and how we plan to tackle the problem.

This year, we present our new priorities under the following domains of quality as defined in our quality strategy: safe, effective, caring, well led and responsive.

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

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

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

We would like to thank everyone who helped us compile our quality account, including members of the public, our people, Healthwatch, Health and Wellbeing Boards, shadow foundation trust members, local authorities and commissioner colleagues.

No document can truly convey the breadth of work taking place across an organisation as large as ours; dedicated work and day-to-day improvements go unreported every day. However, I hope that this quality account paints a clear picture of our commitment to continuous quality improvement, and of how important the safety and experience of our patients are to us all at Imperial College Healthcare NHS Trust.

Dr Tracey Batten
Chief executive, Imperial College Healthcare NHS Trust

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare quality accounts for each financial year. The Department of Health has issued guidance on the form and content of annual quality accounts, which incorporates the legal requirements in the Health Act 2009, the National Health Service (quality accounts) Regulations 2010 and the National Health Service (quality accounts) Amendment Regulations 2011.

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

1. the quality account have been prepared in accordance with Department of Health guidance and present a balanced picture of our performance over the period covered

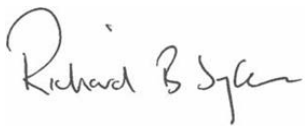
2. the content of the quality account is not inconsistent with internal and external sources of information including:
   - board minutes and papers for the period April 2014 to March 2015
   - papers relating to Quality reported to the Board over the period April 2014 to March 2015
   - feedback from NHS Central London, West London, Hammersmith and Fulham, Ealing and Hounslow Clinical Commissioning Groups
   - feedback from local scrutineers, including Healthwatch and local authority overview and scrutiny committees
   - the Head of Internal Audit's Annual Opinion April 2015
   - the national inpatient survey 2014
   - the national staff survey 2014
   - the General Medical Council's National Training Survey 2014-15
   - mortality rates provided by external agencies (Health and Social Care Information Centre and Dr Foster).

3. There are proper internal controls over the collection and reporting of the measures of performance included in the quality account, and those controls are subject to review to confirm they are working effectively in practice

4. The data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.

The directors have reviewed the quality account at the executive committee meeting on 21 April 2015 and confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality accounts. The quality account was reviewed at our board meeting held on 27 May 2015, where the authority of signing the final quality accounts document was delegated to the chief executive and chair.

By order of the trust board



Chief Executive

Chairman

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Our plans for the future

Our plans for the future

This part of the report sets out our vision for ourselves as an organisation and for the people we care for. It explains our new quality strategy and how that will shape our work – not least, through our trust-wide quality improvement programme. It then sets out our aims for 2015/16, explaining how we selected our priorities across our five quality domains (safe, effective, caring, responsive and well led).

Our vision and objectives

Our vision as a Trust is to be a world leader in transforming health through innovation in patient care, education and research. To deliver this vision, we need to achieve and sustain the following strategic objectives:

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

The objectives reflect our long-term commitment to improve the quality of care, and to ensure that it is delivered to our patients by a skilled, motivated and diverse workforce.

Our new quality strategy is the plan by which we improve our CQC rating to 'good' as a minimum and to 'outstanding' where we can. It will underpin delivery of our overall vision and objectives.

We recognise that delivering this strategy requires a culture shift across the organisation, with a standardised approach to quality improvement. Our aim is to encourage and support our frontline people to make improvements without waiting for permission and with support for delivery. We believe this is the only sustainable way to deliver our ambitious goals.

We have also embarked on a staff-led programme to explore our aspirations for the values, behaviours and promise of the Trust as a healthcare organisation. This work, which has been led by a paediatrician and a midwife, and has been given significant trust board support, has used workshops to engage with 1,300 members of staff to date. This engagement will continue to grow and develop through 2015 and we envisage using the values and behaviours that emerge in our quality improvement work within the Trust.

The quality goals outlined in our quality strategy, and supported here in our quality account, will drive improvement in the care that we deliver. In doing so, they will contribute to all of the objectives and, ultimately, enable us to realise our vision.

Our quality strategy

Our quality strategy is the plan through which we focus on the quality of clinical care across the Trust and ensure that we continuously improve our services. This strategy ensures that quality drives the overall direction of our work. The first strategy was launched in November 2013. In early 2015 we decided to review our strategy following a number of developments including:

- New executive and governance structure
- Clinical strategy agreed in July 2014
- Estates strategy/outline business case agreed in July 2014
- CQC inspection – action plan agreed February 2015 in response to the issues raised

The quality strategy, which will be published in July 2015, sets out our definition of quality, and describes our vision and direction, ensuring that quality is our number-one priority. It then outlines our quality objectives and associated goals, along with the governance arrangements to ensure delivery and sustainability over three years from 2015/16. It is ambitious, setting out our commitment to make quality central to all that we do. Wherever possible, our focus will be on integrating healthcare across community services, social care, embracing new ways of working to improve care for patients and their families.

From 2015 to 2017, our annual quality account will report on progress against the three-year strategy and confirm the priority actions for the following year. The strategy will be supported by the quality strategy implementation action plan, which will enable us to track the implementation of the strategy from ward to board. This ensures sustainability and will mean that our staff are aware of their individual roles in driving quality across the Trust.

We have based our definition of quality on the CQC's 2014 framework [http://www.cqc.org.uk/sites/default/files/20150327_acute_hospital_provider_handbook_march_15_update_01.pdf], which draws on the Francis, Keogh and Berwick reviews and recommendations, and incorporates public consultation.

The combination of performance in each of the five domains outlined below determines the overall quality of the healthcare we provide. We can improve services only by supporting continuous improvement in all areas.

Safe: people are protected from abuse and avoidable harm

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

Caring: staff involve and treat people with compassion, kindness, dignity and respect

Responsive: services are organised so that they meet people's needs

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

The first year of our three-year strategy is focused on making immediate quality improvements and ensuring that we achieve a rating of 'good' in our next CQC inspection, while striving for 'outstanding'. A series of projects will be undertaken under each of the five quality domains, led by an executive director. These are featured in our quality strategy and will form our quality strategy implementation action plan.

The strategy incorporates input from key stakeholders, including our patients, members of the public, our staff and our commissioners, through engagement events held in 2014/2015.

Quality improvement methodology

We have decided to adopt a standardised approach to quality improvement. This is designed to encourage and support our staff by providing them with the tools they need to make sustained improvements without waiting for permission.

Throughout early 2015, we developed a standardised quality improvement methodology for the Trust, which will launch in the summer alongside our quality strategy.

The model is made up of two elements: a quality improvement training programme which will provide training for all our staff, and a new team called the 'Imperial Quality Improvement (iQI) Hub'.

This new team will offer a wide range of skills, including leadership, stakeholder and staff engagement, clinical and nursing, training, research, education, clinical audit, project management, data analytical and administrative support. The hub will involve patients, carers and members of the public as well as permanent staff members.

We want to ensure that we continuously improve our services so that they are safe, effective, caring, well-led and responsive using standardised quality improvement methods where appropriate. There are already great examples of quality improvement going on throughout the Trust, some of which are included as case studies throughout the document, like the one below:

Quality Improvement Case Study: new perspectives on healthcare problems

Imperial College Healthcare NHS Trust has taken the idea of a 'multidisciplinary team' to new levels, with healthcare professionals working alongside actors, engineers and artists in a ground-breaking approach to service improvement known as Quality Improvement Sprints.

These two-day problem-solving events were developed here, based on an idea developed at the Massachusetts Institute of Technology. Each Sprint brings people together to focus on three or four different real-life problems in healthcare. Small groups visit the services to gain a really deep understanding of the situation. Then on day two, everyone comes together, to work up potential solutions.

One Sprint looked at a complex, unwieldy form that clinicians were usually filling in incorrectly, or not at all, requiring an entire administrative team to check their entries. After taking part in a Sprint event, a design student from the Royal College of Art began working with the clinical team to design a form that is more clinician-friendly while also providing space for patients to plan what they want to say in appointments. The form is about to be piloted in outpatients.

Sprints form just one strand of a trust-wide commitment to quality improvement, which includes running 'introduction to quality improvement' workshops for staff at all levels. 'Our vision is that quality improvement is everybody's business,' explains project manager Lauren Harding. 'We want quality improvement to be part of our culture – and the Sprints are helping kick-start that, by generating ideas from entirely new perspectives.'

Our priorities for 2015/16

In deciding our priorities for 2015/16, we have revised the former overarching objectives in our quality accounts for 2013/14 (safety, clinical effectiveness and patient experience) to reflect the goals in our new quality strategy. Our priority is therefore to ensure that we continuously improve our services so that they are safe, effective, caring, well-led and responsive

How we chose our priorities

We developed our priorities in consultation with members of the public, our patients, shadow foundation trust members, Healthwatch, local authority overview and scrutiny committees, commissioners and Trust staff, through a series of development workshops held during quarter four 2014/15. We also assessed our progress against last year's priorities and have identified that in some areas there is still much to be done; meaning some of our targets will be continued during the coming year.

We recognise in particular that we need to improve many of our processes and systems to ensure better outcomes and experience for our patients. We have therefore chosen the priorities outlined over the next few pages to ensure that we focus on making improvements where they are most needed, and on sustaining improvements that have already been achieved. We believe that if we can meet our targets in these priority areas, we will see significantly improved outcomes for our patients and a better working environment for our staff.

The feedback at our engagement events highlighted that we should be more transparent with our data and make it as simple as possible. We have therefore developed our priorities so that each one has an overarching goal, supported and measured by a number of targets. This will provide clarity for our patients and external stakeholders, and ensure that our people have tangible, measurable and reportable goals to aim for.

We will amend our scorecard to include these measurements, with data monitored and reported from ward to board, to ensure transparency.

The newly established quality steering group will meet quarterly to monitor our performance with the priorities in our quality account and quality strategy. This group will report to the executive quality committee and will be made up of both internal and external stakeholders.

Our priorities under the five quality domains

These are set out below under each of the five domains described on page 8. Each domain has a table which outlines our priorities against national comparator data and details of our performance in 2014/15 where applicable.

Quality domain 1: Safe

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

Research conducted by NHS England suggests that around 10% of patients will experience an adverse event while in hospital, half of which are considered avoidable. We want to ensure our patients are as safe as possible while under our care and that they are protected from avoidable harm. Our goal is to be below the national average for the number of incidents causing severe and extreme harm in year one of the strategy, and have none in year three. Throughout the three years of our quality strategy we will be focusing on achieving sustainable improvements in the target areas outlined below; we believe successfully achieving these targets will support the elimination of avoidable harm throughout the Trust and enable us to achieve our goal.

Target 1: We will have sufficient staff in place to deliver safe care to all our patients, as shown through the vacancy rate for staff groups and the percentage of shifts meeting planned safe staffing levels.

We believe our staff, patients and the public need to feel assured that our wards and outpatient areas are adequately staffed to provide the safest possible care. This includes clinical, administrative, management and nursing staff. Our aim is to have a vacancy rate of less than 5% for band 2-6 ward roles and less than 10% generally and to maintain the percentage of shifts meeting planned safe staffing levels at 90% for registered nurses and 85% for care staff.

This was one of the key themes from our engagement events for both staff and patients. It is also one of the Berwick recommendations: (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf).

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

Target 2: We will demonstrate the development of a safety reporting culture by increasing our incident reporting numbers and therefore remaining within the top quartile of Trusts.

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

Target 3: We will have zero ‘never events’.

‘Never events’ are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. We reported three never events in 2014/15.

Target 4: We will ensure we have no avoidable infections.

We chose this target as we want to ensure that our patients are safe from infection in our hospitals. At present, we are not meeting all our infection control targets, so we have chosen this as a 'stretch' target, to make sure we are doing everything we can to reduce the risk of patients picking up an infection during their stay with us.

Target 5: We will ensure we maintain 90% for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams.

Anti-infectives (drugs that are capable of acting against infection) include antibacterials, antifungals and antivirals. These agents are often referred to collectively as antibiotics. They are extremely important and are potentially life-saving therapies. However, if they are used inappropriately and excessively, drug-resistant organisms can emerge, putting patients at an increased risk of developing a more resistant strain of an infection. We will aim to maintain a compliance rate of 90% in 2015/16.

Target 6: We will reduce avoidable category 3/4 trust-acquired pressure ulcers by at least 10% in year one.

We have made some achievements in reducing the number of pressure ulcers over the last year, however with 33 pressure ulcers graded 3 or 4 during 2014/15 we have more we would like to do. For 2015/16, we have chosen to focus on reducing the pressure ulcers that cause the most damage (grades 3 and 4), while striving for complete eradication by the end of our three-year quality strategy.

Target 7: We will assess at least 95% of all patients for risk of venous thromboembolism and prevent avoidable death as a consequence of VTE.

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

Target 8: We will promote safer surgery by ensuring 100% compliance with the elements of the WHO checklist in all relevant areas.

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

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

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

Target 9: We will stop non-clinical transfers of patients out-of-hours.

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

Table A below shows our safe goal and targets against national comparator data and details of our performance in 2014/15 where applicable.

Table A: Safe Priorities Part One

		Measures	14/15 Performance	National Target/ National Average	Target for 15/16
Safe – Part 1	**Goal**	**To eradicate avoidable harm to patients in our care as shown through a reduction in number of incidents causing severe and extreme harm**			
	Goal Part A	To eradicate avoidable harm to patients in our care as shown through a reduction in number of incidents causing severe and extreme harm: Part A - below the national average for severe harm incidents	0.08%	0.4% (national average April-Sept 2014)	Below national average
	Goal Part B	To eradicate avoidable harm to patients in our care as shown through a reduction in number of incidents causing severe and extreme harm: Part B - below the national average for extreme harm incidents	0.16%	0.1% (national average April – Sept 2014)	Below national average
	Target 1a	We will have sufficient staff in place to deliver safe care to all our patients, as shown through the vacancy rate for staff groups and the percentage of shifts meeting planned safe staffing levels: Part A - General Vacancy rate of 10% or less	11.74% (month 12)	N/A	10% or less
	Target 1b	We will have sufficient staff in place to deliver safe care to all our patients, as shown through the vacancy rate for staff groups and the percentage of shifts meeting planned safe staffing levels : Part B -Band 2-6 ward role vacancy rate of 5% or less	13.47% (month 12)	N/A	5% or less
	Target 1c	We will maintain the percentage of shifts meeting planned safe staffing levels at 90% for registered nurses and 85% for care staff	95.31% - registered nurses 91.97% - care staff	90% for registered nurses 85% for care staff	90% for registered nurses 85% for care staff
	Target 2	We will demonstrate the development of a safety reporting culture by increasing our incident reporting numbers and therefore remaining within the top quartile of Trusts	42.98 per 1000 bed days (April-Sept 2014) - top quartile	35.1 per 1000 bed days (April-Sept 2014)	Over 42.98 and remain in top quartile
	Target 3	We will have zero 'never events'.	3 never events	0 never events	0 never events
	Target 4	We will ensure we have no avoidable infections	New reporting criteria – data not currently reported in this way	N/A	0 avoidable infections
	Target 5	We will ensure we maintain 90% for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams	92%	N/A	At least 90%
	Target 6	We will reduce avoidable category 3/4 trust-acquired pressure ulcers by at least 10%	33	N/A	Less than 29 (at least 10% reduction)
	Target 7	We will assess at least 95% of all patients for risk of venous thromboembolism and prevent avoidable death as a consequence	96.40%	over 95%	over 95% 0 avoidable deaths

Table A: Safe Priorities Part Two

		Measures	14/15 Performance	National Average/National Target	Target for 15/16
Safe – Part 2	Target 8	We will promote safer surgery by ensuring 100% compliance with the elements of the WHO checklist in of all relevant areas	Element 1: 100% Element 2: 100% Element 3: 100% Element 4: 100% Element 5: 71% (for month of March 2015)	N/A	100% compliance
	Target 9	We will stop non-clinical transfers of patients out-of-hours	New reporting criteria – data not currently reported in this way	N/A	0

Quality domain 2: Effective

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

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

We have recently developed a new clinical audit programme in order to implement a comprehensive process of practice review. This will ensure that we are providing healthcare in line with standards, and lets us and our patients know where services are doing well, and where improvements could be made. The aim is to focus quality improvement on those areas where it will be most helpful, to improve outcomes for patients. This audit programme includes national clinical audits and locally developed clinical audits. For a full list of the national clinical audits that we currently take part in, see pages 35-36.

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

Target 1: We will improve our mortality rates as measured by the Standard Hospital Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) to be the lowest-risk NHS organisation and improve our position annually in comparison to the Dr Foster Global Comparators data set to be in the top third.

HSMR and SHMI are two indicators that enable us to compare our mortality rates with our peers. We currently have the second lowest SHMI and HSMR for non-specialist acute providers in the country according to the latest available data. However, our goal is to be the safest Trust in the country. For this reason, we aspire to have the lowest rates for non-specialist acute providers across the next year of data, and for the three years of the quality strategy. We will also monitor the percentage of admitted deaths with palliative care coded, with the aim of being below the national average, to make sure we are accurately coding all deaths in our hospitals.

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

Target 2: We will reduce the number of out-of-ICU / ED cardiac arrests.

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

Target 3: We will increase PROMs participation rates to 80% with reported health gain better than national average.

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

Target 4: We will ensure mortality reviews are carried out using a standardised format whenever a patient dies in our care. We will also ensure that the review outcome is presented at a multi-disciplinary team meeting.

Reviewing every death which occurs in our hospitals will enable us to learn from any errors and pick up quickly on potential issues which could result in harm to other patients. Currently this does not happen uniformly across the Trust, and the results are not reported in a standardised format. In year one, we will focus on implementing the processes to ensure that all cases are reviewed at multi-disciplinary team meetings, and results are reported through our governance process. In year three, we will aim to demonstrate 100% compliance across the organisation.

Target 5: We will discharge at least 35% of patients on relevant pathways before noon in year one and sustain year on year improvements.

We have chosen this target to enable us to provide more effective care for our patients, by optimising capacity in our hospitals. By discharging patients earlier where clinically appropriate, we are in a better position to place elective and emergency patients appropriately in the right ward, in the right bed and at the right time. This target also improves clinical outcomes for elective surgery patients, as they do not have an extended stay in theatre recovery or on a ward while waiting for a bed to become available. Timely discharge is important for good patient experience and discharge has been a key theme from our engagement events, and has been identified as a priority by members of the public and our staff.

Target 6: We will consistently meet the national target for recruiting the first patient into clinical trials within 70 days and sustain year on year improvements.

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

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

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

Throughout 2014-15 we have improved our performance from 57.1% in quarter one to 66.5% in quarter three (quarter four data not yet available), however we want to see this improvement sustained, with year-on-year improvements. To facilitate this, we will set up a centralised monitoring process for research and agree trustwide targets.

Table B below shows our effective goal and targets against national comparator data and details of our performance in 2014/15 where applicable.

Table B: Effective Priorities Part One

		Measures	14/15 Performance	National Target/ National Average	Target for 15/16
Effective - Part 1	**Goal**	**To be in the top quartile for all national clinical audit outcomes**	**TBC**	**TBC**	**Top quartile**
	Target 1a	We will improve our mortality rates as measured by the Standard Hospital Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) to be the lowest-risk acute Trust and improve our position annually in comparison to the Dr Foster Global Comparators data set: Part A - lowest-risk as measured by SHMI	2nd lowest risk (73.17 - July 2013 - June 2014)	100	Lowest Risk
	Target 1b	We will improve our mortality rates as measured by the Standard Hospital Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) to be the lowest-risk acute Trust and improve our position annually in comparison to the Dr Foster Global Comparators data set: Part B - lowest-risk as measured by HSMR	2nd lowest risk (72.64 - November 2014)	100	Lowest Risk
	Target 1c	We will improve our mortality rates as measured by the Standard Hospital Mortality Indicator (SHMI)* and the Hospital Standardised Mortality Ratio (HSMR) to be the lowest-risk NHS organisation and improve our position annually in comparison to the Dr Foster Global Comparators data set: Part C - improve our position annually in comparison to the Dr Foster Global Comparator to be in the top third	93 (2013/14 data) – top half	100	To be in the top quarter
	Target 1d	We will improve our mortality rates as measured by the Standard Hospital Mortality Indicator (SHMI)* and the Hospital Standardised Mortality Ratio (HSMR) to be the lowest-risk NHS organisation and improve our position annually in comparison to the Dr Foster Global Comparators data set: Part D – we will be below national average for palliative care coding	36.10% (July 2013 – June 2014)	24.60% (July-2013-June 2014)	Below the national average
	Target 2	We will reduce the number of out-of-ICU / ED cardiac arrests.	286	N/A	Less than 286
	Target 3a	We will increase PROMs participation rates to 80% with reported health gain better than national average: Part A - increased PROMs participation rate (groin hernia)	0%	58.30% (national average April-Sept 2014)	80%
	Target 3b	We will increase PROMs participation rates to 80% with reported health gain better than national average: Part B - increased PROMs participation rate (hip replacement)	90.30%	86.10% (national average April-Sept 2014)	80%

Table B: Effective Priorities Part Two

		Measures	14/15 Performance	National Target/ National Average	Target for 15/16
Effective - Part 2	Target 3c	We will increase PROMs participation rates to 80% with reported health gain better than national average: Part C - increased PROMs participation rate (knee replacement)	116.50%	96.60%(national average April-Sept 2014)	80%
	Target 3d	We will increase PROMs participation rates to 80% with reported health gain better than national average: Part D - increased PROMs participation rate (varicose vein)	66.50%	42.40% (national average April-Sept 2014)	80%
	Target 3e	We will increase PROMs participation rates to 80% with reported health gain better than national average: Part E - reported health gain better than national average (groin hernia) (EQ-5D Index / EQ VAS)	*Post operative health gain not calculated as there were less than 30 modelled records	0.081 / -0.397 (national average April-Sept 2014)	above national average
	Target 3f	We will increase PROMs participation rates to 80% with reported health gain better than national average: Part F - reported health gain better than national average (hip replacement) (EQ-5D Index / EQ VAS)	*Post operative health gain not calculated as there were less than 30 modelled records	0.442 / 12.162 (national average April-Sept 2014)	above national average
	Target 3g	We will increase PROMs participation rates to 80% with reported health gain better than national average: Part G - reported health gain better than national average (knee replacement) (EQ-5D Index / EQ VAS)	*Post operative health gain not calculated as there were less than 30 modelled records	0.328 / 6.369 (national average April-Sept 2014)	above national average
	Target 3h	We will increase PROMs participation rates to 80% with reported health gain better than national average: Part H - reported health gain better than national average (varicose vein) (EQ-5D Index / EQ VAS)	0.054 / -0.944	0.1 / -0.465 (national average April-Sept 2014)	above national average
	Target 4a	We will ensure mortality reviews are carried out in all cases and that they are reviewed at multi-disciplinary team meetings: Part A - mortality reviews carried out in all cases	N/A	N/A	100%
	Target 4b	We will ensure mortality reviews are carried out in all cases and that they are reviewed at multi-disciplinary team meetings: Part B - all cases reviewed at MDT	N/A	N/A	100%
	Target 5	We will discharge at least 35% of patients on relevant pathways before noon	New reporting criteria – data not currently reported in this way	N/A	35% of patients discharged before noon
	Target 6	We will consistently meet the national target for recruiting the first patient into clinical trials within 70 days and sustain year on year improvements	66.5% (data to Q3 – Q4 not yet available)	70%	More than 70%

Quality domain 3: Caring

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

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

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

In addition to the FFT questions, we will be using the real-time system to conduct additional surveys which will be particularly related to areas of improvement highlighted by the national patient experience surveys. This will support our quality improvement work by enabling us to measure its impact on our patients on a day-to-day basis.

We have begun work to triangulate all patient experience data and demographic data to allow us to build a complete picture of how our patients view our services, which we will develop further in 2015/16.

Target 1: We will improve our score in the national inpatient survey relating to responsiveness to patients' personal needs (amalgamation of five questions from national survey).

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

Target 2: We will achieve and maintain a FFT response rate of 40% for inpatients 20% for outpatients.

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

Target 3: We will improve our national cancer survey scores year on year.

We will continue to make improvements to the care that our cancer patients receive, and will use the survey scores to show how our developments are affecting patient experience. We will aim to increase our scores year on year. Currently our score is 72%, which is a significant improvement on last year's result. We will continue to improve patient experience through our work with Macmillan and our cancer patient experience action plan.

Target 4: We will increase our responsiveness to complaints and reduce their overall number.

Complaints were high on the national agenda in 2014/15, with the Ombudsman, Healthwatch and the Patients Association all highlighting the value of each complaint as an opportunity to learn and support continuous improvement. We have been reviewing the way we work to look at how we can create a more responsive and caring complaints service for our patients and identify learning for our staff. We believe that the structures and processes of the current system are the main factors that prolong response times and hence impact the response rates and will be introducing changes to our complaints service in August 2015, which should increase our responsiveness to complaints. The changes will include a dedicated complaints manager being allocated to each complaint and the use of phone calls to resolve formal complaints where possible.

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

Target 5: We will develop a dataset that enables monitoring of protected characteristics against patient experience measures.

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

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

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

Table C on the following page shows our caring goal and targets against national comparator data and details of our performance in 2014/15 where applicable.

Table C: Caring Priorities Part One

		Measures	14/15 Performance	National Target/ National Average	Target for 15/16
Caring – Part 1	**Goal**	**To provide our patients with the best possible experience by increasing the percentage of inpatients and A&E patients who would recommend our Trust to friends and family if the needed similar care or treatment by 95% and 85% respectively**			
	Goal Part A	To provide our patients with the best possible experience by increasing the percentage of inpatients and A&E patients who would recommend our Trust to friends and family if the needed similar care or treatment by 95% and 85% respectively: Part A – 95% inpatient recommendation	95%	95%	95%
	Goal Part B	To provide our patients with the best possible experience by increasing the percentage of inpatients and A&E patients who would recommend our Trust to friends and family if the needed similar care or treatment by 95% and 85% respectively: Part A – 85% A&E patient recommendation	80%	87%	85%
	Target 1	We will improve our score in the national inpatient survey relating to responsiveness to patients' personal needs	6.82 (Individual responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score, the better the Trust is performing)	N/A	6.85
	Target 2a	We will achieve and maintain a FFT response rate of 40% in inpatient departments	41.41%	40%	40%
	Target 2b	We will achieve and maintain a FFT response rate of 20% in A&E	18.28%	15%	20%

Table C: Caring Priorities Part 2

		Measures	14/15 Performance	National Target/ National Average	Target for 15/16
Caring – Part 2	Target 3	We will improve our national cancer survey scores year on year (measure is the mean of all question responses)	72% (13/14 result – 14/15 not yet published)	N/A	75%
	Target 4a	We will increase our responsiveness to complaints and reduce their overall number: Part A - 100% of complaints responded to within the timeframe agreed with the patient (nominally 25 working days)	63.80%	N/A	100%
	Target 4b	We will increase our responsiveness to complaints and reduce their overall number: Part B - Less than 1200 complaints per year (100 per month)	1242	N/A	less than 1200
	Target 5	We will develop a dataset that enables monitoring of protected characteristics against patient experience measures	N/A	N/A	dataset developed and in use

Quality domain 4: Responsive

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

Having responsive services that are organised to meet people's needs is a key factor in improving patient experience and in preventing delays to treatment, which can cause harm to our patients. Our engagement events have shown that our patients agree. They would like to see improvements in our performance against national access targets, as we do not consistently meet them (see page 90). The feedback also focused on our need to improve our services for outpatients.

Our goal for the next two years is to consistently meet the national targets and to exceed them in 2017, when our quality strategy will be updated. To do this, we will continue to review our processes to ensure they are as efficient as possible, while keeping the needs of our patients central.

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

Target 1: We will reduce the unplanned readmission rate for both under and over 15s and be below the national average.

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

Quality Improvement Case Study: Preventing A&E admissions through responsive walk-in care

For patients with conditions such as deep-vein thrombosis, low-risk chest pains and renal colic, there is a new alternative to A&E. Since December 2014, we have three new Ambulatory Emergency Care units; one at Charing Cross, one at Hammersmith and one at St Mary's Hospital.

These units are different from A&E because they specialise in just a few particular conditions, so staff are able to quickly move patients onto the right treatment pathway. And because the units are in hospitals, patients have access to diagnostic services such as MRI scans or X-rays, all under one roof.

With universal pressure on A&E, there are obvious benefits in reducing the number of people attending. But the units are not just about diverting A&E patients to another service – they are also designed to prevent emergencies in the first place, by making specialist care more widely accessible. As well as A&E referral, patients can be referred directly by their GPs or from any hospital service within the Trust.

'It's like a highly specialised GP practice within an acute hospital space,' explains Mike Burbidge, who managed the new scheme. 'For the patient, this type of care is far better organised and streamlined, with less waiting to be seen and immediate links to all the specialisms under one roof. The ultimate aim is to see patients before they become so unwell that they reach the point where they need to go to A&E.'

Target 2: We will have no inpatients waiting over 52 weeks for elective surgery and ensure a clinical validation process is in place for each patient who waits for over 18 weeks.

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

Target 3: Hospital initiated cancellation of outpatient appointments – we will audit our performance in quarter one and set improvement targets for the 3 years of the strategy.

Improving our processes and the experience of our outpatients was a key theme both of the CQC inspection and at our engagement events. Throughout quarter one of 2015/16 we will audit the number of cancelled outpatient clinic appointments which are initiated by the hospital. This will allow us to develop a process to improve our performance and set targets for the 3 years of the strategy to ensure that our patients are not inconvenienced or harmed by cancelled appointments.

Target 4: Outpatient letter turnaround time – we will audit our performance in quarter one set improvement targets for the rest of the year.

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

Target 5: We will reduce the proportion of clinics that are delayed due to late arrival of doctors.

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

Target 6: We will improve the number of out-patient consultations that occur with the original set of medical records available.

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

Target 7: We will improve our National Patient Led Assessment of the Care Environment (PLACE) annually to be in the top 25% nationally where possible.

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

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

All patients should be cared for with compassion and dignity in a clean, safe environment. PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced. The Trust's environment was a key issue raised by patients during our engagement process, and was also picked up by the CQC as an area of concern during their inspection. We will focus on improving our PLACE scores annually, with the goal of being in the top 25% nationally by year three for the first three PLACE headings. The condition, appearance and maintenance of our estates are dictated by the age of our buildings and the future plans which are in place to redevelop all our sites. Whilst we go through the planning stages of our redevelopment, we will continue to face challenges in this area. Our goal for heading four is therefore to maintain our current performance.

Table D on the following page shows our responsive goal and targets against national comparator data and details of our performance in 2014/15 where applicable.

Table D: Responsive Priorities Part One

		Measures	14/15 Performance	National Target/ National Average	Target for 15/16
Responsive – Part 1	**Goal**	**To consistently meet all relevant national access standards through responsive patient pathways in year one**	**See page 90**	**See page 90**	**All national targets met**
	Target 1	We will continue to reduce the unplanned emergency readmission rate for both under and over 15s and remain below the national average	6.31% - below national average (15 and under) 8.84% - above national average (16 and over) [data: Dr Foster April-Sept 2014]	8.10% (15 and under) 7.97% (16 and over) [national average will change when 2015 data is reported]	Above national average for both indicators
	Target 2	We will have no inpatients waiting over 52 weeks for elective surgery and ensure a clinical validation process is in place for each patient who waits for over 18 weeks	13 (month 12 performance)	N/A	Zero 52 week waits on a monthly basis 100% validation
	Target 3	Hospital initiated cancellation of outpatient appointments – we will audit our performance in Q1 set improvement trajectories for the rest of the year	TBC	TBC	TBC
	Target 4	Outpatient letter turnaround time – we will audit our performance in Q1 set improvement trajectories for the rest of the year	TBC	TBC	TBC
	Target 5	We will reduce the number of doctors arriving late for the start of their outpatient clinics	TBC	TBC	TBC

Table D: Responsive Targets Part Two

		Measures	14/15 Performance	National Target/ National Average	Target for 15/16
Responsive – Part 2	Target 6	We will improve the number of outpatient consultations that occur with the original set of medical records available	TBC	TBC	TBC
	Target 7	We will improve our National Patient Led Assessment of the Care Environment (PLACE) scores annually where possible	Cleanliness – 98.19% (top 25%) Food – 88.18% (below average) Privacy etc. – 77.75% (bottom 25%) Condition etc. – 87.26% (bottom 25%)	Cleanliness – 97.25% Food – 88.79% Privacy etc. – 87.73% Condition etc. – 91.97%	All scores above national average in year 1, except for condition where we will maintain current performance

Quality domain 5: Well led

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

Evidence shows that staff who are engaged and happy in their jobs, respected and given opportunities to learn provide better care for their patients. Our goal is to increase the percentage of staff who would recommend our Trust as a place of work or to come for treatment to friends and family by 2% in year one. This will enable us to have evidence that by supporting our staff to develop, we are improving the culture and ethos of the Trust – both as a place to work, and as a place to be a patient. This goal will be supported by the targets outlined below.

Target 1: We will launch our ward accreditation programme with evidence documented of rapid improvements where issues arise.

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

Target 2: We will achieve a voluntary turnover rate of 9.50% or less.

We have chosen to focus on reducing voluntary turnover as retention of staff is a key aspect of building a strong, consistent workforce able to sustain the quality improvements we need to achieve over the next three years. Our turnover rate is currently 10.37%; we want to reduce this to at least 9.50% in year one and sustain this in year three.

Target 3: We will reduce our sickness absence rate to 3.40% or less in year one, with a reduction to 3.35% in year two and 3.30% by year three.

Low sickness absence is an indicator of effective leadership and good people management. As such, we have chosen this target as a measure of staff satisfaction and wellbeing. We believe that our new health and wellbeing programme will play a significant part in improving our staff's physical and mental health. We aim to reduce the rate of sickness absence from its current position of 3.46% to 3.40% or less in year one, with a reduction to 3.30% in year three.

Target 4: We will achieve a performance development review rate of 95% and a non-training grade doctor appraisal rate of 95%.

In 2014-5 we rolled out a new appraisal scheme 'Performance Development and Review (PDR)' for all staff, excluding doctors, which is aimed at driving a new performance culture across the Trust. We required all our managers to undergo re-training in the skills of having effective performance conversations, training 1600 during 2014. The new PDR process involves ratings for staff and for the first time makes a link between performance and obtaining increments, and also a clear link to our Values and Behaviours.

As a result of this programme, our national staff survey results show that the number of staff believing they had a well-structured appraisal was in our top five scoring questions and in the top 20% of Acute Trusts. We also conducted our own evaluation which showed us that "80% direct reports felt that their PDR had been an improvement on previous experience" and also "90% managers felt that the PDR process will improve the engagement of their team and will improve the performance of the team." The current rate for PDR at the end of 2014/15 is 93.65%, a big improvement on the appraisal compliance results from previous years; however our target is to make sure the improvements made this year are sustained by ensuring at least 95% of our non-clinical staff have had their performance development review on an annual basis.

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

Target 5: We will achieve consistent compliance of 95% with statutory and mandatory training.

Our statutory and mandatory training programme ensures the safety and well-being of all our staff and patients. During 2014/5 we moved the majority of our training to online e-learning and also implemented a new reporting tool (WIRED 2) to improve our ability to monitor and report on compliance. We have chosen a target of 95% compliance to demonstrate that our staff comply with statutory and mandatory requirements which have a direct impact on patient safety, this includes training in Information Governance, safeguarding adults and safeguarding children.

A key objective this year was to ensure that the required number of staff received level 1 adult safeguarding training. The compliance with this training was well below the required level at the beginning of 2014/15 and action was taken to increase this to 85% by the end of the year; this level was achieved by December 2014. We have also worked to improve our compliance with training for safeguarding children, which was at 84% overall by March 2015 against a target of 80%. Training has been delivered in a range of ways, including ward based sessions and joint adult and child safeguarding training "loop days".

Target 6: We will reduce the number of programmes with red flags in the General Medical Council's national trainee survey by 5% annually and increase the overall number of green flags.

As one of London's largest teaching hospitals, we want to provide the best training for our junior doctors, as we believe this is a key element of us being a 'well-led' organisation. The General Medical Council's annual national survey is an important measure of trainee satisfaction, which can highlight not only problems with teaching in organisations, but also patient safety issues and problems with bullying and undermining. Although we have seen improved survey results in recent years, in the 2014/15 survey 39% of our programmes have a 'red flag' (where we are shown to be a significant national outlier). We have chosen this target to drive improvements across education in order to reduce the number of programmes with red flags by 5% each year, while increasing our number of 'green' flags.

Target 7: We will obtain a minimum score of 0.5 for placement satisfaction for all medical student placements as measured by Student Online Evaluation (SOLE) feedback.

As well as junior doctors, we also run placements for medical students at the Trust and are keen to focus on how we can improve their experience. The feedback we receive through the national SOLE system is usually mixed. We will focus on how we can improve their experience

throughout the year in a consistent manner, with the aim of obtaining a minimum score of 0.5 (which corresponds to a 'mostly agree' score) for satisfaction for all student placements.

Target 8: We will have trained departmental safety co-ordinators in all departments.

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

Quality Improvement Case Study: Transforming staff and patient experience through clever design

For many years, nurse practitioners have worked alongside A&E doctors and GPs at the Urgent Care Centre at St Mary's Paddington, dependably managing a wide range of conditions from sprains and fractures to abscesses and cuts, 24 hours a day. But conditions were cramped and staff felt that the environment was not conducive to a good experience for their patients. 'Even though the care was very good, we felt it was difficult to afford patients the privacy and dignity that they deserved,' explains Mary Dawood, Consultant Nurse for the Emergency Directorate.

In 2014, we involved staff in a comprehensive design programme to create a purpose-built space focussed on how the patients and staff interact. The service moved into the new area on 18 February and staff have already have seen a major transformation in the service.

'I've definitely noticed a difference in patients,' says Mary. 'Now, we can bring them into a room and close the door and say "How can I help you?" Patients respond completely differently. Ensuring privacy and giving your undivided attention undoubtedly improves the patient experience. The changes have improved job satisfaction for staff, too – an important factor at time when recruiting and retaining the right people is a high priority. 'Our job satisfaction is greatly enhanced because you feel you're doing a really good job,' says Mary. 'It's so lovely to actually look after patients properly and have them turn round and "thank you" – it restores your faith in human nature. Having the right environment to see people in makes all the difference.'

Table E on the following page shows our well-led goal and targets against national comparator data and details of our performance in 2014/15 where applicable.

Table E: Well-led Priorities Part One

		Measures	14/15 Performance	National Target/ National Average	Target for 15/16
Well-led Priorities – Part 1	**Goal**	**To increase the percentage of our staff who would recommend this Trust to friends and family as a place to work or a place for treatment on a year-by-year basis**			
	Goal Part A	To increase the percentage of our staff who would recommend this Trust to friends and family as a place to work or a place for treatment on a year-by-year basis: Part A – 5% increase in staff who would recommend as a place to work	58%	N/A	2% increase
	Goal Part B	To increase the percentage of our staff who would recommend this Trust to friends and family as a place to work or a place for treatment on a year-by-year basis: Part B – 5% increase in staff who would recommend as a place for treatment	77%	N/A	2% increase
	Target 1	We will launch our ward accreditation programme with evidence documented of rapid improvements where issues arise	N/A	N/A	Ward accreditation programme launched - improvements documented
	Target 2	We will achieve a voluntary turnover rate of 9.50% or less	10.37%	N/A	9.50% or less
	Target 3	We will reduce our sickness absence rate to 3.40% or less	3.46%	N/A	3.40%
	Target 4a	We will achieve a performance development review rate of 95% and a non-training grade doctor appraisal rate of 95%: Part A - 95% PDR rate	93.65%	N/A	95%
	Target 4b	We will achieve a performance development review rate of 95% and a non-training grade doctor appraisal rate of 95%: Part B - 95% non-training grade doctor appraisal rate	88.90%	N/A	95%
	Target 5	We will achieve consistent compliance of 95% with statutory and mandatory training	80%	95%	95%
	Target 6a	We will reduce the number of programmes with red flags in the General Medical Council's national trainee survey by 5% in year one and increase the overall number of green flags: Part A - 5% reduction in number of programmes with red flags	39%	N/A	5% reduction
	Target 6b	We will reduce the number of programmes with red flags in the General Medical Council's national trainee survey by 5% in year one and increase the overall number of green flags: Part B - increased number of green flags	20	N/A	More than 20

Table E: Well-led Priorities Part 2

		Measures	14/15 Performance	National Target/ National Average	Target for 15/16
Well-led Priorities – Part 2	Target 7	We will obtain a minimum score of 0.5 for placement satisfaction for all student placements as measured by Student Online Evaluation (SOLE) feedback	16 with 0.5 or more (40%) 24 with less than 0.5 (60%) (results from 2013/14 feedback – 2014/15 not published yet)	N/A	100% of placements with 0.5 or more
	Target 8	We will have trained departmental safety co-ordinators in 90% of departments	c. 60%	N/A	90% departments with trained co-ordinators

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Statements of assurance from the board – 2014/15

Statements of assurance from the board

In this section of the quality account, we are required to present mandatory statements about the quality of services that we provide, relating to financial year 2014/15. This information is common to all quality accounts and can be used to compare our performance with that of other organisations. The statements are designed to provide assurance that the board has reviewed and engaged in cross-cutting initiatives which link strongly to quality improvement.

A review of our services

In 2014/15, Imperial College Healthcare NHS Trust provided and/or sub-contracted 75 NHS services.

Imperial College Healthcare NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services through our performance management framework and its assurance processes.

The income generated by the NHS services reviewed in 2014/15 represents 100% of the total income generated from the provision of NHS services by Imperial College Healthcare NHS Trust for 2014/15.

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 2014/15, the NHS services that we provide were covered by 41 national clinical audits and five national confidential enquiries.

During that period Imperial College Healthcare NHS Trust took part in 100% of national clinical audits and 100% of national confidential enquiries in which we were eligible to participate.

The national clinical audits and national confidential enquiries that Imperial College Healthcare NHS Trust participated in, and for which data collection was completed during 2014/15, are listed below in table F alongside the number of cases submitted to each audit or enquiry as a percentage.

Table F: National Clinical Audit Participation

Title	Eligible	Participated	% Submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	✓	76%
Adult Community Acquired Pneumonia	✓	✓	data submissions close 01/06/15
British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing	✓	✓	100%
Bowel cancer (NBOCAP)	✓	✓	79%
Cardiac Rhythm Management (CRM)	✓	✓	data submissions close 30/05/2015
Case Mix Programme (CMP)	✓	✓	88%*
Chronic Kidney Disease in primary care	No	N/A	N/A
Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	✓	✓	100%
Coronary Angioplasty/National Audit of PCI	✓	✓	98%
Diabetes (Adult)	✓	✓	Data submission July 2015
Diabetes (Paediatric) (NPDA)	✓	✓	100%
Elective surgery (National PROMs Programme)	✓	✓	72%
Epilepsy 12 audit (Childhood Epilepsy)	✓	✓	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	✓	✓	Data submission May 2015
Fitting child (care in emergency departments)	✓	✓	Data submission is not yet open. Pilot trusts only.
Head and neck oncology (DAHNO)	✓	✓	Audit not active 2014/15
Inflammatory Bowel Disease (IBD) programme	✓	✓	100%
Lung cancer (NLCA)	✓	✓	Data submission not commenced
Major Trauma: The Trauma Audit & Research Network (TARN)	✓	✓	91%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	✓	✓	100%
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	✓	95%
Mental health (care in emergency departments)	✓	✓	Data submission is not yet open. Pilot trusts only.
National Adult Cardiac Surgery Audit	✓	✓	Audit not active 2014/15
National Audit of Dementia	✓	✓	Audit not active 2014/15
National Audit of Intermediate Care	✓	✓	100%
National Cardiac Arrest Audit (NCAA)	✓	✓	79%
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	✓	✓	Data submissions close 10/07/15
National Comparative Audit of Blood Transfusion programme	✓	✓	100%
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	No	N/A	N/A
National Emergency Laparotomy Audit (NELA)	✓	✓	100%
National Heart Failure Audit	✓	✓	65%
National Joint Registry (NJR)	✓	✓	100%

Table F: National Clinical Audit Participation – cont.

Title	Eligible	Participated	% Submitted
National Prostate Cancer Audit	✓	✓	100%
National Vascular Registry	✓	✓	100% (subject to NCA data validation report 01/06/2015)
Neonatal Intensive and Special Care (NNAP)	✓	✓	100%
Non-Invasive Ventilation - adults	✓	✓	Audit not active 2014/15
Oesophago-gastric cancer (NAOGC)	✓	✓	100%
Older people (care in emergency departments)	✓	✓	Data submission is not yet open. Pilot trusts only.
Paediatric Intensive Care Audit Network (PICANet)	✓	✓	100%
Pleural Procedures Audit	✓	✓	*
Prescribing Observatory for Mental Health (POMH)	No	N/A	N/A
Renal replacement therapy (Renal Registry)	✓	✓	100%
Pulmonary Hypertension (Pulmonary Hypertension Audit)	✓	✓	100%
Rheumatoid and Early Inflammatory Arthritis	✓	✓	100%
Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	91%
Sepsis (NCEPOD)	✓	✓	73%
Acute Pancreatitis (NCEPOD)	✓	✓	100%
Tracheostomy Care: On the Right Trach? (NCEPOD)	✓	✓	100%
Lower Limb Amputation: Working Together (NCEPOD)	✓	✓	100%
Gastrointestinal Haemorrhage Study (NCEPOD)	✓	✓	100%

*participation rates currently unconfirmed

There were a total of 25 national clinical audit reports issued in the period April 2014 to March 2015. The reports of 21 national clinical audits were reviewed by the provider in 2014/15; the remaining 4 reports are currently under review by our clinical specialties.

We continue to follow up the reports from all relevant national audits to identify how we make improvements. Many of these audits demonstrated effective care, with no actions being required. Imperial College Healthcare NHS Trust intends to take the following actions to improve the quality of healthcare provided (see appendix A).

The reports of 53 local clinical audits were reviewed by the provider in 2014/15 (out of 149 local clinical audits registered and completed in 2014/15) and Imperial College Healthcare NHS Trust intends to take the following actions to improve the quality of healthcare provided (see appendix B).

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Imperial College Healthcare NHS Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 19,713.

Within the specific context of the National Institute for Health Research (NIHR) Portfolio (see below for more information), 15,518 patients were recruited into 367 Portfolio studies in 2014-15, an increase of 6% from 2013-14. This included 560 patients within 68 studies sponsored by commercial clinical R&D organisations (17% increase in number of studies, but the same number of patients, compared to 2013-14).

We are committed to encouraging innovation in everything that we do. Part of this involves carrying out pioneering research into novel diagnostic methods and treatments across a broad spectrum of specialities and for some of the most complex illnesses, with benefits for patients everywhere. Our clinical staff keep abreast of the latest possible treatments – active participation in research leads to more successful patient outcomes.

The Trust has continued to make significant scientific advances in 2014-15 and to attract further new investment to support clinical research and development (R&D). The Trust's research strategy is integrated with that of Imperial College London – together we constitute the Imperial academic health science centre (AHSC), a designation we successfully renewed in 2013 for a further five years (one of only six AHSCs in the country).

We are also part of Imperial College Health Partners (ICHP), a network which brings together academic and health science organisations across North West London (NWL). As the designated academic health science network for NWL, ICHP aims to deliver demonstrable improvements in health and wealth for the region and beyond, through collaboration and innovation.

National Institute for Health Research (NIHR) Biomedical Research Centre

The Trust hosts the largest of the eleven NIHR Biomedical Research Centres (BRCs) in the country. BRCs are awarded to the most outstanding NHS and university research partnerships – leaders in scientific translation and in the early adoption of new insights in technologies, techniques and treatments for improving health. Patient and public engagement activity runs through all workstreams of the NIHR Imperial BRC, with a cross-sector Patient and Public Involvement (PPI) Forum for best practice and joint projects running through ICHP and the Imperial Patient Experience Research Centre (PERC) leading on exemplar projects including Consent to Contact and important initiatives in genomics and informatics. 2014/15 is the midpoint of the current NIHR Biomedical Research Centre and has seen many achievements in improving treatment for patients:

Dietary supplementation with specific amino acids to treat obesity

Obesity is a chronic and growing problem, presenting a huge financial burden to the NHS. Our investigators have developed a novel way of delivering short chain fatty acids to the colon. They have carried out first-in-human clinical research studies and demonstrated that this molecule increases the release of particular gut hormones which suppress appetite, and have gone on to demonstrate that this molecule limits weight gain in overweight people.

Potential therapy for Friedrich's ataxia

Friedreich's ataxia is a rare, progressive degenerative disorder caused by deficiency of a particular protein. In a BRC-funded phase 1 clinical research study our researchers have demonstrated for the first time the potential of the molecule nicotinamide as a treatment for patients with this condition. Although this research still has a long way to go, its potential was demonstrated in this study with several patients reporting improved motor function.

Development and validation of the I-Knife for surgical decision-making

In the Surgery and Stratified Medicine Themes of the BRC, work on development of the iKnife technology has moved on to breast and glioma clinical trials. The I-Knife aims to improve cancer surgery by detecting – in real-time – the difference between healthy and cancerous tissue as the surgeon operates. As well as cost savings in terms of avoiding return surgery, this technology will improve patient experience, by improving cosmetic and functional outcome, and reducing surgical trauma and unnecessary removal of healthy tissue.

Early pregnancy outcome study

Our work on criteria to diagnose miscarriage led to an immediate change in national guidelines in the UK in 2012 and has subsequently been incorporated into NICE guidelines. This change will lead to several hundred wanted pregnancies in the UK, currently being terminated in error, surviving. The importance of this work was recognised in a review in the New England Journal of Medicine.

New trigger for ovulation could make IVF safer

Kisspeptin is a naturally occurring hormone that stimulates the release of other reproductive hormones inside the body. In a BRC-funded proof of concept study 53 infertile women were given a single injection of kisspeptin to induce ovulation during IVF treatment. 96% women had successful egg maturation of the participants and 12 healthy babies were born. This research represents a potentially safer and better-tolerated method of IVF treatment.

Further achievements include:

- the launch of the Imperial Joint Translation Fund, a scheme to accelerate clinical and biomedical translational research through competitive project calls;
- In partnership with the Royal Marsden, Royal Brompton and Chelsea & Westminster, we were successful in bidding to lead one of eleven regional NHS Genomic Medicine Centres (GMC) in cancer and inherited rare diseases, which will deliver the Prime Minister's 100K Genomes initiative by the end of 2017.

The National Institute for Health Research (NIHR) Clinical Research Network NW London

We were selected to host the NW London Clinical Research Network - one of 15 regional networks established throughout the UK - in 2014. Approximately £13 million was awarded to the network last year and we engage with 10 partner organisations and up to 400 General Practices to deliver research across the region.

NW London is the smallest UK network with a population of two million but consistently recruits highly to clinical trials when measured by population. We are currently ranked third in the UK for recruitment by population. 29,000 patients were recruited into portfolio trials during the course of this year an increase from the previous year of approximately 10%. Commercial recruitment, a component of the overall numbers, increased by 28% from 1137 patients last year to 1451 patients this year.

The number of commercial trials in the portfolio has grown by 9% increasing from 116 to 126 since last year. The number of non-commercial trials decreased slightly with 510 open recruiting studies this year compared to 521 last year. In total there were 404 new studies opening this year compared to 381 last year, an increase of 6%.

During the course of the year Imperial were designated as one of only eight Hyper-Acute Stroke Units through a competitive national assessment process. We are the only new organisation to achieve this status.

Our CQUIN performance – CQUIN framework and data quality

Commissioning for Quality and Innovation (CQUIN) is a payment framework that allows commissioners to agree payments to hospitals based on agreed quality improvement and innovation work. Through discussions with our commissioners, we agreed a number of improvement goals for 2014/15 that reflect areas of improvement interest nationally, within London and locally.

A proportion of Imperial College Healthcare NHS Trust's income in 2014/15 was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (CQUIN) payment framework. These are objectives agreed between the Trust and its commissioners reflecting a range of national and local priorities for quality.

In 2014/15 the value of the scheme was 2.5% of the contract value for NHS acute healthcare services as agreed with our local Clinical Commissioning Groups. This equated to £8.03 million of our income from North West London CCGs, with amount earned dependent on achievement against the improvement goals.

Further details of the agreed national CQUIN goals for 2014/15 are available via the NHS England website and further details of the local CQUIN goals are available on request.

In line with national guidance on the tariff arrangements, a proportion of our income will not be dependent on CQUIN funding in 2015/16. This is because we have opted to remain on the existing tariff arrangements and no national CQUIN is available within this option.

A summary of the 2014/15 CQUIN goals and achievement is provided in table G below. The figures are based on our projected year end and are subject to final agreement.

Table G: CQUIN 2014/15 Summary

CQUIN categories	Full year value £000s	Achieved £000s Projected year end (TBC)	Achieved % Projected year end (TBC)
National CQUINs			
N1.1 FFT: Implementation of staff FFT	121	121	100%
N1.2 FFT: Early implementation in outpatients	60	60	100%
N1.3 FFT: A&E and inpatient response rate	60	30	50%
N1.4 FFT: Inpatient response rate	161	161	100%
N2 NHS Safety Thermometer: Pressure ulcers reduction	402	402	100%
N3.1 Dementia: Find, Assess, Investigate and Refer	482	482	100%
N3.2 Dementia: Clinical leadership	80	80	100%
N3.3 Dementia: Supporting carers	241	241	100%
Local Commissioner CQUINs			
R1.1 Shared Patient Records - eHealth	500	480	96%
R1.2 Shared Patient Records - Structure and content	500	470	94%
R1.3 Shared Patient records - NW London diagnostic cloud	750	750	100%
R2.1 Emergency Care - Implementation of MCAP	206	83	40%
R2.2 Emergency Care - Notifying GPs in 24hrs of an emergency admission	171	128	75%
R2.3 Emergency Care - Frequent attenders	200	101	50%
L1 Ambulatory Emergency Care pathways for adults	1,000	830	83%
R3.1 Planned Care - Roll out of Coordinate my Care	250	250	100%
R3.2 Planned Care - Streamlining pathways	1,100	396	36%
R4.1 Seven day services - Action plan	100	0	0%
R4.2 Seven day services - A&E consultant recruitment	650	553	85%
R4.3 Seven day services - Diagnostics services	1,000	720	72%
Total	**8,034**	**6,337**	**79%**

Care Quality Commission (CQC) registration status

The Care Quality Commission is the independent regulator of health and social care in England. It makes sure health and social care services provide people with safe, effective, caring, well-led and responsive care, and encourages care services to improve.

The CQC inspects hospitals and other health and social care providers to make sure they meet fundamental standards of quality and safety, and publishes its findings.

Imperial College Healthcare NHS Trust is required to register with the Care Quality Commission (CQC). At all of our sites, our current registration status is ‘registered without conditions’.

The CQC has taken enforcement action against Imperial College Healthcare NHS Trust during 2014/15. On 19 September 2014, the CQC served a warning notice in relation to concerns about the cleanliness of premises and equipment, and infection control practices in the A&E department at St Mary’s Hospital. We responded by developing an action plan to ensure that we were compliant with the requirements of the Warning Notice by 17 October. At its follow-up inspection of St Mary’s A&E on 25 November, the CQC confirmed that we were now compliant with the regulatory requirements. No other enforcement action was taken against us by the CQC in 2014/15.

Imperial College Healthcare NHS Trust has participated in special reviews or investigations by the CQC relating to the following areas during 2014/15:

- September 2014 – routine CQC inspection of St Mary's, Hammersmith, Queen Charlotte's & Chelsea and Charing Cross Hospitals
- November 2014 – Follow-up inspection at St Mary's A&E department

The CQC inspected the Trust in September 2014 by visiting four of our main sites: St Mary's, Charing Cross, Hammersmith and Queen Charlotte's & Chelsea hospitals. They inspected the following 'core services':

- Urgent and emergency services
- Medical care (including older peoples' care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging
- Neonatal services

For each of these nine core services, the inspectors provided a rating for the five CQC quality domains. They also used the domains to rate us and the four hospitals inspected overall (Western Eye was not inspected and so it was not given a rating).

We received an overall rating of 'requires improvement'. The full report is available on the CQC website. Our services were rated as 'good' for being effective and caring, but as 'requires improvement' for being safe, responsive and well-led.

Our ratings by individual hospitals are shown below:

Hospital	Rating
Queen Charlotte's & Chelsea Hospital	Overall rating: **Good**
Charing Cross Hospital	Overall rating: **Requires improvement**
Hammersmith Hospital	Overall rating: **Requires improvement**
St Mary's Hospital	Overall rating: **Requires improvement**

Whilst we were disappointed with the overall findings, the inspection did highlight some areas of good practice:

- Patients were treated with dignity and respect by staff. People said that they felt involved in their care, and that staff were compassionate and considered their individual care needs.
- Clinical outcomes for patients were good, and there was a clear commitment to multi-disciplinary working.
- Staff had a clear sense of pride in their work and a commitment to support the clinical strategy for the Trust.

Imperial College Healthcare NHS Trust intends to take the following action to address the conclusions or requirements reported by the CQC:
We have developed a comprehensive action plan to deal with the issues they found, which has informed our quality strategy and quality account. We recognise there is further work to do in

areas such as outpatients, critical care and medical care. Since the inspection we have re-doubled our efforts and commitment to making improvements and have accelerated some of the actions identified in the CQC action plan.

Imperial College Healthcare NHS Trust has made the following progress by 31 March 2015:

- We are reducing our vacancy rates for our nurses and midwives and improving our recruitment processes to minimise delays.
- We are implementing an outpatients improvement programme which has already seen the implementation of self-check-in kiosks, a 'queue buster' telephone system, the development and monitoring of key performance indicators and a reduction in the backlog of letters sent to patients.
- We are recruiting of midwives to improve the midwife to birth ratio.

We have developed a Compliance and Improvement Framework to ensure achievement of a constant state of 'compliance'. This includes compliance with regulations and assurance that services are of a good or outstanding standard. The framework will be implemented throughout 2015/16 and consists of the following components:

- Director led compliance reviews
- Core service reviews (mock style CQC inspections)
- A ward accreditation programme
- Deep dives undertaken by internal audit
- Staff focus groups
- Back to the floor Friday – back to basics.

Our data quality

Imperial College Healthcare NHS Trust will be taking the following actions to improve data quality:

We implemented Cerner Millennium as our Patient Administration/ Electronic Patient Records system in April 2014. As part of the implementation, we established a robust structure, overseen by the Data Standards Committee, for monitoring and reporting on data quality. The data quality dashboard was re-configured to use Cerner data and over 100 indicators were built, drawing on learning from other Trusts. The dashboard is available to all our staff. We continue to improve our data quality and have a robust governance structure for monitoring and improvement. We report our data quality indicators to the board and executive committee. We also include them in our monthly divisional performance scorecards, to ensure that data quality governance is aligned with our performance management framework.

Building on the indicators, we established plans to ensure data quality improved and any risks to patient safety, operational performance or income were mitigated. For 2015/16 the structure for managing data quality is being re-addressed to ensure the gains in 2014/15 can be sustained.

NHS number and general medical practice code validity

Imperial College Healthcare NHS Trust submitted records during 2014/15 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data to month 11 2014/15 (most recent available) which included the patient's valid NHS number was:

- 95.4% for admitted patient care
- 98.0% for outpatient care
- 85.1% 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% for admitted patient care
- 100% for outpatient care
- 99.9% for accident and emergency care

Information governance toolkit scoring

The information governance toolkit is the way we demonstrate our compliance with information governance standards. All NHS organisations are required to make three annual submissions to Connecting for Health in order to assess compliance.

Our information governance assessment report overall score for 2014/15 was 67% and was graded 'green' or 'satisfactory'. The rating was achieved by ensuring that we were able to return a minimum level 2 assessment against all standards. The information governance toolkit return was subject to a two stage independent audit conducted in October and in February. The final audit report gave us 'substantial assurance' of the self-assessment. We have maintained a satisfactory information governance toolkit return for the last three years.

All staff including students, temporary staff and honorary contract holders, must undertake annual mandatory information governance training. This is provided using our independently audited online information governance training programme. The requirement set by the Department of Health is 95% of staff must undertake approved information governance training on an annual basis. If we fail to reach this target then we must submit an unsatisfactory information governance toolkit return. In the 14/15 financial year, we achieved 97% compliance. In recognition of the need to continuously improve our information governance training, from August 2015 we will be offering four separate assessment types based upon job role.

Clinical coding quality

Imperial College Healthcare NHS Trust was not subject to the Payment by Results clinical coding audit during 2014/15 by the Audit Commission. The next audit will take place in Q1 2015-16.

3

A review of our quality progress 14/15

A review of our quality progress 14/15

This part of the report shares the quality improvement priorities that we set ourselves for 2014/15 and reports our progress against each of these. It also outlines our performance against the NHS Outcomes Framework 2014/15 and national targets and regulatory requirements.

Our quality account improvement priorities for 2014/15 were divided into the following three categories:

- patient safety
- clinical effectiveness
- patient experience.

The following pages describe each priority, and set out the progress made in 2014/15. We have also included some other examples of our quality improvement achievements over the last year.

Patient safety priorities

This section highlights our progress with the following patient safety priorities:

- to achieve year-on-year reductions in infection prevention and control
- to increase incident reporting rates and reduce their reported harm to meet NRLS peer target
- to ensure high performance against the NHS Safety Thermometer
- to increase the awareness of dementia and ensure that relevant patients who are admitted as an emergency are screened for dementia and have access to specialist assessments as needed

Table G below details our performance against these priorities in 2014/15. Where applicable, it presents national targets and averages and information relating to our performance against these indicators in 2013/14.

Table I: Patient Safety Priorities

		Measures	13/14 Performance	National Target/National Average	Target for 14/15	Outcome	Target Achieved?
Patient Safety Priorities – Part 1	**Priority 1**	**To achieve year-on-year reductions in Healthcare Associated Infections (HCAIs)**					
	Target 1	To achieve the clostridium difficile Department of Health objective of fewer than 65 cases in the Trust [data source: Public Health England]	58	less than 65 cases	less than 65 cases	**79**	**No**
	Target 2	To achieve the national directive to have zero tolerance for all healthcare-associated MRSA blood stream infections [data source: Public Health England]	13	0	0	**8**	**No**
	Target 3	To be 90% compliant with our anti-infective prescribing [data source: Point Prevalence Study on Anti-infective Use Full Report - January 2015]	83%	N/A	more than 90%	**85%**	**No**
	Priority 2	**To increase incident reporting rates and reduce their reported harm to meet NRLS peer rate**					
	Target 1	We will meet the National Reporting and Learning System (NRLS) peer median reporting rate for patient safety reporting rates per 1,000 bed days [data source: NRLS Organisation Patient Safety Incident Report - Reported incidents between 01 April 2014 to 30 September 2014]	7.38 (different methodology used)	35.1	35.1 or above	**42.98** (NRLS published data April-Sept 2014) **45.25** (Trust reported rate for 2014/15)	**Yes**
	Target 2	We will be below our peers for incidents graded as extreme (death) [data source: NRLS Organisation Patient Safety Incident Report - Reported incidents between 01 April 2014 to 30 September 2014]	0.20%	0.1%	less than 0.1%	**0.30% (NRLS published data April-Sept 2014)** **0.16% (Trust reported rate for 2014/15)**	**No**

		Measures	13/14 Performance	National Target/National Average	Target for 14/15	Outcome	Target Achieved?
Patient Safety Priorities – Part 2	Target 3	We will be below our peers for incidents graded as severe (major harm) [data source: NRLS Organisation Patient Safety Incident Report - Reported incidents between 01 April 2014 to 30 September 2014]	0.10%	0.4%	less than 0.4%	**0.10%** (NRLS published data April-Sept 2014) **0.08%** (Trust reported rate for 2014/15)	**Yes**
	Target 4	We will have a zero tolerance for 'never events' [data source: month 12 scorecard]	1	N/A	0	**3**	**No**
	Priority 3	**To ensure high performance against the NHS Safety Thermometer**					
	Target 1	Safety Thermometer - We will reduce avoidable harm of patients acquiring a venous thromboembolism through risk assessment and appropriate treatment [data source: month 12 scorecard]	97% (month 12 2013/14)	more than 95%	more than 95%	**96.61%**	**Yes**
	Target 2	Safety Thermometer - We will ensure the number of falls with harm remains below the national average [data source: month 12 scorecard]	0.26% (month 12 2013/14)	N/A	less than 1.00%	**0.22%**	**Yes**
	Target 3	Safety Thermometer - We will reduce the total number of all grades of pressure ulcer	3.17%	N/A	10% reduction on last year's score i.e. less than 2.85%	**2.65%**	**Yes**
	Target 4	Safety Thermometer - We will continue to submit Safety Thermometer data on urinary catheter related infections and to monitor our performance against peer Trusts [data source: month 12 scorecard]	0.18% (month 12 2013/14)	N/A	less than 1.51%	**0.15%**	**Yes**
	Priority 4	**We want to increase the awareness of dementia and ensure that relevant patients who are admitted as an emergency are screened for dementia and have access to specialist assessments as needed**					
	Target 1	Dementia CQUIN - 90% compliance with 'FAIR' Elements • Element A: **F**ind and **A**ssess– identify patients aged 75 and over and ask case-finding questions • Element B: **I**nvestigate • Element C: **R**efer – ask GP to refer on for specialist memory service assessment. [data source: month 12 scorecard]	N/A	N/A	More than 90%	**Element A** - 90.30% **Element B** - 94.20% **Element C** - 95.65%	**Yes**

Priority 1: To achieve year-on-year reductions in Healthcare Associated Infections (HCAIs)

This priority was chosen to support the 'Safety' goal in our previous quality strategy. We measure our success with this priority through the following three targets:

- to achieve the Clostridium difficile Department of Health objective of fewer than 65 cases in the Trust
- to achieve the national directive to have zero tolerance for all healthcare-associated MRSA blood stream infections
- to be 90% compliant with our anti-infective prescribing

Our performance against these targets is explained below.

Target 1: We will achieve the Clostridium difficile Department of Health objective of fewer than 65 cases in the Trust during 2014/15.

Clostridium difficile is a common cause of healthcare associated diarrhoea. It is a common bacterium that exists harmlessly in the bowel of 3% of healthy adults and up to 30% of older people. If antibiotics disturb the balance of bacteria in the bowel, Clostridium difficile can multiply and produce toxins that cause diarrhoea and illness. The bacteria can spread on the hands of healthcare staff and others who come into contact with patients who have the infection, or with environmental surfaces contaminated with the spores.

Target for 2014/15: Fewer than 65 cases during 2014/15

Outcome: 79 cases of Clostridium difficile [data source: Public Health England]

Progress: Objective not achieved

Explanation of progress:

Of the 79 cases to March 2015, only eight cases have been recognised as being due to a potential lapse of care and attributed to the Trust, while the other cases are related to external factors. Two cases which occurred in quarter four are currently under review to see if these are attributable to a potential lapse of care.

The number of cases of Clostridium difficile, as a rate of patients admitted to our hospitals per 100,000 bed days is 26.47 (using 2013/14 bed days data, supplied by Public Health England). We do not restrict testing of stool samples and we process on average 600 - 700 specimens each month. The guidance released by Public Health England for 2014/15 was explicit in that retrospective tests or clinical reviews could not take place once a sample testing positive for Clostridium difficile has been identified. Therefore we report all positive results even if another reason for the diarrhoea has been identified.

Improvements achieved:

- We have held quarterly review meetings with our commissioners to identify and agree any potential lapses of care in cases that have been attributed to the Trust.
- We have improved the process around isolating patients with Clostridium difficile within two hours and improved feedback mechanisms to the clinical teams for action and learning.
- We have carried out a rapid review of all cases, with local actions logged and reviewed at weekly HCAI taskforce meetings.
- We reviewed our guidelines for treating and managing patients with Clostridium difficile, to include newly recommended treatments.

- We added Clostridium difficile status to the electronic discharge summary, to strengthen communication between community colleagues and other providers.
- We redesigned noticeboards in each clinical area, to make information on Clostridium difficile and other infection control indicators clearer and more readily available for patients and staff.

Further improvements identified:

- We will make details of cases and relevant issues available to primary care colleagues, to help raise awareness and mitigate risk.
- We will continue to monitor isolation practice and increase the isolation capacity on all our hospital sites.
- We will provide patients with the Department of Health 'C. difficile now you are going home' leaflet, to give them information about their infection and how to manage it.
- We will roll out electronic prescribing across all wards and departments, to enable closer monitoring of antibiotic prescriptions.
- We will set ourselves a target of 'no avoidable infections' for 2015/16.

Target 2: We will aim to achieve the national directive to have zero tolerance for all healthcare-associated MRSA blood stream (BSIs)

MRSA is a bacterium found on the skin and in the nostrils of many healthy people without causing problems. It can cause disease – particularly if there is an opportunity for the bacteria to enter the body – for example through broken skin or a medical procedure.

Target for 2014/15: Zero cases during 2014/15

Outcome: 8 cases of MRSA BSI [data source: Public Health England]

Progress: Objective not achieved

Progress explained:

We have not achieved the national directive of zero tolerance for MRSA for 2014/15. However, we have seen an improvement since 2013/14, when we reported 13 cases. We will be continuing this priority next year as part of our goal of zero avoidable infections.

We believe that two of the eight cases have been inappropriately allocated to the Trust because these infections were as a result of factors beyond our control. We are contesting the final allocation of these.

Of the six other cases; two were contaminants, one was a probable contaminant and three cases were related to vascular access devices. Contaminants are not true infections; these are cases where the sample has become contaminated during the taking of the blood. Of the total eight cases allocated to us, we consider three of these to be avoidable infections.

Improvements achieved:

- We have added MRSA status to the electronic discharge summary, to strengthen communication between community colleagues and other providers.
- We have redesigned noticeboards in each clinical area, to make information on MRSA and other infection-control indicators clearer and more readily available for patients and staff.
- We have standardised our vascular access devices, including a device insertion pack, to reduce risk of MRSA.

- We have installed a new system that monitors and reviews all actions that arise following MRSA investigations.

Further improvements identified:

- We will review and update our MRSA policy as part of our on-going process of review of all policies.
- We will audit compliance with the new MRSA policy with regard to prescribing and administering MRSA suppression therapy.
- We will roll out electronic prescribing across all wards and departments.
- We will set ourselves a target of 'no avoidable infections' for 2015/16.

Target 3: We will be 90% compliant with the Trust anti-infective prescribing

Anti-infectives (drugs that are capable of acting against infection) include antibacterials, antifungals and antivirals. These agents are often referred to collectively as antibiotics. They are extremely important and are potentially life-saving therapies. However, if they are used inappropriately and excessively, drug-resistant organisms can emerge, putting patients at an increased risk of developing a more resistant strain of an infection or Clostridium difficile.

Our performance with this target was assessed by measuring our compliance with our three anti-infective prescribing standards:

- antibiotics prescribed in line with our antibiotic policy or approved by specialists from within our infection teams
- a reason for starting the antibiotic clearly documented within the patient's medical notes/drug chart
- a stop/review date on the drug chart, to optimise duration of therapy.

Target for 2014/15: Over 90% compliant
Outcome: 85% [data source: Point Prevalence Study on Anti-infective Use Full Report - January 2015]
Progress: Objective not achieved

Progress explained:

We achieved our target of over 90% compliance with two of the standards above (prescribing antibiotics in line with Trust policy and documenting the reason for starting the antibiotic). However, we did not meet the 90% target for documenting the antibiotic stop/review date. This resulted in us not meeting the overall target.

We will continue to work next year to ensure all nursing, pharmacy and medical staff are aware of the need to document the stop/review date.

Improvements achieved:

- We introduced a number of antibiotic policies within the specialities of respiratory medicine, gastroenterology and critical care, together with reviewing our empirical antimicrobial guidance.
- We worked with paediatric colleagues to develop and launch a paediatric antibiotic mobile phone app, to help with antibiotic prescribing. This was well received.
- We promoted the Department of Health's "Start Smart then Focus" campaign promoting the messages of reviewing antibiotic prescriptions daily, switching intravenous therapy to oral as soon as possible and reviewing therapy in light of culture results.

Further improvements identified:

- We will develop further protocols around sepsis and resistance of gram-negative organisms.
- We will introduce a new Department of Health antibiotic prescribing indicator.
- We will develop electronic prescribing.
- We will continue to engage with healthcare professionals across the Trust and primary care to address the antibiotic stewardship agenda.

A note on infection prevention and control training

Core Skills Training is overseen and led by the People and Organisation Development Directorate within the Trust. The Infection Prevention and Control (IPC) service will support the team in ensuring the appropriate and efficient delivery of the IPC component and positively reinforce the need for good practice with all staff groups and divisions. A particular focus on the rotating population of junior doctors and trainees is being explored and a stronger link to patient safety training will be developed. In addition the IPC component will be increased to an annual requirement.

Of note, in addition to this web based training there is comprehensive Trust wide Aseptic Non Touch Technique (ANTT) and hand hygiene competency assessment programme.

Priority 2: To increase incident reporting rates and reduce their reported harm to meet NRLS peer target

This priority was chosen to support the 'Safe' goal in our quality strategy. We measure our success with this priority through the following four targets:

- to meet the National Reporting and Learning System (NRLS) peer median reporting rate for patient safety reporting rates per 1000 bed days
- to be below our peers for incidents graded as extreme
- to be below our peers for incidents graded as severe
- to have zero tolerance for 'never events'.

Our performance against these targets is explained below.

Target 1: We will meet the National Reporting and Learning System (NRLS) peer median reporting rate for patient safety reporting rates per 1000 bed days

The National Reporting and Learning System (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database on a voluntary basis and is designed to promote learning. Participation enables us to compare our incident reporting rates with our peers.

However, there is no nationally established and regulated approach to the reporting and categorising of patient safety incidents and as such; clinical judgement is often relied upon. This may differ between professionals and between organisations. In addition, the classification of an incident may change as a result of lengthy investigations. This change may not be reported externally and the data held by a Trust may not be the same as that held by the NRLS. Therefore, it may be difficult to explain the differences between the data reported by the different organisations as this may not be comparable.

Target for 2014/15: To meet the peer reporting rate of 35.1 (data from April-September 2014)
Outcome: 42.98 [data source: NRLS Organisation Patient Safety Incident Report - Reported incidents between 01 April 2014 to 30 September 2014]

Progress: Objective achieved

Progress explained:

A patient safety incident is any unintended or unexpected incident that could have led, or did lead, to harm for one or more patients receiving NHS care. An important measure of an organisation's safety culture is its willingness to report adverse events, learn from them and deliver improved care. A high reporting rate is viewed as a positive reporting culture, as it shows that staff feel supported to report incidents. The rate is now calculated by 1,000 bed days where previously it had been against 100 admissions.

In April 2014, we upgraded our incident reporting system. The upgrade process included improved staff awareness regarding incident reporting, training in the use of the system, development of an intuitive system led by clinical staff and consultation regarding incident classification. Since then, we have seen an increase in our reporting rate to its current level within the top quartile when compared to our peers. We believe this is also due to a culture of increasing openness and transparency, which is reflected by the improved responses to the safety questions in our staff survey

We are pleased with the progress made this year as we have exceeded our target on reporting, while reporting a low level of harm. The results shown here are for the most recent published data available, from April 2014 – September 2014. Internal unpublished data for the whole financial year shows an overall rate of 45.24.

Improvements achieved:

- We continued developing the upgraded Datix incident reporting system, to provide improved systems and processes for monitoring, reporting and learning from adverse events.
- We linked incident trends and themes to service improvement and junior doctors' training.
- We reported all pressure ulcer damage through Datix.
- We developed a Safety Dashboard to incorporate all safety data extracted from Datix. This is available to all staff through an online system.

Further improvements identified:

- We will continue to develop Datix to make it easier for staff to report, and will encourage them to do so through a sustained communication programme.
- We will be within the top quartile of trusts with high levels of reporting and be below our peers for incidents graded as extreme and severe.

Target 2: We will be below our peers for incidents graded as extreme

Target for 2014/15: To be below the peer rate of 0.1% for incidents graded as extreme

Outcome: 0.3% [data source: NRLS Organisation Patient Safety Incident Report - Reported incidents between 01 April 2014 to 30 September 2014]

Progress: Objective not achieved

Progress explained:

We did not achieve our goal of a lower number of incidents graded as 'extreme' in comparison to peer average, with a total of 19 incidents graded as extreme during the data period April 2014-Sept 2015. We believe this is partly due to a culture of increasing openness and transparency, which is reflected by our high reporting rate and the improved responses to the

safety questions in our staff survey. We continue to have one of the lowest mortality rates in the country. Internal unpublished data for the whole financial year shows 0.16% of reported incidents were graded extreme (a total of 25 incidents).

Target 3: We will be below our peers for incidents graded as severe

Target for 2014/15: To be below the peer rate of 0.4% for incidents graded as severe

Outcome: 0.1% [data source: NRLS Organisation Patient Safety Incident Report - Reported incidents between 01 April 2014 to 30 September 2014]

Progress: Objective achieved

Progress explained:

We achieved our goal of a lower number of incidents graded as 'severe' in comparison to the peer average, with a total of 6 incidents graded as severe during the data period April 2014-Sept 2015. Internal unpublished data for the whole financial year shows 0.08% of reported incidents were graded severe (a total of 13 incidents).

Improvements achieved:

- We sustained and streamlined the incident review panel, chaired by the Medical Director, for review of all incidents reported and/or assessed to be moderate, major and extreme.
- We produced trust-wide communication regarding incidents and learning, following the incident review panel meeting and serious incident reviews.
- We continued to share learning from all serious incidents with staff, through our intranet site.

Further improvements identified:

- We will work to improve our systems and processes to enable root cause analyses to be completed in a timely way to ensure immediate action can be taken and learning disseminated.
- We will review actions from incident investigations regularly to ensure they are carried out in a timely manner.
- We will reduce the numbers of incidents causing severe and extreme harm to be below the national average in year one, and have none in year three of the strategy.

Target 4: We will have a zero tolerance for 'never events'

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

Target for 2014/15: 0 never events

Outcome: 3 never events (1 occurred in 2013/14 but was reported retrospectively) [data source: month 12 scorecard]

Progress: Objective not achieved

Progress explained:

We have not achieved our goal of zero never events, with three declared in 2014/15. One never event relating to a retained vaginal swab occurred in 2013/14 but was reported in April 2014. Between March and August 2014, we reported two 'never events' and two serious incidents where patients had been fed through mis-placed nasogastric or nasojejunal tubes. Three of these incidents were due to the chest x-ray, used to confirm the position of the tube, being misinterpreted.

Improvements achieved:

We have taken the following actions to prevent similar events occurring:

- We have introduced new standard operating procedure. This involves using a pink wristband when a swab is intentionally left in a patient, which will alert staff to the retained item.
- We have developed a new online training module for maternity, which includes WHO checklist procedures and also the Standard Operating Procedure for the pink wristband.
- We have incorporated the pink wristband and WHO checklist initiatives, detailed above, in the 'safer surgery' priority of our 'Sign Up To Safety' improvement programme.
- We have amended our nasogastric (NG) tube policy to remove responsibility for chest x-ray interpretation from the junior doctors. Now, all chest x-rays taken to confirm the position of nasogastric tubes have to be approved by the radiologist before they are used for feeding.
- We ran training for nursing staff on placing nasogastric tubes in September 2014. Further training is being delivered across all relevant areas across the Trust during the rest of the year.
- We conducted a Placement and Confirmation Audit in September 2014. This led to reviews of the Nutrition Nurse Specialist support, appropriate nasogastric tube stock, redesigning associated forms, and updating and awareness-raising of our policy in relation to positioning tubes, the nutrition screening process and referral to the dietician.
- We updated an online training programme for doctors, to include questions on interpreting the position of nasogastric tubes on chest x-rays.

Further improvements identified:

- We will continue to monitor, audit and review progress with the above actions, making changes and improvements where necessary.
- We will maintain our target of zero never events in 2015/16.

Priority 3: To ensure high performance against the NHS Safety Thermometer

Keeping our patients safe while they are under our care is our most important goal. Every month, we use a tool called the Safety Thermometer to audit our patients' care, which helps us understand how well we are doing and highlights areas for improvement. The Safety Thermometer is a 'point prevalence audit' – it measures patient safety incidents that have occurred on a particular day each month.

Our goal is to deliver 95% harm-free care to our patients by reducing the number of falls, pressure ulcers and catheter-related infections, as evidenced by the Safety Thermometer. This allows frontline teams to measure how safe their services are and to deliver improvements locally.

We measure our success with this priority through the following four targets:

- to ensure that falls with harm to remain below the national average
- to reduce the total number of all grades pressure ulcers
- to reduce avoidable harm of patients acquiring a venous thromboembolism
- to continue to submit the Safety Thermometer data and to monitor our performance against peer trusts on urinary catheter-related infections.

Our performance against these targets is explained below.

Target 1: We will ensure the number of falls with harm remains below the national average

Across England and Wales, approximately 152,000 falls are reported in acute hospitals every year. A significant number of falls result in severe or moderate injury. Falls are most likely to occur in older patients, and it is these patients who are most likely to experience serious injury.

Target for 2014/15: less than 1%

Outcome: 0.22% [data source: month 12 scorecard]

Progress: Objective achieved

Progress explained:

We reported an average of 0.22 falls per 100 patients in 2014/15 as measured by the Safety Thermometer, compared with the national average of 1%. We continue to report a low rate of falls with harm when compared nationally using the Safety Thermometer data.

Improvements achieved:

- We have started undertaking a risk assessment for each patient within six hours of admission with care plans designed to reflect individual needs.
- We have put in place a system where high-risk patients undergo a medication review to ensure that a fall will not be caused by the medications they are taking.
- We are conducting collaborative work with patients around continence management to ensure that preventable falls are not caused by patients being anxious about getting to the toilet.

Further improvements identified:

- We will review our falls policy to include the latest guidance.
- We will audit compliance with the new guidance across the Trust.

Target 2: We will reduce the total number of all grades of pressure ulcer by 10%

A pressure ulcer is a type of injury that affects areas of the skin and underlying tissue, caused when the affected area of skin is placed under too much pressure. Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. Pressure ulcers are graded from 1 to 4 to indicate their severity, with 1 indicating less damage and 4 indicating serious damage.

Target for 2014/15: Less than 2.85% (10% reduction of pressure ulcers of all grades by end of Q4 as measured by the Safety Thermometer) [data source: National Safety Thermometer]

Outcome: 2.65%

Progress: Objective achieved

Progress explained:

We met our target of a 10% reduction of all pressure ulcers as measured by the safety thermometer and will continue to work to reduce the number further throughout the coming year, with a focus on reducing grade 3 and 4 pressure ulcers by a further 10%, aiming for complete eradication by the end of 2017.

Improvements achieved:

- We have achieved a sustained reduction in category 3 pressure ulcers through training and effective root cause analysis of all pressure damage.
- We reported no category 4 pressure ulcers in 2014/15.
- We have sustained high performance when compared nationally with Safety Thermometer data.
- We have launched a data application that is updated hourly and shows all reported pressure damage across the Trust. Ward sisters and charge nurses can see at a glance what has been reported in their area and use the data for improvement work.
- We have rolled out pressure ulcer management competency training to all staff in high risk areas.
- We have appointed a patient safety fellow to further our understanding of community acquired pressure ulcers.
- We have developed a pressure ulcer information application for patients and carers.
- We have rolled out enhanced documentation in high risk areas of the medical division.
- We have provided pressure relieving mattress stores in high risk areas to facilitate early access for high risk patients.
- We have instigated quality rounds led by the tissue viability team.
- We have introduced SKIN champion roles for ward based staff.

Further improvements identified:

- We will focus on categories 1 and 2 and continence damage (a common cause of pressure ulcers), as these frequently deteriorate to higher categories.
- We will continue to drive down trust-acquired pressure damage, with a goal of reducing grade 3 and 4 pressure ulcers by 10% by the end of 2015/16 and their complete eradication within three years.

Target 3: We will reduce avoidable harm of patients acquiring a venous thromboembolism through risk assessment and appropriate treatment

Venous thromboembolism (VTE) incorporates both deep-vein thrombosis and its possible consequence: pulmonary embolism. A deep-vein thrombosis (DVT) is a blood clot that develops in the deep veins of the leg. If the blood clot becomes mobile in the blood stream, it can travel to the lungs and cause a blockage (pulmonary embolism) that could lead to death. In 2005, the House of Commons Health Committee reported that an estimated 25,000 people die from preventable hospital-acquired VTE in the UK every year. The risk of hospital-acquired venous thromboembolism can be greatly reduced by risk-assessing patients and prescribing them appropriate measures that prevent it occurring.

Target for 2014/15: 95% of all inpatients assessed for VTE

Outcome: 96.61% [data source: month 12 scorecard]

Progress: Objective achieved

Progress explained:

In 2014/15 96.61% of our inpatients underwent assessment for VTE within 24 hours, as measured by the Safety Thermometer. This is an improvement on last year's performance.

Improvements achieved:

- We have continued to report weekly on the number of VTE assessments completed ward by ward. We have reviewed wards that have not met their targets and supported them to improve.
- This year, root cause analyses have been carried out for 83.19% of patients identified as having a hospital-acquired VTE, compared with 61% last year [data source: month 12 scorecard].

Further improvements identified:

- We will continue to monitor progress and instigate improvements where necessary
- We will report our performance against this target in 2015/16 and aim for no avoidable deaths as a consequence of VTE.

Target 4: We will continue to submit Safety Thermometer data on urinary catheter related infections and to monitor our performance against peer trusts.

A urinary tract infection can happen anywhere along the urinary tract. People are at increased risk of these infections if they are diabetic, older, have kidney stones, are immobile, or have had surgery or a urinary catheter inserted, to drain the bladder.

Target for 2014/15: Less than 1.51%

Outcome: 0.15% [data source: month 12 scorecard]

Progress: Objective achieved

Progress explained:

We have continued to submit urinary tract infection (UTI) data and monitored our performance against our peers; this data is included in the quality account for the first time. The national average for the percentage of patients who had a urinary catheter fitted and developed an infection as a result is 1.51%, we achieved our objective of having fewer than the national average and our internal target of less than 1%, with 0.15% of our patients developing a urinary tract infection following a catheter fitting as per the safety thermometer data.

Improvements achieved:

- We have continued to submit UTI data as part of the Safety Thermometer throughout the year.
- We have reinforced best practice with inserting and caring for urinary catheters, ensuring they are removed at the earliest opportunity.

Further improvements identified:

- All catheter associated UTIs will be logged as an incident and will be investigated with local learning and actions implemented.
- We have a target of ‘no avoidable infections’ for 2015/16.

Priority 4: We want to increase the awareness of dementia and ensure that relevant patients who are admitted as an emergency are screened for dementia and have access to specialist assessments as needed

Target: 90% compliance with 'FAIR' Elements A, B and C

The aim of this CQUIN is to improve care for patients with dementia, including sustained improvement in the 'FAIR' elements of dementia care. These are as follows:

- Element A: **F**ind & **A**ssess – identify patients aged 75 and over and ask case-finding questions
- Element B: **I**nvestigate
- Element C: **R**efer – ask GP to refer on for specialist memory service assessment.

Our aim for 2014/15 was to achieve our CQUIN target of 90% compliance with these three elements as follows:

Outcome for Element A: 90.30% [data source: dementia care team CQUIN report]

Outcome for Element B: 94.20% [data source: dementia care team CQUIN report]

Outcome for Element C: 95.65% [data source: dementia care team CQUIN report]

Progress: Objective achieved

Progress explained:

We have met our CQUIN targets for all elements of dementia care.

Improvements achieved:

- We have encouraged use of the blue screening sticker, to be placed in the notes of all eligible patients to ensure that patients are screened for the possibility for dementia. Posters are used to remind practitioners to use the stickers.
- We communicate results of screening assessments to the GP as part of the electronic discharge letter, to prompt appropriate referral and follow-up after the patient leaves hospital.
- Dementia now features at doctors' induction, including information about the dementia CQUIN and use of the blue screening sticker, described above.
- By February 2015 we had introduced weekly carers' drop-in sessions, run by the dementia care team, across all three sites.
- We have piloted an audit of carers of patients with dementia. This has been trialled on five wards and will be rolled out to others once it is established. The audit asks carers whether they felt supported during the stay in hospital and whether they felt they received sufficient information.
- We offer all carers a carer's passport – a scheme which enables carers of patients who have dementia or are vulnerable to visit outside hospital visiting hours.
- We are supporting 'John's Campaign' (www.johnscampaign.org), which is campaigning for the right to stay in hospital with loved ones who have dementia.
- We have created packs for people with dementia to explain what can happen following an operation, and hand these out at pre-assessment clinics.

Further improvements identified:

- We will adapt our dementia strategy to ensure we continue to exceed our targets with the move to electronic patient records.
- We will roll out the audit of carers to all wards.
- The Dementia Care Team will be working with the Alzheimer's Society 'Side by Side' befriending project, which will be appointing a community support manager within the Trust.
- The Dementia Care Team has developed an annual benchmark tool to evaluate dementia care in the Trust, which we will report on through our governance structure.

Clinical effectiveness priorities

This section sets out our achievements towards the following clinical effectiveness priorities:

- to continuously improve Hospital Standardised Mortality Rates and Standardised Hospital-level Mortality Indicators ratios and reduce variation across the week days
- to reduce the number of emergency readmissions to hospital within 28 days of discharge
- to increase our participation rates to above 80% for all Patient Reported Outcome Measures.

Table J below details our performance against these priorities in 2014/15. Where applicable, it presents national targets and averages and information relating to our performance against these indicators in 2013/14.

Table J: Clinical Effectiveness Priorities

		Measures	13/14 Performance	National Target/National Average	Target for 14/15	Outcome	Target Achieved?
Clinical Effectiveness Priorities – Part 1	**Priority 1**	**To continuously improve Hospital Standardised Mortality Rates (HSMR) and Standardised Hospital-level Mortality Indicators (SHMI) ratios and reduce variation across the week days**					
	Target 1	We will be better than the national average for mortality rates as measured by SHMI [data source: Dr Foster Intelligence for Imperial Business Intelligence Q2 2013/4 – Q1 2014/15]	79	100	less than 100	**73.17**	**Yes**
	Target 2	We will be better than the national average for mortality rates as measured by HSMR [data source: Dr Foster Intelligence for Imperial Business Intelligence Dec13 – Nov14]	73	100	less than 100	**72.64**	**Yes**
	Priority 2	**To reduce the number of emergency readmissions to hospital within 28 days of discharge**					
	Target 1	To reduce the rate of emergency readmissions to hospital within 28 days of discharge for patients 15 years and under [Data source: Dr Foster – April – September 2014]	5.95%	8.10%	less than the Trust's rate for 13/14 – 5.95%	**6.31%**	**No**
	Target 2	To reduce the rate of emergency readmissions to hospital within 28 days of discharge for patients 16 years and over [Data source: Dr Foster – April – September 2014]	7.90%	7.97%	less than the Trust's rate for 13/14 – 7.90%	**8.84%**	**No**
	Target 3	To remain below the national average and reduce the rate of emergency readmissions to hospital within 28 days of discharge for patients aged 15 years or younger [Data source: Dr Foster – April – September 2014]	5.95%	8.10%	less than the national average of 8.10%	**6.31%**	**Yes**
	Target 4	To remain below the national average and reduce the rate of emergency readmissions to hospital within 28 days of discharge aged 16 years or older [Data source: Dr Foster – April – September 2014]	7.90%	7.97%	less than the national average of 7.97%	**8.84%**	**No**

		Measures	13/14 Performance	National Target/National Average	Target for 14/15	Outcome	Target Achieved?
Clinical Effectiveness Priorities – Part 2	**Priority 3**	**To increase our participation rates to above 80% for all PROMS**					
	Target 1	PROMS - To increase our participation rates to above 80% for groin hernia surgery (April-September 2014 data)	55.1%	58.30% (national average April-Sept 2014)	80% or above	**0.00%**	**No**
	Target 2	PROMS - To increase our participation rates to above 80% for hip replacement surgery (April-September 2014 data)	66.9%	86.10% (national average April-Sept 2014)	80% or above	**90.30%**	**Yes**
	Target 3	PROMS - To increase our participation rates to above 80% for knee replacement surgery (April-September 2014 data)	66.4%	96.60% (national average April-Sept 2014)	80% or above	**116.50%**	**Yes**
	Target 4	PROMS - To increase our participation rates to above 80% for varicose vein surgery (April-September 2014 data)	62.1%	42.40% (national average April-Sept 2014)	80% or above	**66.50%**	**No**

Priority 1: To continuously improve Hospital Standardised Mortality Rates (HSMR) and Standardised Hospital-level Mortality Indicators (SHMI) ratios and reduce variation across the week days.

We chose this priority to support the 'Safety' domain in our previous quality strategy. We measure our success with this priority through the following target:

Target 1: We will be better than the national average for mortality rates as measured by SHMI & HSMR

The Summary Hospital-level Mortality Indicator is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

This indicator is used to report on mortality at trust level across the NHS in England, using a standard and transparent methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre, with the first publication in October 2011.

The Hospital Standardised Mortality Ratio (HSMR) is an overall quality indicator that compares a hospital's mortality rate with the average national experience, accounting for the types of patients cared for. It has been used by many hospitals worldwide to assess and analyse mortality rates and to identify areas for improvement.

This figure is calculated as the ratio of the actual number of deaths to the expected number of deaths, multiplied by 100. It is based on diagnosis groups that account for 80% of all deaths in acute care hospitals, and is adjusted for factors such as diagnosis group, age and sex, length of stay, admission category, co-morbidities, and transfers.

A ratio of less than 100 indicates that the hospital's mortality rate is lower than the average national rate.

Target for 2014/15: Less than 100

Outcome: 73.17 (SHMI – Q2 2013/4 – Q1 2014/15) and 72.64 (HSMR – Dec13 – Nov14) [data source: Dr Foster Intelligence for Imperial Business Intelligence]

Progress: Objective achieved

Progress explained:

Our SHMI and HSMR scores are excellent when compared nationally. The rate for each is the second lowest for non-specialist acute providers across the available data.

Improvements achieved:

- Our mortality rates remain consistently low.

Further improvements identified:

- We will work to reduce out of ICU/ED cardiac-arrest call rates.
- We will ensure that reviews of all mortalities that occur in our hospitals are carried out and reviewed at multi-disciplinary team meetings.
- We will be the lowest-risk acute trust nationally for 2015/16.
- We will monitor our performance against our global comparator hospitals in 2015/16 with the aim to improve our position annually in comparison to be in the top third.

Priority 2: To reduce the number of emergency readmissions to hospital within 28 days of discharge

We chose this priority because it is a mandated indicator in the Department of Health reporting arrangement for the quality accounts. We measure our success in this priority through the following four targets:

Target 1: To reduce the rate of emergency readmissions to hospital within 28 days of discharge for patients under the age of 15 years

Target for 2014/15: Less than 5.95%

Outcome: 6.31% [Data source: Dr Foster April-Sept 2014]

Progress: Objective not achieved

Target 2: To reduce the rate of emergency readmissions to hospital within 28 days of discharge for patients 15 years and over

Target for 2014/15: Less than 7.90%

Outcome: 8.84% [Data source: Dr Foster April-Sept 2014]

Progress: Objective not achieved

Target 3: We will be below the national average for this indicator for patients aged 15 years old or younger

Target for 2014/15: Less than 8.10%

Outcome: 6.31% [Data source: Dr Foster April-Sept 2014]

Progress: Objective achieved

Target 4: We will be below the national average for this indicator for patients aged 16 or above

Target for 2014/15: Less than 7.97%

Outcome: 8.84% [Data source: Dr Foster April-Sept 2014]

Progress: Objective not achieved

Progress explained:

The unplanned emergency readmission rate at the Trust in 2014/15 for paediatric patients has fallen to just below the UK average for non-specialist acute trusts; however for adult patients this is just above the UK average. We have failed to reduce the rate of emergency readmissions for both age groups in comparison to last years' performance.

Improvements achieved:

- We have continued to work with GPs and community teams to review patients who have been readmitted and agree specific actions to prevent further readmissions.
- We have established a 24-hour Urgent Care Centre at Hammersmith Hospital.
- We have established ambulatory care centres on all sites to ensure that we can provide rapid access to assessment and planned care for our patients.
- We have established bespoke targeted services for homeless patients at St Mary's – working across organisational and geographical boundaries alongside the complex discharge team, the Homeless Outreach Team support patients who attend the emergency department or are admitted. They provide an extended hours specialist service for homeless people with a focus on supporting effective discharge and prevention of readmission.

- We work with the Red Cross Next Steps Team who provide support at home to tri-borough resident patients who attend or are admitted to any of our sites; services are focussed on supporting effective discharge and prevention of readmission through providing direct patient support in the community which can range from contacting relatives, identifying issues with medication compliance, referrals on to social care if a patient is not managing in the community or simple social support such as shopping.

Further improvements identified:

- We will review, streamline and improve our discharge processes to ensure effective discharge and reduce the risk of readmission.
- We will further expand the Homeless Outreach Team to cover Charing Cross and Hammersmith.
- We will work with the Red Cross Next Steps Team to identify opportunities to expand services to seven days and to cover external boroughs.
- We will continue to monitor readmission rates as part of the quality strategy 'Responsiveness' domain to meet all national access targets.

Priority 3: To increase our participation rates to above 80% for all PROMS

Patient Reported Outcome Measures (PROMs) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following one of these four clinical procedures:

- groin hernia surgery
- varicose vein surgery
- hip replacement surgery
- knee replacement surgery.

Patients who have these procedures are asked to complete the same short questionnaire both before and after surgery. The first questionnaire (part A) is completed by the patient shortly before surgery and scores the patients' health status prior to having their surgical procedure. The number of pre-surgery forms sent into the Health and Social Care Information Centre (HSCIC) by the Trust is compared to the number of surgical procedures carried out as recorded on our hospital information system; and it is this figure that is used to calculate the Trust's PROMs participation rates. The HSCIC are responsible for posting out the second PROMS questionnaire (part B) to patients. The patient is responsible for completing the part B form and returning it to HSCIC and it is the difference in the scores between the part A and part B forms that is used to calculate the patients' health gain.

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

HSCIC only post out part B (post-surgery) forms to a selected sample of patients. Sometimes only a low number of these are returned by patients and when this number is less than 30 forms it is not possible to calculate a statistically valid score for health gain. This is why the Trust may report a high participation rate for a surgical procedure at the same time as reporting an insufficient number of records to calculate health gain.

The difference between the two is used to determine the outcome of the procedure as perceived by the patient. To ensure that the data is reflective of our patient groups, we need to increase our participation rates.

Responsibility for PROMS transferred to the Medical Director in Q3 2014/15 and a full review of our processes completed in Q4. We measure our success with this priority through the following four targets:

Target 1: To increase our participation rates to above 80% for groin hernia surgery

Target for 2014/15: Participation of 80%

Outcome: 0%

Progress: Objective not achieved

Target 2: To increase our participation rates to above 80% for varicose vein surgery

Target for 2014/15: Participation of 80%

Outcome: 66.50%

Progress: Objective not achieved

Target 3: To increase our participation rates to above 80% for hip replacement surgery

Target for 2014/15: Participation of 80%

Outcome: 90.30%

Progress: Objective achieved

Target 4: To increase our participation rates to above 80% for knee replacement surgery

Target for 2014/15: Participation of 80%

Outcome: 116.50% (outcome over 100% due to methodology – see above)

Progress: Objective achieved

[Data source: Health & Social Care Information Centre: the data above refers to patients questioned between April and September 2014]

Overall progress explained:

We met our target of 80% participation for hip and knee replacement surgery and achieved an average participation of 57.80% across the four procedures between April and September 2014 (latest data available). However, a review of PROMs data and follow-up with service teams has revealed that there was a breakdown in PROMs reporting systems for varicose vein and groin hernia surgery from summer 2014. The Safety and Effectiveness team is working with the services to re-establish the systems and improve participation rates across all four measured procedures.

Further improvements identified:

- We will re-establish and improve the PROMs reporting systems to ensure the data is reflective of our patient groups.
- We will assist patients to complete the PROMs part A questionnaire at the surgical pre-assessment clinic to increase participation, with compliance auditing of this process being undertaken through the corporate team
- We will maintain this as a quality account priority for 2015/16.

Patient experience priorities

This section sets out our achievements towards the following patient experience priorities:

- to ask patients in adult inpatient, outpatient and A&E departments the Friends and Family Test
- to improve reported experience of our patients, including responsiveness to the personal needs of patients
- to remain above average of 60% of staff who would recommend us as a Trust to friends/family needing care
- to nurse our patients in single-sex accommodation.

Table I below details our performance against these priorities in 2014/15. Where applicable, it presents national targets and averages and information relating to our performance against these indicators in 2013/14.

Quality Improvement Case Study: Improving patient experience by tackling sleep disturbance on wards

The restorative qualities of sleep are well evidenced, but in hospital wards a good night's sleep is notoriously elusive. That is why a team conducted a quality improvement project to remove the barriers to sleep across the Trust.

The first step was to get a clear picture of what was happening, with an electronic survey 180 patient interviews, and night-time observations on 18 wards, recording levels of noise, light and temperature on each site. Only 1% of patients reported their overall sleep as excellent or very good 25% as good, 38% as fair and 36% as poor, bad or very bad.

The team identified not one culprit, but many, including excessive light, loud voices, faulty equipment, patient and staff mobile phones and 'clicky' heels. Temperature was a factor too, with one ward kept at 30 degrees.

The team then worked with ward teams, helping them find ways to address the problems. The solutions were often simple and cost effective, explains project lead, Professor Christine Norton: cheap black-out blinds, asking estates teams to service banging bins and squeaky trolleys, and rescheduling noisy laundry and catering rounds from 4am to later in the morning.

One year later, the outcomes have been positive, with just 8% of patients describing their overall sleep as poor, 23% fair, 45% good, and 24% excellent or very good. 'It was a very simple project and very low cost,' says Christine, 'but it made a big difference to patients' experience of care.'

Christine Norton
Project Lead

Table K: Patient Experience Priorities

		Measures	13/14 Performance	National Target/National Average	Target for 14/15	Outcome	Target Achieved?
Patient Experience Priorities	**Priority 1**	**We will ask patients in adult inpatient, outpatient and A&E departments the Friends and Family Test (FFT)**					
	Target 1	FFT Inpatient response rate of 25% in Q1, 30% in Q2 and 40% in Month 12 [data source: month 12 scorecard]	41.27% (month 12)	40%	40%	**46.27%** (month 12)	**Yes**
	Target 2	FFT A&E response rate of 15% in Q1, 20% in Q4 [data source: month 12 scorecard]	18.83% (Q4)	20%	20%	**15.87%** (Q4)	**No**
	Target 3	We will complete the implementation of the FFT question for all outpatient areas by October 2015	N/A	N/A	100%	**100%**	**Yes**
	Priority 2	**To improve reported experience of our patients, including responsiveness to the personal needs of patients**					
	Target 1	To improve on our 2013 scores in the National Patient Survey in relation to responsiveness to patient needs	6.78	N/A	Over 6.78	**6.82**	**Yes**
	Target 2	To improve on our scores in the National Cancer Survey [data source: National Cancer Survey - Sept-Nov 2013 - published 2014]	69% (Sept-Nov 2012, published 2013)	N/A	more than 69%	**72%** (Sept-Nov 2013, published 2014)	**Yes**
	Priority 3	**To remain above average of staff who would recommend the Trust to friends/family needing care**					
	Target 1	To remain above average of staff who would recommend the Trust to friends/family needing care [data source: National Staff Survey - Oct 2014]	69%	75%	above 64%	**77%**	**Yes**
	Priority 4	**We will nurse our patients in single-sex accommodation as defined by the Department of Health and our trust policy**					
	Target 1	We will have a zero tolerance of breaches of mixed sex accommodation as defined by the trust policy [data source: Eliminating mixed sex accommodation (EMSA) 2014/15 annual declaration]	1	N/A	0	**14**	**No**

Priority 1: We will ask patients in adult inpatient, outpatient and A&E departments the Friends and Family Test (FFT)

As part of our aim to provide the highest quality of healthcare, we asked patients in adult inpatient, outpatient and A&E departments the Friends and Family Test. This involves asking the question 'How likely are you to recommend our ward/A&E department to friends/family if they needed similar treatment or care?' We capture this data anonymously through our I Track devices and booths located throughout the hospital.

We chose this priority to support the 'patient-centredness' domain in our previous quality strategy. We measure our success with this priority through the following three targets:

Target 1: Inpatient response rate of 25% in Q1, 30% in Q2 and 40% in Month 12 (March 2015)

Outcome: Q1: 41.9%, Q2: 39.0%, Month 12: 46.27% [data source: month 12 scorecard]

Progress: Target achieved

Target 2: A&E response rate of 15% in Q1, 20% in Q4

Outcome: Q1: 22%, Q4: 15.87% [data source: month 12 scorecard]

Progress: Target not achieved

Target 3: We will complete the implementation of the FFT question for all outpatient areas by October 2015

Outcome: Friends and Family Test implemented in all outpatient areas

Progress: Target achieved

Progress explained:

We have achieved success in two of the three targets above, by increasing our inpatient response rate and fully implementing the FFT question in all outpatient areas by October 2015. We missed our target for the A&E response rate in quarter four, although our performance throughout the year was above 20%. In order to attain a more complete picture of our patient experience in A&E, and make improvements in response where necessary, we will focus on increasing and sustaining the response rate to the FFT question in our A&E departments to 20% in 2015/16.

Improvements achieved:

- We have actively monitored our performance using real-time I-Track devices.

Further improvements identified:

- We will implement the new guidance for the Friends and Family Test from April 2015 – for example, extending it to children and in our urgent care centres.
- We will implement a new system for collecting and reporting Friends and Family Test responses, and will implement a more comprehensive yet focused suite of real-time patient surveys.

Priority 2: To improve reported experience of our patients, including responsiveness to the personal needs of patients

We chose this priority to support the patient centredness goal in our previous quality strategy. This priority is also a mandated indicator in the Department of Health reporting arrangement for the quality accounts. We measure our success with this priority through the following two targets:

- to improve on last year's score in relation to responsiveness to patient needs.
- to improve on our 2013 scores in the National Cancer Survey

Our performance against these targets is explained below.

Target 1: To improve on last year's score in relation to responsiveness to patient needs.

Responsiveness to inpatients' personal needs is a composite score taken from five questions in the national inpatient survey. The score is a driver to ensure that people have a positive experience of care by focusing on hospitals' ability to meet the personal needs of their patients. The score is based on a scale of 1 to 10. This is used as a proxy measure for our overall performance in the national inpatient survey.

Target: a score of over 6.78

Outcome: 6.82

Progress: Target achieved

Progress explained:

We are making year-on-year improvements in our responsiveness score, with a score of 6.82 this year compared to 6.78 in 2013 and 6.64 in 2012. The figures may seem small, but they represent a significant amount of work and the continued upward trajectory is important. Our trust patient experience plan is refreshed after each annual survey is published, however the overarching themes remains consistent: treating patients with respect and dignity, building trust and confidence in our people and increasing their engagement.

Improvements achieved:

- We improved our score for the question related to finding someone to talk to about worries and fears by 5%.

Further improvements identified:

- We will focus on improving our discharge process as the responses show we are not improving as we would hope.
- We will continue to refresh our trust patient experience plan after each annual survey.

Target 2: To improve on our 2013 scores in the National Cancer Survey

Target: a score of over 69%

Outcome: 72% [National Cancer Survey Sept-Nov 2013 – published 2014]

Progress: Target achieved

Progress explained:

We have improved our scores by 3% while the national mean has remained static, and we have seen a significant improvement in 10 of the questions.

Improvements achieved:

- Our scores make us the 13th most improved Trust in the country.
- In 10 questions, we showed statistically significant improvement, with key areas of improvement being information and ward nursing.
- We have ensured that Clinical Nurse Specialists are more visible and easier to contact, which should see an improved result in the 2015 survey.
- We have redesigned pathways to ensure they are as effective possible.
- We have introduced the SMILE campaign in response to previous survey results to improve the experience of our cancer patients (for further information see page 76).
- We entered into a collaboration with Macmillan Cancer Support in 2014 which has enabled us to appoint additional nurse specialists and develop a navigator service, which consists of specific staff who support and guide patients through the often complex pathways of care.

Further improvements identified:

- We will continue to implement the cancer patient experience action plan, particularly through joint working with Macmillan Cancer Support, the new navigator roles and the introduction of Schwartz Rounds.

Priority 3: To remain above average of staff who would recommend the Trust to friends/family needing care

We recognise that by listening to our people and improving our staff engagement, we will make a difference to our patients' experience. We chose this priority to support the patient centredness domain in our previous quality strategy.

Target for 2014/15: to be above the national average of 75%
Outcome: 77% [data source: National Staff Survey]
Progress: Target achieved

Progress explained:

Since the introduction of the Staff Friends and Family Test in April 2014 we have modified our quarterly engagement surveys to include the test questions. 25% of our people are invited to complete the survey each quarter and the survey is issued to all staff within a year. In the 2014/15 surveys, 77% of our people would recommend the Trust to friends and family requiring care, which was above the average of all acute trusts.

Improvements achieved:

- We run local engagement surveys every quarter. Each manager receives local results at specialist and ward level and then develops quarterly action plans to address the issues raised.
- We have produced a new Health and Wellbeing strategy for staff. This includes activities such as yoga, weight management, health and wellbeing days on all sites, and walking challenges.
- Senior leaders have developed many new ways of communicating with staff, from web chats to local forums and walkabouts.
- We have rolled out a new Performance Management Review process throughout the Trust. This has involved training for 1,600 managers in effective performance conversations.

Further improvements identified:

- We will continue our quarterly surveys and will focus on working with managers and leaders to ensure that any issues raised are addressed through action plans.
- We will measure staff engagement through the key metrics under the 'Well led' domain of our quality strategy.

Priority 4: We will nurse our patients in single-sex accommodation as defined by the Department of Health and our trust policy

In 2010, NHS England said that all NHS organisations 'are expected to eliminate mixed sex accommodation, except where it is in the overall best interests of the patient, or their personal choice'. It also issued detailed guidance on what was meant by 'overall best interests', including situations when a patient is admitted in a life-threatening emergency. Every year, trusts are required to declare their compliance with the statement above. We measure our success with this priority through the following target:

Target for 2014/15: 0 breaches of single-sex accommodation
Outcome: 14 [Eliminating mixed sex accommodation (EMSA) 2014/15 annual declaration]
Progress: Target not achieved

Progress explained:

In 2014/15 there were a total of 14 reportable breaches of single-sex accommodation at the Trust. At a rate of 0.03 per 1,000 finished consultant episodes this figure does comply with the Department of Health's expectations, but it does not meet our target of 0 cases.

Gender mixing within the trust only occurs within critical care units and the emergency department. The breaches that occurred were where patients in critical care became level 2. Sharing with members of the opposite sex will only happen by exception based on clinical need – for example where patients need specialist equipment such as in critical care areas. This is in line with the overall best interests criteria.

Improvements made:

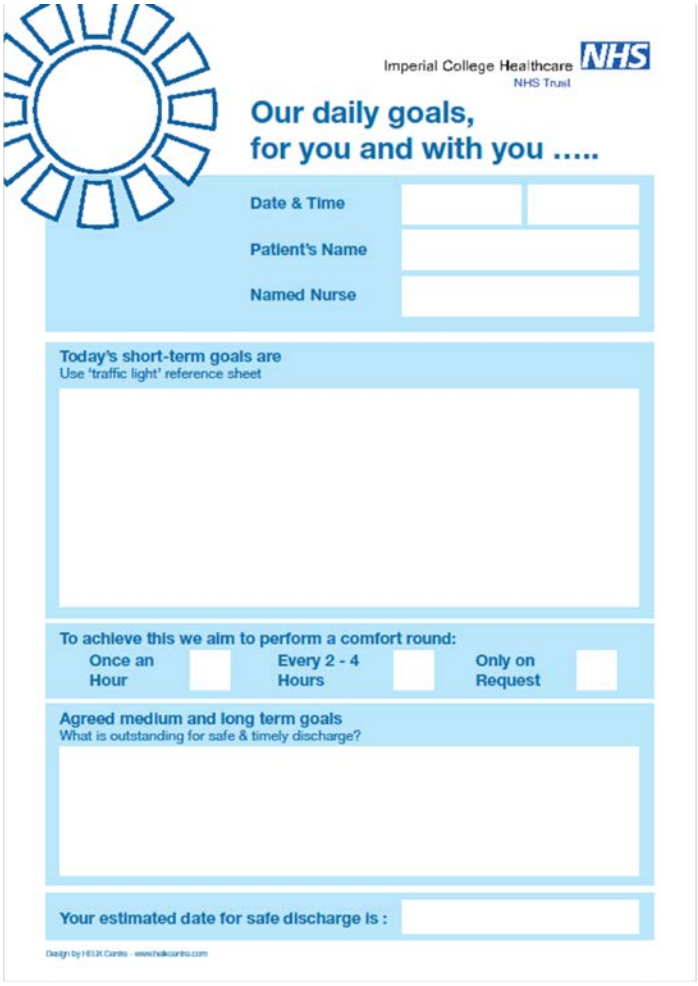
- No complaints regarding breaches of single-sex accommodation
- All adult inpatient wards are either single sex or, where they are mixed sex, areas within the ward are designated as male or female, with separate designated toilets and bathrooms.

Further improvements identified:

- We will continue to exercise a zero-tolerance approach to mixed-sex accommodation and will monitor compliance.

Quality Improvement Case Study: Involving patients and staff for better care

Person-centred care lies at the heart of good healthcare, but putting it into practice can be a challenge. In 2014, Rebecca Kenny, a Senior Sister and Darzi Fellow at St Mary's Hospital, began developing a series of quality improvement tools, with the assistance of designer Matthew Harrison, from the Helix team. The aim was to increase person-centredness, improve the patient experience and increase staff morale.



Staff were presented with a selection of options, and one team, led by Matron Lucia Gallagher, chose a 'daily goals' tool to implement on their orthopaedic ward. The tool involves the team and patient working together during ward rounds, to set shared goals for the day. The nursing staff ask the patient about their preferences – for example, would they like to be checked every hour, or only when they use the buzzer – while the patient makes their own commitments, such as to carry out their physiotherapy exercises, as well as any personal goals. The commitments, by staff and patients, are recorded on an A4 sheet and kept at the bedside.

'Being involved in making decisions in this way can improve patient experience and staff morale. This tool seeks to tackle both,' says Kenny. 'The tool is being evaluated by measuring staff morale, patient experience and reduction in falls, and we aim to highlight our pilot in a forthcoming issue of the British Medical Journal.'

Quality Improvement in 2014/15

During 2014-15 we continued in our commitment to making quality central to all we do through the implementation of our first quality strategy. We have made some significant achievements throughout the last year, although we recognise we have some way to go before we can meet all our goals. Some examples of our continued work to improve the quality of healthcare in our Trust are outlined below.

Improving Dignity for Older People in Hospital

We are currently taking part in a research study to look at 'Improving Dignity for Older People in Hospital'. The study aims to improve the way that nurses and other health professionals protect the dignity of older people in hospital. Many older people are admitted to hospital for a wide range of needs, and whilst the care they receive for their health problem is usually of a very high standard, other aspects of care, such as protecting privacy and dignity, are often less well managed.

Privacy and dignity are important to us all, but there is no real evidence of what works best to help nurses and other health professionals protect patient dignity. We have designed a research study which will help us identify ways of protecting dignity, and then help staff change the way they care for older patients so that their dignity is protected.

We have designed the survey to help us continuously measure how patients feel about their care. We are focusing on 17 adult wards and are asking patients to complete a survey, focusing on those aged 65 years and older. To date we have had 2,500 responses.

"The use of the Dignity Survey allows the research team to map improvements in patient experience against the data generated from observations, interviews and interventions. It provides a meaningful and substantial measure of outcome." Marcelle Tauber, Practice Educator, Delivering Dignity through Empowered Leadership Project.

Each month, the individual ward manager and/or matron receives a breakdown of responses to each question and is notified of any free text comments made by patients; this allows improvements to be made immediately.

The Dignity Survey will continue to collect responses until the study ends in April 2016, when we will evaluate the results and use them to transform the care given to our older patients.

Delivering flexible services to replace A&E

When we implemented planned changes to urgent and emergency care services at Hammersmith Hospital in September 2014, our priority was to ensure high quality patient care and safety. We were also determined to find better ways of delivering flexible local services.

The Hammersmith A&E department was not in fact a fully functioning emergency unit. Its status meant that it could not treat children, trauma, minor injuries or acute surgical patients. This in

turn meant it could not host medical trainees and so faced the continuing challenge of attracting appropriately qualified medical staff.

The Independent Reconfiguration Panel in its advice on the 'Shaping a healthier future' proposals submitted to the Secretary of State for Health in September 2013 said the following about Hammersmith Hospital's A&E: "the range of conditions able to be treated is constrained by the absence on-site of relevant back-up services such as emergency surgery. Both the commissioners and the provider of this service agree that better care could be provided by concentrating A&E resources at St Mary's Hospital linked to a 24-hour urgent care centre at Hammersmith Hospital."

The changes to urgent and emergency care aimed to ensure we have high quality specialist services where they are most needed. We can provide better care, more sustainably, by concentrating more resources for seriously ill and injured patients at St Mary's and Charing Cross hospitals while ensuring good local access for those with urgent but not life-threatening conditions at our urgent care centres. We know that we are saving more lives through this sort of approach for major trauma, strokes and heart attacks.

By the time the Hammersmith emergency unit closed in September 2014, we had planned new schemes to give local people the responsive urgent care they needed:

- an expanded 24-hour urgent care centre so that anyone can still walk into Hammersmith Hospital and receive urgent care on site. Anyone arriving at Hammersmith as an emergency with a serious condition will receive immediate care and be transferred to the A&E or specialist unit most suitable for their health needs.
- patient passports enabling patients receiving treatment for long-term conditions at Hammersmith direct access to wards in emergencies, via a specialist assessment centre
- a new dedicated phone line enabling GPs to speak to hospital consultants to discuss whether a patient needs an urgent medical referral and arrange it directly, where necessary.

In addition, more specialist A&E capacity – including new beds and staff – were put in place at St Mary's and Charing Cross hospitals.

Improving patient experience while reducing costs – developing a new procedure

Colonoscopy is a clinical procedure that involves passing a tube or a fibre optic camera through the small bowel to perform a visual check for medical symptoms. It is a relatively simple procedure with low risk, but for patients it is invasive from the preparation, which includes drinking only liquids beforehand and taking medication, to the procedure itself, which is often done under sedation.

In October 2014 we began offering faecal calprotectin testing – an investigation that can help differentiate inflammatory bowel disease, such as Crohn's disease and ulcerative colitis, from non-inflammatory bowel diseases, such as irritable bowel syndrome. The symptoms of these conditions are often similar but the inflammatory diseases can require surgery, while IBS can be simply treated by the GP.

The test involves measuring the quantities of faecal calprotectin in the intestines. This substance is released in large quantities when there is any inflammation in the bowel, so high levels indicate inflammatory bowel disease such as Crohn's disease or ulcerative colotis. The new test saves people with irritable bowel syndrome from having to undergo invasive and costly procedures to rule out an inflammatory bowel disease, and is expected to avert the need for up to 500 colonoscopies a year across the Trust.

Reporting and Monitoring Safety & Effectiveness

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

- Monthly safety & effectiveness reports for each clinical division - these include information regarding mortality rates split by specialty, themes from serious incidents, including lessons learnt and actions to be taken, divisional incident reporting rates and participation in local and national audit. These allow divisions to monitor their performance at specialty level and make improvements were necessary.
- Monthly quality reports report the same information at trust level to our executive committee and quality committee.
- Business case approved to develop a clinical effectiveness team in the medical director's office. This team will mean we can run a more comprehensive programme of local audit, focusing quality improvement on those areas where it will be most helpful, to improve outcomes for patients. We anticipate that the team will be in place in summer 2015.

These measures will be embedded throughout 2015/16 and we anticipate will have a significant impact by directing our efforts to the areas which most need improvement in an evidence-based way.

Being Open - Duty of Candour

In 2014, a new requirement for hospitals to inform patients of mistakes or incidents was introduced. We have always promoted a culture of transparency in our Trust, and have put in place a duty of candour policy which will support our staff to be open with our patients, their carers and families, especially in difficult circumstances and to apologise when things go wrong.

We have carried out training for all heads of specialties who have in turn trained the staff in their clinical areas in how to use the policy. Each division also has a duty of candour advisor who can provide advice and reassurance to support staff in undertaking these difficult conversations.

Volunteer Development Programme

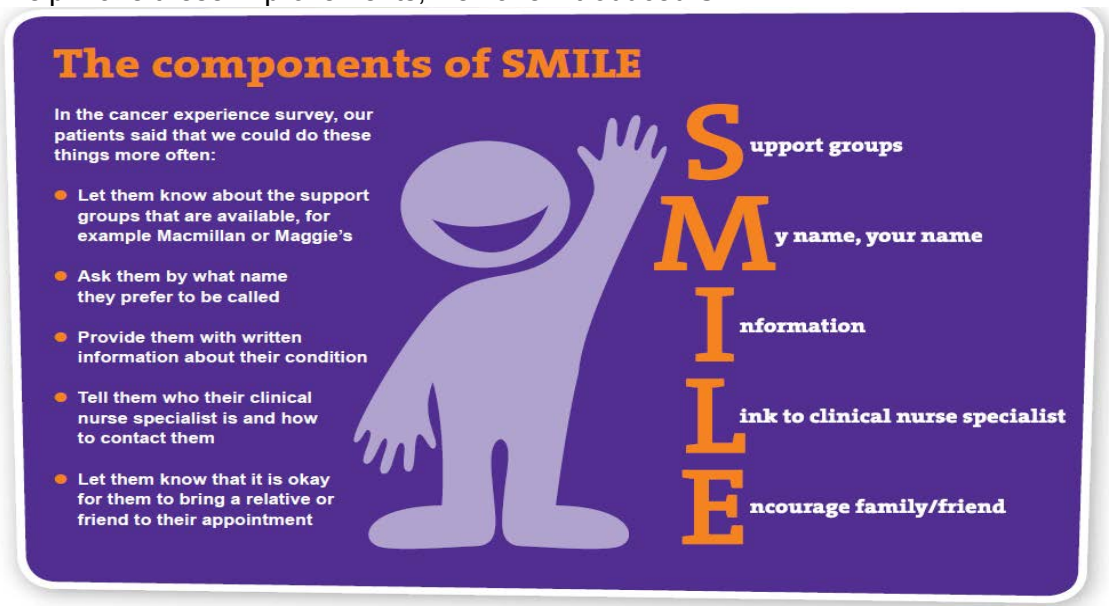
Volunteers are a vital resource to any NHS trust, providing valuable support to both patients and staff. We are currently reviewing the role that volunteers play at Imperial. During 2014/15 we explored two extensions to this role; "meeting & greeting" in our hospital receptions and helping patients with their meals. Both of these will be developed further in 15/16 through our volunteer development programme, which will aim to expand the programme and provide greater availability and coverage of volunteer services.

Improving Patient Experience – SMILE

The Trust's Cancer Patient Experience Survey (2013) highlighted several areas for improvement including:

- Support groups and services for patients
- Staff introducing themselves and addressing patients by their preferred name
- Information for patients e.g. treatment and tests
- Patients knowing who they can contact and how
- Patient support at appointments

To help make these improvements, we have introduced SMILE:



We have also used the SMILE project to implement a national driver for improving patient experience, referred to as: #hellomynameis. This national campaign was driven by a clinician, Dr Grainger, to improve patient experience in hospital, shortly after she was diagnosed with cancer three years ago. Dr Grainger observed that staff did not introduce themselves when caring for her.

Over the past year, we have been focusing on all elements of SMILE. We have:

- Provided information for our people to share with patients on support groups applicable to their cancer tumour group;
- Developed a new badge with our people and patients, supported by our communications team. The new badge displays staffs' preferred name in larger font;
- Developed contact sheets for our cancer clinical nurse specialists;
- Changed our clinic template to ensure patients know they can bring someone with them to appointments.

We will evaluate this project this summer, to see how it has improved our patients' experiences.

Major Trauma Centre

We are proud of our specialist services, in particular our Major Trauma Centre which has some of the best outcomes in the country.

The 24/7 centre is based at St Mary's Hospital, covers north-west London and is one London's four Major Trauma Centres. It sees patients with multiple, serious injuries that could result in significant physical harm or death.

The Major Trauma Centre at St Mary's Hospital comprises specialist teams and individuals from over a dozen departments and specialities including the emergency department, critical care and neurosurgery. These join forces to save the lives of people affected by trauma caused by road traffic incidents, serious accidents and falls from height. The centre provides a 24-hour consultant-led service for both adults and children and has some of the top survival scores in the country. It receives over 2,500 major trauma calls every year.

At the end of 2013, the Imperial College Healthcare Charity launched a £1m Major Trauma appeal. This has raised the profile of Major Trauma within the hospital and has provided the funding for many essential pieces of equipment and allowed initiatives such as the Youth Violence project to start. We are very grateful for the support of the charity which has prioritised improving the outcomes and experiences for our staff and patients.

St Mary's Youth Violence Prevention Project

Through our Youth Violence Prevention Project, registered youth charity Redthread works alongside emergency department staff at St Mary's Hospital to provide support and holistic care for young people who are the victims of violence and trauma. Working in partnership with healthcare professionals, the teams provide direct intervention to support these young people in disengaging from violence, sexual exploitation and crime.

Every day across London numerous young people are involved in, and are the victims of, violence. For some this pattern of behaviour leads to hospitalisation – at the capital's Major Trauma Centres. In this unfamiliar and daunting environment many young people feel vulnerable and alone and contemplate the consequences of their actions. Whilst other services focus on the immediate crisis, Redthread gives young people the invaluable opportunity to discuss why they have ended up in hospital, and what they can do to break away from the volatile and chaotic cycle they have found themselves in.

The crime prevention minister, Norman Baker, visited St Mary's in October 2014, describing the work as hugely encouraging, advantageous and innovative.

""I am hugely encouraged by the results projects such as Redthread are achieving. Intervening early to bring young people out of gang activity has huge advantages for their lives, for society as a whole, and the public purse…Vulnerable boys and girls can be reluctant to speak to authority figures such as medical professionals and the police. However, we know that if someone they identify with is on hand, they often confide in them. Placing youth workers within A&E units in problem areas is an innovative approach and I am delighted the Home Office was able to provide funding to expand the Redthread scheme." Norman Baker, October 2014.

Health and Wellbeing - a look back over the year

It is widely acknowledged there is a distinct relationship between workforce wellbeing and performance outcomes. The impact of this is not just about our people, but also the positive impact this will have on our patients.

In the last year, we have introduced a range of high impact Health & Wellbeing initiatives which included:

- two Wellbeing Weeks with mass participation; over 1,500 people at the first event and over 2,500 at the second, as well as outreach programs in all ward areas, visiting over 1,000 people with a roving masseuse, fruit baskets and healthy goody bags at each event;
- a weight management programme, with over 150 people already registered across 3 programmes;
- the introduction of occupational physiotherapy through PhysioMed, with over 135 people being supported over the last 6 months;
- launch of Challenge 2015, which has already seen close to 700 people commit to a range of activities, including 'Walk your Way to Wellbeing' a team step challenge to create an interdepartmental competition;
- smoking cessation clinics, which have already seen more than 50 people quit.

With a realisation that mental wellbeing is a real problem within the NHS, our initiatives also involve the enhancement of positive psychological wellbeing, a focus on the reduction of negative pressure and coping strategies, which has included the introduction of yoga (18 classes per week across 3 hospital sites) has seen over 150 of our people benefit from this activity.

We are at the beginning of our journey, we believe our staff are the best judge of what they would like to see introduced to improve their health and wellbeing and as a result of feedback received, the next three months will see the introduction of an Occupational Health Clinical strategy, the launch of the Bike User Group, and the introduction of meditation and mindfulness classes.

Improving the experience of patients with learning disabilities

As part of our drive to treat all our patients with compassion, kindness, dignity and respect, we introduced training sessions during 2014/15, delivered by people with learning disabilities, to senior nursing groups. These have proved effective and enlightening. We hope to extend the reach of these in the coming year.

With support from Royal Boroughs of Kensington & Chelsea and Westminster, we have been able to fund a learning disability administrator post. This post has delivered improvements such as rationalising patient information, updating procedures and organising training. They have also been able to support admissions of people with learning disabilities and best interest meetings.

Following discussion with the Patient Experience Research Centre at Imperial College we have also secured charitable funds to appoint a researcher for one year to conduct an experience based co-design project around learning disabilities. Working with patients, their carers and community services we will aim to establish what improvements need to be made and then pursue their implementation.

Improving our Maternity Services

The reconfiguration of maternity services occurring in North West London as a result of the planned closure of Ealing maternity services has given us the opportunity to make some significant improvements in our maternity services, including improvements to our estates and an extension of service provision into the community.

Recruitment

As a result of the transition of maternity work from Ealing, next year we will be delivering an extra 1,000 births. To cater for this increase, we have been actively recruiting consultants and midwives with a view to increasing our current 1:33 ratio of midwives to births, to an improved ratio of 1:30. We have had 98 hour consultant labour ward presence since April 2014 and are increasing this to 140 hours at Queen Charlotte's and Chelsea Hospital with extended 7 day working.

Estates & service developments

We have also been working to improve our estates and the way we provide our services, which will positively impact on all women using our maternity services. At St Mary's hospital we are completing a purpose built Maternity Day Assessment Unit which will be separate from the labour ward. This area will have the space required for a dedicated assessment area, offering improved privacy and dignity for women than the previously shared area on the labour ward.

At Queen Charlotte's & Chelsea Hospital we are improving our patient pathway and flow by redesigning existing areas to accommodate a 16% increase in activity. We are completing the development of a dedicated Maternity Day Assessment Unit for triage and day assessment on our ground floor, increasing accessibility, extending our postnatal ward area, and providing a separate antenatal ward including an induction of labour suite.

We are increasing the provision of complex maternal medicine and obstetric diabetes clinics at Queen Charlotte's & Chelsea Hospital in order to cater for the expected increase in pregnant women affected by these disorders from the Ealing transition and from the changing demographics in London. Indirect deaths are the major cause of maternal mortality in the UK and in London and we wish to address the needs of these complex high risk patients.

Community Services

We have implemented an enhanced model of maternity community provision to ensure women receive both continuity of care and care individualised to their medical or social needs. Women are provided with a named midwife who works in a team of six midwives delivering care locally. These midwives provide antenatal and postnatal care. We also run a scheme for vulnerable women who have a named midwife providing all their care throughout their pregnancy, during delivery and after the birth. Vulnerable women receiving this model of care include those with mental health illnesses, drug and alcohol misuse, safeguarding concerns, teenage pregnancies, homeless women and asylum seekers. Women having a home birth are also cared for by this team. This Imperial team and model of care won the Royal College of Midwives National team of the year award last year.

Both these models of community care will be expanded into Ealing and Brent to ensure women delivering at our hospitals from these areas have local care provided by a named midwife.

FGM

We have a well-established midwifery led FGM (female genital mutilation) service which has been expanded as part of a pilot in response to the national recommendations around FGM. Women attending this clinic are seen by a multidisciplinary team consisting of a midwife, councillor, health advocate and a social worker. This ensures that the clinical as well as the social aspect of their care can be provided. It also provides education and continued support for

women and helps to empower them to prevent FGM being undertaken on the next generation of children.

Perinatal Mental Health

We are planning to provide joint obstetric and psychiatric clinics in perinatal mental health to help address this important area which is a major cause of illness and maternal mortality.

Make a Difference - Recognising great work

Make a Difference is our way of recognising the hard work, dedication and achievements of our staff. The scheme is called Make a Difference to reflect the impact of people who go the 'extra mile' for their patients and colleagues. People can be nominated for one of several awards which includes instant recognition thank you cards and badges, team and individual excellence awards, a lifetime achievement award, and awards for volunteers and bank workers. Teams can also enter a special chairman's award for outstanding achievement on a theme of strategic importance selected annually by the chairman.

The scheme has been very popular, with high take up rates throughout the year with an estimated 1,500 instant recognition award and 250 nominations for the other awards. A Make a Difference annual awards ceremony will take place in June 2015 and will be the culmination of a very successful first year for the scheme.

Safeguarding Children

We are committed to the protection and safeguarding of all patients, including children and young people, and work closely with multi-agency partners to ensure that the outcomes for children are improved by having robust arrangements in place for safeguarding.

We meet all statutory requirements in relation to Disclosure and Barring Service (DBS) checks. All staff employed at the Trust undergo a DBS check prior to employment and those working with children undergo an enhanced level of assessment.

We have a policy and process in place for following up children who miss outpatient appointments within any speciality to ensure their care and wellbeing is not compromised. In addition, we have a system in place for flagging children who are subject to a child protection plan from the four neighbouring boroughs.

All eligible staff undertake relevant safeguarding children training and this is regularly reviewed to ensure that it is up to date.

We have a Safeguarding Children and Young People Team in place which is led by a Named Doctor, Named Nurse and Named Midwife. The Trust Board takes the issue of safeguarding extremely seriously and receives an annual report on Safeguarding Children issues.

In addition, we have carefully considered the recommendations from the Savile review (Lampard 2015) and have ensured the following are in place:

- We comprehensively reviewed safeguarding arrangements following the initial investigation and regularly review them on an ongoing basis.
- We reviewed the voluntary services arrangements to ensure they are appropriately robust.

- We provide safeguarding training to all relevant staff at least every three years.
- We produced and launched a visiting policy for children and young people
- Our public Wi-Fi provider is a member of the 'Friendly Wi-Fi' Scheme. This ensures that it has been checked and verified so that pornography and child abuse websites are blocked.

Implementing Nursing Revalidation

The Nursing and Midwifery Council, the professional regulator for England, Wales, Scotland and Northern Ireland will be introducing a process of 'revalidation' for nurses and midwives from April 2016. Revalidation for these professions is intended to ensure that nurses and midwives stay up to date and meet the minimum standard requirements for their development and practice, in line with the NMC Code of practice.

Work is underway to ensure that our nurses and midwives are prepared for the requirement of revalidation and can meet the standards set out by the NMC. The plan includes using the revalidation requirements as an opportunity to ensure that our staff get the best from their learning and reflect on their practice in a meaningful way.

The NHS Outcomes framework indicators 2014/15

The NHS Outcomes Framework 2014/15 sets out high level national outcomes which the NHS should be aiming to improve. The framework provides indicators which have been chosen to measure these outcomes. An overview of the indicators and our performance is outlined below in table L. Some of this data is repeated because we chose to measure some of these indicators as our trust priorities for 2014/15. It is important to note that whilst these indicators must be included in the quality accounts, the most recent national data available for the reporting period is not always the most recent financial data. Where this is the case, the time period used is noted underneath. This data is included in line with reporting arrangements issued by NHS England.

Table L: NHS Outcomes framework indicators 2014/15

Indicator	ICHT 2014/15	National Average (Median Reporting Rates)	Where Applicable - Best performer	Where Applicable - Worst Performer	Trust Statement	2013/14	2012/13	2012/11
SHMI value and banding (July 2013 - June 2014)	73.17 Band 3 (Band 3 = lower than expected)	100 Band 2 (Band 2 = as expected)	N/A	N/A	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from nationally reported data • ICHT were one of only 13 NHS trusts nationally that consistently recorded a lower than expected SHMI rate for the years 2013/14 - 2012/11 and has sustained a high level of performance against this indicator in 2014/15. Imperial College Healthcare NHS Trust intends to take the following actions to improve this rate: • We will continue to develop Datix to make it easier for staff to report, and will encourage them to do so through a sustained communication programme. • We will aim to be within the top quartile of trusts with high levels of reporting and be below our peers for incidents graded as extreme and severe in 2015/16.	Band 3	Band 3	Band 3
% of admitted deaths with palliative care coded (July 2013 - June 2014)	36.10%	24.60%	N/A	N/A	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from nationally reported data Imperial College Healthcare NHS Trust intends to take the following actions to improve this rate: • A monthly review process is in place with consultant leads to ensure accuracy of coding of death episodes – this includes palliative care coding • Results are monitored monthly through the trust Quality Report.	32.70%	30.10%	30.90%

Indicator	ICHT 2014/15	National Average (Median Reporting Rates)	Where Applicable - Best performer	Where Applicable - Worst Performer	Trust Statement	2013/14	2012/13	2012/11
Patient reported outcome scores (PROMs) for groin hernia surgery (April - September 2014)	* (low sample size)	0.081	0.493[x]	0.350[x]	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the independently administered HSCIC PROMS database Imperial College Healthcare NHS Trust intends to take the following actions to improve this rate: • We will re-establish and improve the PROMs reporting systems to ensure the data is reflective of our patient groups. • We will assist patients to complete the PROMs Part A questionnaire at the surgical pre-assessment clinic to increase participation, with compliance auditing of this process being undertaken through the corporate team • We will maintain this as a quality account priority for 2015/16.	0.327	0.301	0.309
PROMs for varicose vein surgery (April - September 2014)	0.054 (87)	0.1	0.376[x]	*[x]	See above.	0.474	0.441	0.418
PROMs for hip replacement surgery (April - September 2014)	* (Low sample size)	0.442	0.501[x]	0.422[x]	See above.	0.324	0.295	0.274

Indicator	ICHT 2014/15	National Average (Median Reporting Rates)	Where Applicable - Best performer	Where Applicable - Worst Performer	Trust Statement	2013/14	2012/13	2012/11
PROMs for knee replacement surgery (April - September 2014)	* (Low sample size)	0.328	0.501[x]	0.418[x]	See above.	0.77	0.083	0.067
28 day readmission rate for patients aged 0-15 (Dr Foster data – April-Sept 2014)	6.31%	8.10%	N/A	N/A	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data obtained from Dr Foster • A readmission is defined as being readmitted to an English trust as a non-elective emergency admission within a defined period following discharge. Imperial College Healthcare NHS Trust intends to take the following actions to improve this percentage: • We will review, streamline and improve our discharge processes to ensure effective discharge and reduce the risk of readmission. • We will continue to monitor readmission rates as part of the quality strategy 'Responsiveness' domain to meet all national access targets.	5.95%	5.81%	5.32%

Indicator	ICHT 2014/15	National Average (Median Reporting Rates)	Where Applicable - Best performer	Where Applicable - Worst Performer	Trust Statement	2013/14	2012/13	2012/11
28 day readmission rate for patients aged 16 or over (Dr Foster data – April-Sept 2014)	8.84%	7.97%	N/A	N/A	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data obtained from Dr Foster • A readmission is defined as being readmitted to an English trust as a non-elective emergency admission within a defined period following discharge. Imperial College Healthcare NHS Trust intends to take the following actions to improve this percentage: • We will review, streamline and improve our discharge processes to ensure effective discharge and reduce the risk of readmission. • We will further expand the Homeless Outreach Team to cover Charing Cross and Hammersmith • We will work with the Red Cross Next Steps Team to identify opportunities to expand services to seven days and to cover external boroughs. • We will continue to monitor readmission rates as part of the quality strategy 'Responsiveness' domain to meet all national access targets.	7.90%	7.95%	7.59%
Responsiveness to inpatients personal needs: CQC National Inpatient survey score	75.8 [national inpatient survey overall score – published May 2015] 6.82 [Responsiveness Score is taken from 5 questions in the national inpatient survey. Individual responses are converted into scores on a scale from 0 to 10]	76.6 [overall average score for England]	87.4 [overall score London Area]	67.4 [overall score London Area]	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data from the CQC National Inpatient Survey Imperial College Healthcare NHS Trust intends to take the following actions to improve this figure: • We will continue to work to improve patient experience throughout the Trust and monitor our progress • We will increase our responsiveness to complaints and reduce their overall number • We will develop a dataset that enables monitoring of protected characteristics against patient experience measures • We will maintain this as a quality account priority for 2015/16.	74.4 [overall score] 6.78 [responsiveness score]	76.2 [overall score] 6.64 [responsiveness score]	72.8 [overall score – responsiveness score not available]

Indicator	ICHT 2014/15	National Average (Median Reporting Rates)	Where Applicable - Best performer	Where Applicable - Worst Performer	Trust Statement	2013/14	2012/13	2012/11
% of staff who would recommend the provider to friends or family needing care	71%	66%	94%	36%	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data from the National Staff Survey • We run local engagement surveys every quarter. Each manager receives local results at specialist and ward level and then develops quarterly action plans to address the issues raised. Imperial College Healthcare NHS Trust intends to take the following actions to improve this response: • We will continue our quarterly surveys and will focus on working with managers and leaders to ensure that any issues raised are addressed through action plans. • We will measure staff engagement through the key metrics under the 'Well led' domain of our quality strategy.	69%	68%	N/A
% of admitted patients risk-assessed for VTE	96.56%	Data not available	Data not available	Data not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data • We have continued to report weekly on the number of VTE assessments completed ward by ward. We have reviewed wards that have not met their targets and supported them to improve. Imperial College Healthcare NHS Trust intends to take the following actions to improve this response: • We will continue to monitor progress and instigate improvements where necessary • As a mandated priority, we will report our performance against this target in 2015/16.	96%	91%	43%

Indicator	ICHT 2014/15	National Average (Median Reporting Rates)	Where Applicable - Best performer	Where Applicable - Worst Performer	Trust Statement	2013/14	2012/13	2012/11
Rate of C-Diff per 100,000 bed days	26.47* (79 cases in total) *using 2013/14 bed days data supplied by Public Health England	Data not available	Data not available	Data not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data Imperial College Healthcare NHS Trust intends to take the following actions to improve this response: • We will make details of cases and relevant issues available to primary care colleagues, to help raise awareness and mitigate risk. • We will continue to monitor isolation practice and increase the isolation capacity on all our hospital sites. • We will provide patients with the Department of Health 'C. difficile now you are going home' leaflet, to give them information about their infection and how to manage it. • We will roll out electronic prescribing across all wards and departments, to enable closer monitoring of antibiotic prescriptions. • We will set ourselves a target of 'no avoidable infections' for 2015/16.	19.4 (58)	31.2 (86)	33.3 (142)
Rate of reported patient safety incidents per 1,000 bed days (NRLS data April 2014 to Sept 2014)	42.7 (NRLS published data April 2014 – Sept 2014) 45.24 (internal unpublished data for the full financial year 2014/15)	33.3	74.96	0.24	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • the NRLS data is nationally reported and verified • It is comparable to trust internal data for that period • We continued developing the upgraded Datix incident reporting system, to provide improved systems and processes for monitoring, reporting and learning from adverse events. • We linked incident trends and themes to service improvement and junior doctors' training. • We reported all pressure ulcer damage through Datix. • We developed a Safety Dashboard to incorporate all safety data extracted from Datix. This is available to all staff through an online system. Imperial College Healthcare NHS Trust intends to take the following actions to improve this rate: • We will continue to develop Datix to make it easier for staff to report, and will encourage them to do so through a sustained communication programme.	6.5 (data reported per 100 admissions)	6.5 (data reported per 100 admissions)	5.8 (data reported per 100 admissions)

Indicator	ICHT 2014/15	National Average (Median Reporting Rates)	Where Applicable - Best performer	Where Applicable - Worst Performer	Trust Statement	2013/14	2012/13	2012/11
% of patient safety incidents reported that resulted in severe harm or death	0.34% (25 incidents - NRLS published data April-Sept 2014) 0.08% - severe harm (13 incidents - internal unpublished data for the full financial year 2014/15) 0.16% - extreme harm (25 incidents - internal unpublished data for the full financial year 2014/15)	0.49% (Acute Non-Specialist NHS trusts)	Data not available	Data not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data • We sustained and streamlined the incident review panel, chaired by the Medical Director, for review of all incidents reported and/or assessed to be moderate, major and extreme. • We produced trust-wide communication regarding incidents and learning, following the incident review panel meeting and serious incident reviews. • We continued to share learning from all serious incidents with staff, through our intranet site. Imperial College Healthcare NHS Trust intends to take the following actions to improve this rate: • We will review actions from incident investigations regularly to ensure they are carried out in a timely manner. • We will aim to be within the top quartile of trusts with high levels of reporting and be below our peers for incidents graded as extreme and severe.	0.3% (38 incidents)	0.1% (2 incidents)	N/A

Indicator	ICHT 2014/15	National Average (Median Reporting Rates)	Where Applicable - Best performer	Where Applicable - Worst Performer	Trust Statement	2013/14	2012/13	2012/11
Inpatient Friends & Family Test	95%	94%	Data not available	Data not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data • We have actively monitored our performance using real-time I-Track devices Imperial College Healthcare NHS Trust intends to take the following actions to improve this rate: • We will implement the new guidance for the Friends and Family Test from April 2015 – for example, extending it to children and in our urgent care centres. • We will implement a new system for collecting and reporting Friends and Family Test responses, and will implement a more comprehensive yet focused suite of real-time patient surveys.	95%	N/A	N/A
A&E Friends & Family Test	89%	87%	Data not available	Data not available	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data • We have actively monitored our performance using real-time I-Track devices Imperial College Healthcare NHS Trust intends to take the following actions to improve this rate: • We will implement the new guidance for the Friends and Family Test from April 2015 – for example, extending it to children and in our urgent care centres. • We will implement a new system for collecting and reporting Friends and Family Test responses, and will implement a more comprehensive yet focused suite of real-time patient surveys.	91.9%	N/A	N/A

Performance against national targets and regulatory requirements 2014/15

We aim to meet all national targets and priorities; however consistently meeting them has been particularly challenging this year, partly as a knock-on effect of high demand in A&E. We are focusing on improving and streamlining our operational processes and have chosen to prioritise meeting all national targets as one of our quality strategy and Quality Account priorities for 2015/16. The table below shows our performance throughout the year divided by quarter; targets we have not achieved are highlighted in red, with an explanation given below.

Table H: Performance against national targets

National Targets and Minimum Standards	Measure	Threshold	Q1	Q2	Q3	Q4	Target achieved in all 4 quarters?
Access to Treatment	18 weeks referral to treatment - admitted	90.00%	88.87%	83.88%	83.97%	82.31%	No
	18 weeks referral to treatment - non admitted	95.00%	94.66%	94.35%	91.59%	89.38%	No
	18 weeks referral to treatment - incomplete pathway	92.00%	92.15%	87.14%	81.41%	86.65%	No
Access to Cancer Services (Q4 data covers Jan-Feb only, Month 12 not yet available)	2 week wait from referral to date first seen all urgent referrals	93.00%	93.70%	94.90%	94.60%	93.90%	Yes
	2 week wait from referral to date first seen breast cancer	93.00%	88.40%	93.10%	94.80%	94.40%	No
	31 days standard from diagnosis to first treatment	96.00%	97.40%	97.60%	97.00%	96.70%	Yes
	31 days standard to subsequent Cancer Treatment - Drug	98.00%	99.60%	100.00%	100.00%	100.00%	Yes
	31 days standard to subsequent Cancer Treatment - Radiotherapy	94.00%	97.60%	99.30%	100.00%	99.60%	Yes
	31 days standard to subsequent Cancer Treatment - Surgery	94.00%	96.90%	95.30%	95.70%	96.80%	Yes
	62 day wait for first treatment from urgent GP referral	85.00%	85.40%	85.20%	85.40%	79.10%	No
	62 day wait for first treatment from NHS Screening Services referral	90.00%	91.00%	93.90%	88.40%	92.80%	No
Access to A&E	A&E maximum waiting times 4 hours	95.00%	95.86%	95.47%	91.17%	91.90%	No
Infection Control	Clostridium Difficile (C-Diff) Post 72 Hours	65	23	20	15	21	No
	MRSA	0	3	0	3	2	No
VTE	VTE Risk Assessments	95.00%	95.30%	95.92%	97.02%	98.19%	Yes
Cancelled Operations	Cancelled operations for non-clinical reasons	0.80%	0.82%	0.69%	1.15%	0.84%	No
	Rebooking non-clinical cancellations within 28 days	<5%	12.30%	5.73%	5.19%	9.00%	No

Access to Treatment

There are three referral to treatment (RTT) standards we are expected to deliver on: 90% of patients treated as an inpatient should be treated within 18 weeks; 95% of patients treated as an outpatient should be treated within 18 weeks; and 92% of patients still waiting for treatment (on a waiting list) should be under 18 weeks.

Following the implementation of a new patient administration system in April, we experienced some issues with data quality. Throughout 2015/16, this affected our ability to report accurate data on the number of patients waiting for treatment and the number of patient treated outside of 18 weeks.

In addition, there were challenges at a speciality level, where there was a backlog of patients waiting over 18 weeks.

Investment from NHS England and the TDA, and a planned reduction in performance to enable us to treat more of the patients who had been waiting over 18 weeks, allowed us to reduce the number of reported patients waiting over 18 weeks significantly.

A plan is in place to support reducing the size of the waiting lists to allow us to return to achieving the three RTT standards within the first six months of 2015/16, supported by our commissioners.

Access to Cancer Services

In 2014/15 our cancer access performance remained broadly strong, maintaining and building on the improvement work undertaken in 2013/14. We achieved the two week wait standard in all four quarters. We achieved the breast symptom two week wait standard in three quarters, with only quarter one being lost due to service-specific capacity problems, which were quickly resolved. All four 31-day standards (first definitive treatment, subsequent drug treatments, subsequent radiotherapy treatments, subsequent surgery) were achieved in all four quarters. We underperformed against the 62-day first treatment standard in quarter four, but did achieve this in March, maintaining our performance into quarter one 2015/16, when we expect to meet the target again. We have achieved the 62-day screening standard in three quarters, with underperformance reported in quarter three due to delays relating to patient comorbidities (one or more additional disorders or diseases co-occurring with a primary disease or disorder).

We have enhanced the cancer administrative team, recruiting more tracking staff to support the delivery of cancer targets. We have also undertaken network-wide pathway mapping work with other providers in North West London to reduce the number of delays related to inter-trust referrals. Internally, the Cancer Performance and Improvement Team continues to work with clinical teams to resolve operational barriers to the delivery of cancer services.

Accident and Emergency

Like many hospitals over winter, we have struggled to meet our A&E wait target, missing this in both quarter three and quarter four; this is partly due to the unprecedented demand which has been seen nationally. However, while this is out of our control, we believe that many of the barriers to meeting our target can be mitigated by changing or streamlining our processes.

In February, we launched a ‘breaking the cycle’ week giving us the opportunity to focus on and address the operational difficulties we were experiencing. During this week, we put extra resources into the hospitals, the executive team worked with teams across the Trust to unblock barriers, and staff were encouraged and authorised to make and suggest changes that would reduce inefficiency, enhance the patient experience and contribute to improving our performance.

During that week, we achieved 95.28% against the 95% four-hour wait standard for A&E, with the key improvement factor being effective discharge planning, in particular bringing forward discharges so they happen before noon. This helps optimise capacity before we hit the peak in A&E attendances and it puts us in a better position to place elective and emergency patients appropriately in the right ward, in the right bed and at the right time. Facilitating early discharge will be one of our priorities for 2015/16.

Areas we have identified that require further improvement include early escalation of potential breaches and improving our out of hours operations. We also need to work more closely with our internal providers as well our external partners including social services and community services to explore better ways of working together.

We have been working to sustain the improvements made during breaking the cycle week, and have seen our performance improve in March 2015, with the standard being achieved for a number of days during the reported month. There is still much to be done, however we are confident that the improvements we are making will start to take effect and that this will be reflected in our performance against the target next year.

Infection Control

We did not meet the national targets for infection control in 2014/15. Further information can be found in our locally chosen priority pages above, specifically pages 48-51.

Cancelled Operations

We did not meet the targets for cancelled operations and rebooking throughout the year. Nearly half of all non-clinical reasons for cancellation were because a bed was not available. This was particularly difficult in quarter three when we had high numbers of non-elective admissions.

In the later part of quarter four, we began to see an improvement and expect that we will return to achieving the target in quarter one 2015/16. We have a process in place whereby the Head of Site Operations is the only person able to make the decision to cancel an operation due to a bed not being available. This is to ensure that we have explored all other possible options. We are also working to improve surgical pathways and will consistently monitor the clinical impact of any future delays. One of our priority areas next year will be to reduce the backlog of patients waiting for elective surgery and ensure a clinical validation process is in place for each patient who waits for over 18 weeks.

4

Statements from our stakeholders

Statements from our stakeholders

Before the final document is published, our external stakeholders are given the opportunity to review and provide statements on our quality account. The statements are published in this section; our comments in response can be found in the footnotes at the end of this section. We would like to thank our stakeholders for submitting their statements, which provide helpful feedback on how we might improve the quality account next year. We will take them into account in our improvement plans for the coming year and when developing our next quality account. We look forward to continuing to work with our stakeholders throughout the year as we strive to achieve our goals.

Statement from Hammersmith & Fulham Clinical Commissioning Group

CWHHE Central London. West London. Hammersmith & Fulham. Hounslow. Ealing. Clinical Commissioning Groups

Hammersmith and Fulham Clinical Commissioning Group response to the Imperial College Healthcare NHS Trust Quality Account 2014-2015

Hammersmith and Fulham Clinical Commissioning Group in its role as Co-ordinating Commissioner welcomes the opportunity to provide this CCG commissioners' statement on Imperial College Healthcare NHS Trust's Quality Account. The CCGs can confirm that the information contained within the Quality Account reflects the data, discussions, and contract performance issues. The trust has also included an overview of the Care Quality Commissioner (CQC) hospital inspection that took place in late 2014 and the required improvements arising from the inspection, these have informed the priorities for the Trust.

The Quality Account has been reviewed by Hammersmith and Fulham Clinical Commissioning Group and Associate Commissioners, who can confirm that the contents comply with the Department of Health prescribed form and content. The Quality Account presents a summary and balanced overview of the quality of care at the Trust.

The 2014/15 Quality Account has the Trust Quality Strategy woven throughout and this supports the focus on quality and safety for the organisation using the key priorities identified. We were pleased to see that quality improvement is a key feature for the Trust and look forward to the outcomes for patients and staff.

The trust has set some ambitious priorities for 2015/16 that are welcomed by the CCGs. In particular in relation to Cancer patient experience and referral to treatment times for elective surgery where the trust has continued to face challenges in achieving national targets in some specialities. Through achieving these targets we look forward to the improved outcomes both in terms of clinical outcomes and a quality experience for patients. We welcome this as a trust priority and look forward to marked improvement in 2015/16 including the improved performance of the four hourly accident and emergency quality indicator to ensure patients have the best

experience possible. The trust has continued to maintain its participation in National Clinical Audit programmes and clinical research. We acknowledge that the trust is designated (through competitive national process) as one of only 8 Hyper-Acute Stroke Units.

The Trust achieved 100% of the national CQUINs however there needs to be a greater focus on achievement of the locally agreed CQUINS as their achievement is variable but crucial to the quality experience of patients attending the Trust.

We were pleased to see the inclusion of a robust plan relating to the recent CQC inspection and concentration on the areas requiring improvement. Key to this is the implemented a new patient information system in 2014. The challenges in relation to this cannot be minimised and have had an impact across the organisation with particular challenges in terms of data validity. We are gladdened to see this is now being addressed as part of their overall action plan.

We look forward to the Trust achieving their target of having a vacancy figure of five percent and will monitor this in conjunction with the trust, especially with the transfer of maternity services from another Provider.

We note with approval that there is a new process in place relating to complaints responses and look forward to the Trust meeting the standards for this. In addition to this we will continue to work with the trust in strengthening its response to elective surgery waiting times and GP communication.

As part of the quality account we would welcome the opportunity to work closely with the trust and other stakeholders in the creation of next years quality account and look forward to the final version.

Yours sincerely

Janet Cree
Interim Managing Director, Hammersmith & Fulham Clinical Commissioning Group

Statement from the Adult Social Care and Health Scrutiny Committee, Royal Borough of Kensington and Chelsea

Introduction

We welcome the opportunity to comment on the Imperial College Healthcare NHS Trust (ICHT) Quality Account 2013/14.

Vision

We support the Trust's vision for being 'a world leader in transforming health through innovation in patient care, education and research.'

We are pleased the NHS England announced in December that ICHT has been designated a Genomic Medical Centre in partnership with Royal Brompton & Harefield, Royal Marsden and Chelsea and Westminster.

We note the North West London investment making business case (IMBC) to deliver the Shaping a Healthier Future (SaHF) programme was approved by the clinical commissioning groups (CCGs). The Trust's preferred option (option four) of SaHF outline business case – namely the major redevelopment of St Mary's Hospital (including the relocation of the Western Eye Hospital), a new local hospital at Charing Cross Hospital and modest investment at Hammersmith Hospital – is the option reflected in the CCG's preferred option in the IMBC.

We also note ICHT has been awarded the lead health provider role (subject to contract) for the Tri-borough Community Independence Service, to be financed through the Better Care Fund.

We are pleased ICHT has improved its financial performance in the last year.

We are disappointed the Trust has had to put on hold its foundation trust application to focus on the implementation of the CQC action plan. A re-inspection by the CQC is anticipated within 12 months at which point a rating of 'good' will need to be achieved to recommence the foundation trust process. We continue to support the Trust on its ambitions to becoming a foundation trust.

Quality Strategy

A number of comments are made against each of the five domains of quality.

Safe

- It crucial to ensure patient safety is paramount and we would expect the Trust to make a sustained and concerted effort to review all serious incidents in a timely fashion.
- We note that following a report by the Parliamentary and Health Service Ombudsman which stated that the death of a patient, in 2011, was avoidable, the chief executive apologised. The ICHT press release said: 'All actions put in place as a result of this investigation are complete'.
- We are disappointed in 2014/15:
    - The CQC had to take enforcement action against ICHT during 2014/15. Then after CQC inspection in September 2014, ICHT was rated overall as 'requires improvement' and the three sites (St. Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital) were individually rated as 'requires improvement'.
    - There were 3 'never events' [target zero]
    - There were 33 avoidable category 3/4 trust acquired pressure ulcers this year (29 target)[i]

- There were 72 cases of clostridium difficile [target fewer than 65][ii]
- There were 8 cases of MRSA bloodstream infections [target zero]
- The trust was only 85% compliant with anti-infective prescribing [target less than 90%]
- The number of incidents causing severe and extreme harm (partly): 0.3% (0.1% target)
- The Trust is above its peers for incidents graded as extreme (death): 0.3% (below 0.1% target)
- On planned safe staffing levels: Part A general vacancy rate: 11.74% (10% target): Part B and 2 to 6 Ward role vacancy rate of 13.47% (5% target)[iii]

Effective

- The Trust has excellent SHMI and HSMR scores compared nationally.
- We are pleased the major trauma centre at St Mary's hospital was judged by NHS England as top of a list of 25 centres treating critical injuries.
- The Trust should ensure that each service layaways have a defined up to date set of clinical standards based on Care Quality Commission, NICE and professional clinical guidelines.[iv]
- We are disappointed in 2014/15:
  - Participation rate for groin hernia surgery below target
  - Participation rate for varicose vein surgery below target
  - The rate of emergency readmissions admission to the hospital within 28 days of discharge patients for: 15 years or under performance was 6.31% (5.95% target): 16 years or over performance was 8.84% (7.9% target)

Caring

- Only 63.8% of complaints were responded to within the timeframe agreed with the patient (normally 25 working days). We are pleased target 4 is 'we will increase our responsiveness to complaints' but we are disappointed that the Trust's has no plans to address the comments of the CQC that complaint responses are not usually signed by the Chief Executive. A key recommendation from Putting Patients Back in the Picture was that the Chief Executives need to take responsibility for signing off complaints https://www.gov.uk/government/publications/nhs-hospitals-complaints-system-review.
- We are disappointed in 2014/15:
  - FFT A&E response rate was 15.87% in Q4 (target 20%)
  - 40 breaches of mixed sex accommodation this year [target zero]
  - In the National Patient Led Assessment of the Care Environment the trust was below average for food and in the bottom quarter of trusts for privacy and condition of environment.
  - Compliance with statutory and mandatory training was 80% in 2014-15 (95% target)

We would have liked more on the competence of the workforce. Trusts rated well by the Care Quality Commission tend to have better scores in the NHS staff survey, HSJ analysis has found. Well-motivated staff are essential to the success of the Trust.

Responsive

We note the access failure of these National targets:

- To treatment: 18 week referral to treatment-admitted
- To treatment: 18 weeks referral to treatment-not admitted
- To treatment: 18 week referral to treatment-incomplete pathway
- To cancer services: 62 day waits for first treatment from urgent GP referral
- To cancer services: 60 to wait the first treatment from NHS screening service referral

- To A&E: A&E maximum waiting time four hours
- To A&E: Clostridium Difficile (C-Diff) Post 72 Hours
- To A&E: MRSA
- Cancelled operations: Cancelled operations for nonclinical reasons
- Cancelled operations: Rebooking for nonclinical cancellations within 28 days

We support all work to: reduce waiting times for appointments; and improve patient experience. This also includes improving administrative processes such as reducing the time for answering the phone.

Well led

- We are pleased the 2014 HSJ Clinical Leaders identified Professor Sigsworth, Director of Nursing, in the 'nurses and midwives' category while Lord Darzi, Chair was identified in the 'Clinical Managers' category.
- We are pleased the Professor Jacqueline Dunkley-Bent, Director of midwifery was named one of the HSJ BME Pioneers 2014. [v] HSJ BME Pioneers 2014 http://www.hsj.co.uk/resource-centre/supplements/hsj-bme-pioneers-2014/5076440.article?blocktitle=BME-Pioneers&contentID=15617

All five domains

We welcome the majority of targets set by the Trust. However, we believe chosen targets, should be quantifiable so they lend themselves to be comprehensively assessed. It is often difficult to see improvements when the Trust includes a process (e.g. introduce programme X or Y or Z). The Trust will need to be open and provide adequate information into the public domain for people to be able to make an assessment in each category. We would also have liked more data set out on the individual hospitals under the Imperial umbrella.

Longer-term plans

Clinical care is generally of a high order at ICHT but it needs a good patient environment. Currently, many of the hospital buildings are in a poor condition and so cannot provide an environment that facilitates patient recovery.

We still await the publication of Imperial's Business Case. It is critical for Imperial College Healthcare NHS Trust to maintain full dialogue with their local authority partners. There needs to be clarity about future plans.

The St Mary's site combines modern advanced buildings and facilities - such as the Intensive Care Unit and Trauma Centre on the ninth floor of the Queen Elizabeth the Queen Mother Wing and the Patterson Centre which includes the new surgical innovation centre – whilst other infrastructure is in need of modernisation.[vi]

Conclusion

Overall, the progress that the Trust has made in performance over the last year is to be welcomed, and we look forward to being informed of how the priorities outlined in the Quality Account are implemented over the course of 2015/16. We look forward to continuing our strong working relationship with Imperial College Healthcare NHS Trust in 2015/16.

Councillor Charles Williams,
Chairman,
Adult Social Care and Health Scrutiny Committee, Royal Borough of Kensington and Chelsea

Statement from the Adults, Health & Public Protection Committee, Westminster

We welcome the publication of the Quality Account 2014 / 2015 from Imperial College Healthcare NHS Trust. We look forward to working with the Trust to ensure the quality priorities set down in the Quality Account are delivered in the next year.

We understand that 2014 / 2015 has been a challenging but important transition year for the Trust, with a new management team taking charge and a large CQC inspection, in the midst of the initial phase of the implementation of the *Shaping a Healthier Future* programme. However we believe that Imperial College Healthcare NHS Trust is beginning to change for the better and we have very much welcomed the improved communications with local authority stakeholders.

As we go forward we hope that Imperial College Healthcare NHS Trust continues to engage with stakeholders, patients and the public to ensure safe and clinically effective healthcare with a positive patient experience.

Quality Account Priorities 2014 / 2015

PATIENT SAFETY

Priority 1 – To achieve year-on-year reductions in Healthcare Associated Infections (HCAIs)

The Committee are disappointed to discover that Imperial have not met any of the targets for reducing Healthcare Associated Infections. We are most concerned at the deteriorating position on *clostridium difficile*, with the Trust hoping to attain fewer than 65 cases (from a 58 (13/14 base) but instead registering 78 patients with the condition in 14/15.[vii]

We welcome the downward trend on the numbers of MRSA blood stream infections for the Trust (from 13 to 8 in 14/15). We do understand that the zero-tolerance policy on MRSA will be difficult to achieve in such a large Trust as Imperial College Healthcare NHS Trust.

Following the Committee's own examination in public of Imperial's anti-infective prescribing, we are slightly disappointed to note that compliance did not reach 90%, as hoped, but we do welcome the increase to 85% compliance with anti-infective prescribing practice in 14/15.

We are disappointed to note that *reducing Healthcare Associated Infections* at Imperial does not appear as a 15/16 priority, which is difficult to understand given the Trust's failure on all three performance indicators. We do hope that Imperial will continue to try and drive down HCAIs at the Trust, despite not appearing as individual items in this year's Quality Account.[viii]

Priority 2 – increasing reporting rates and reducing harm

The Committee welcomes the Trust meeting the National Reporting and Learning System peer median reporting rate for patient safety. As the Westminster Health Committee we have highlighted the importance of incident reporting in all of our communications with the Trust since 2012, in the strong belief that **an open and transparent organisation is a safe organisation**. We are therefore delighted that Imperial are improving on this vital measure of accountability.

We are, naturally, slightly alarmed that instead of meeting the target for percentage of incidents graded as extreme (death), the Trust appears to be higher than both the peer and national average, but by the same token we welcome the honesty and transparency that these figures will represent.

Priority 3 – ensuring high performance against the NHS Safety Thermometer

We are pleased that the Trust has achieved all the targets within this priority group, including meeting targets on **venous thromboembolism assessments**, **reducing falls, pressure ulcers** and **urinary catheter related infections**. The Committee considers that meeting these targets is very welcome given our strong concerns in last year's response to Imperial's Quality Account, within which we raised concerns around the high level of urinary catheter related infections.

Priority 4 – increasing the awareness of dementia and ensuring that relevant patients who are admitted as an emergency are screened for dementia

The Committee welcomes the higher than 90% compliance with the 'FAIR' elements of *finding*, *assessing*, *investigating* and *referring* relevant patients to the specialist memory service. We are further encouraged that meeting this target allowed the Trust to meet its CQUIN target for all elements of dementia care.

CLINICAL EFFECTIVENESS

Priority 1 – to continue to improve mortality rates and indicators and reduce variation across the week days

We are pleased that Imperial has improved both mortality rates as measured by both Standardised Hospital-level Mortality Indicators (SHMI) and Hospital Standardised Mortality Rates (HSMR). The Committee welcomes the improvement, year-on-year, which shows that **Imperial is one of the most clinically effective hospitals in the country**.

Priority 2 – to reduce the number of emergency readmissions within 28 days of discharge

We find that it is disappointing that Imperial have failed to reduce the rate of emergency readmission for both age groups in comparison to last year's performance. We agree with the action plan outline on page 62 and 63 of the Quality Account, but consider that more managerial oversight should be given in order to meet this target. Given the changing health and social care landscape, it is imperative that out local acute trusts ensure patients are discharged appropriately and directed to appropriate health and social care resources for further assistance.

Priority 3 – to increase participation rates for 'Patient Reported Outcome Measures' (PROMs)

We note the failures in reporting systems for the PROMs data and we welcome the inclusion of the priority in the Quality Account in 2015 / 2016.

PATIENT EXPERIENCE

Priority 1 – to improve on the Friends and Family Test (FFT)

We welcome the improvement in response rate for inpatients and congratulate the Trust on exceeding expected performance on this measure. We consider that a high response rate leads to a more representative conclusion about performance. We are concerned that the same boost in response rate was not seen for patients in Accident & Emergency. We see this as especially troubling given the problems experienced in Imperial's A&E facilities throughout the year. We

strongly advise the Trust to mainstream patient feedback in A&E in order to ensure that patient experience does not suffer.

Priority 2 – to improve reported experience of our patients, including responsiveness to the personal need of patients

We welcome the Trust's scores in the National Patient Survey which saw Imperial rate higher on being responsive to patient need. We also welcome the Trust's improvement in the National Cancer Survey, however, we would like to highlight to the Trust that there is *still a very long way to go* on cancer patient experience, as Imperial College Healthcare NHS Trust is still one of the poorest performing Trusts in the country. We welcome the recent announcement that Imperial will be working with Macmillan on cancer patient experience.

Priority 3 – to remain above average of staff who would recommend the Trust

We welcome Imperial's performance on the National Staff Survey, which indicates that 77% of staff would recommend the Trust to their friends and family (above the 75% national average). However, whilst Imperial is slightly above national average, it would be remiss if we did not ask Imperial to strive for a higher target in subsequent years.

Priority 4 – to nurse patients in single-sex accommodation

We are slightly concerned at the fourteen breaches of single-sex accommodation in the last year, given the excellent performance in previous years and the zero-tolerance policy.

Quality Account Priorities 2015 / 2016

We welcome the priorities outlined for 2015 / 2016, including new targets around **sufficient staffing**, **reducing 'never events'**, **reducing non-clinical transfers of patients out-of-hours**, **discharging patients on time** and **increasing the Trust's responsiveness in dealing with complaints**. Together with the priorities which carry over from 2014 / 2015, we consider that the targets for the upcoming year reflect the challenges that face the Trust at this time. We welcome further working with the Trust to meet these targets in the upcoming year.

Cllr David Harvey, Chairman, Adults, Health & Public Protection Committee

Statement from Healthwatch, Central West London

Healthwatch CWL appreciates our close working relationship with Imperial College Healthcare Trust. We acknowledge the good work of the Trust in ensuring improving quality of services for patients.

In relation to quality domain 1, target 7 outlines the Trusts increased ambition for the prevention of VTE, whilst we welcome the proposed interventions outlined, following on from our dignity champions visit to Hammersmith hospital in 20141 patients told us how bored they were with nothing to do during their stay. We would therefore suggest that the Trust considers adding a programme on mobilisation for patients.[ix]

As the Trust did not achieve their 2014/15 target to reduce Healthcare Associated Infections (HCAIs) we are unclear as to whether the 'stretched' target of achieving zero avoidable infections (target 4) will include data on HCAIs and if not then our members would like clarity about how this will be reported next year.[x]

We welcome the news that the Trust has listened to concerns raised about patients being transferred at night (target 9). Our members have often cited their concerns for this both with internal transfers and transfers home. Our members will very much welcome the data for this target when available (table A).

We would also note that this target strongly relates to a later target in your quality domain 2 (target 5) outlining plans to effectively discharge patients appropriately by noon to the appropriate pathway**.**

To this aim we welcome Imperial's extended focus on effective pathways in to and out of hospital. We are pleased to be working with the Trust to ensure that patient experience and outcomes are central to the design and implementation of the new Community Independence Service (CIS).

Also, in quality domain 2; our members feel that the PROMS data (target 3) should be placed within one of the other quality domains and for future, the trust may consider pooling the patient experience (FFT, PLACE, etc) data in to one area of the quality account for ease of use.
Our members would like to commend the trust on their improved work on the national cancer survey, (domain 3, target 3) this has been an area that members have monitored for several years and whilst it does not reach the national target the significant improvement should be commended.

This year (2014/15) our members have felt that patient engagement mechanisms have been somewhat haphazard with the dispersal of the ICHT SaHF PPRG. However we are also pleased that the Healthwatch quarterly meeting continues to thrive with honest conversations about issues and complaints raised from patients and carers. Therefore we are pleased with the Trusts ambition to improve this function (quality domain 4 target 4) and look forward to learning about the implementation of this.[xi]

As one of Healthwatch CWL's priorities in 2014/15 was dementia, we are pleased to note that the Trust has exceeded its CQUIN targets on Dementia in particularly target 3, the communication with GPs. Our research on this topic has shown that inadequate early diagnosis/referrals can cause significant upset for both patients and carers.

It is also important to note that most of the failures (Tables G, H & J) relate to the delivery of emergency medicine. We are particularly interested in the ways that the Trust plans on improving the delivery of emergency care – and would recommend that initiatives such as public education could be co-produced with Healthwatch members.

During a period of significant infrastructural change at the Trust we would implore the Trust to continue to work closely with Healthwatch and have welcomed the recent communication with Healthwatch namely on the CQC visit and the imminent changes to the Stroke unit provision.

Our members continue to work with the Trust on the administration of the PLACE assessments, and we welcome the inclusion of the data. This has highlighted that the Trust has not met the national targets set out for 3 out of 4 of the areas; food, privacy and condition etc. We look forward to understanding what mechanisms the Trust will be putting in place to improve upon this.

We would like to finish by acknowledging a number of very good management and leadership initiatives that the Trust should be praised for and the very high standard of clinical care.

Our members would also like to acknowledge the many research initiatives that have a direct effect on improving patient care.

We look forward to working with the Trust this year particularly as our members have chosen to prioritise projects on; urgent care and maternity. As well as continued work on SaHF and quality.

Statement from the Hammersmith and Fulham Health, Adult Social Care and Social Inclusion Policy and Accountability Committee (HASCSIPAC)

The Hammersmith and Fulham HASC&SI PAC has scrutinised Imperial College NHS Trust several times during 2014-15. The main issues have been: the A&Es at Charing Cross and Hammersmith Hospitals; A&E waiting times; and the ICHT CQC report. Our assessments have been as follows:

A&E plans

We have continued to express our serious concerns about the closure of the A&E at Hammersmith Hospital and the future plans for the Charing Cross Hospital site. (Plans that have been opposed by the H&F administration and large numbers of residents in our borough.) In particular, we have recommended that there should be a full public consultation on the future plans for the Charing Cross site, which we understand should be made public in autumn 2015. We have expressed our frustration that these plans not been shared with the Committee to date given that the Independent Reconfiguration Panel recommended that the original plans should be amended nearly two years ago.[xii]

A&E waiting times

We expressed serious concerns about A&E waiting times at two meetings during 2014-15. Those concerns remain as ICHT seems to have been consistently unable to meet its waiting times targets during the year. So, we would expect further action to rectify this situation in 2015-16.

CQC report

We shared ICHT's disappointment with the outcome of the CQC inspection, which graded it as 'requires improvement', and we noted the following key points from the report:

1. There were some basic areas of cleanliness upon which ICHT needed to improve.
2. ICHT needed to build the feedback from patients, peers and other organisations into its review of systems and decision making process.
3. The CQC was impressed with the current leadership, and the committee hoped that the CQC would continue to reach the same judgement in a year's time.
4. Outpatients was a particular area that needed attention.

We note that ICHT took urgent action to rectify the cleanliness issue and is continuing to work towards making the required improvements elsewhere. We will be inviting ICHT back to the PAC during 2015-16 to discuss that progress, particularly in areas such as outpatients.

Rory Vaughan
Chair, H&F Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF IMPERIAL COLLEGE HEALTHCARE NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent assurance engagement in respect of Imperial College Healthcare NHS Trust's Quality Account for the year ended 31 March 2015 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

This report, including the conclusion, is made solely to the Board of Directors of Imperial College Healthcare NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Imperial College Healthcare NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following indicators:

- Rate of clostridium difficile infections per 100,000 bed days (26.47); and
- Percentage of patient safety incidents resulting in severe harm (0.08% as disclosed in the Quality Account) or death (0.16%).

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2013/14 issued by the Audit Commission on 17 February 2014 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2014 to June 2015;
- papers relating to the Quality Account reported to the Board over the period April 2014 to June 2015;
- feedback from the Commissioners received in June 2015;
- feedback from Local Healthwatch dated 18 June 2015;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey;
- the latest national staff survey;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 19/05/2015;
- the annual governance statement dated 02/06/2014;
- Care Quality Commission Intelligent Monitoring Report dated December 2014;

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively "the documents"). Our responsibilities do not extend to any other information.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

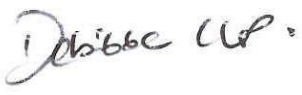
The indicators tested represent “point-in-time” measurements, and therefore may be subject to validation changes following completion of our limited assurance procedures.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.



Deloitte LLP

St Albans, UK

29 June 2015

[i] Trust response: The target of 29 or fewer category 3/4 trust acquired pressure ulcers is our target for 2015/16. Our target for 2014/15 was to reduce the number of all grades of pressure ulcers by 10% according to the safety thermometer data. We achieved this target in 2014/15 (see pages 55-56).

[ii] Trust response: The total number of clostridium difficile cases has since been confirmed as 79.

[iii]Trust response: The targets mentioned above in relation to safe staffing levels are the Trust targets for 2015/16, not 2014/15.

[iv] Trust response: We maintain a managed clinical guidelines database that is available to all staff through our intranet.

[vi] Trust response: In July 2014, we published our clinical strategy which sets out how our clinicians would like to connect our many different services and specialties across our sites in order to achieve the best clinical outcomes. To support this, we proposed re-developing our three main sites to have their own distinct, yet interdependent, offer. Our clinical and estates strategies reflect the wider programme for service reconfiguration agreed for North West London, led by our local clinical commissioning groups. An outline business case (OBC) for our estates redevelopment proposals is being considered at a national level within the NHS.

Development milestones include the anticipated approval of the OBC in 2015/16 followed by the development and further approval of the final business case towards the end of 2016/17. This would enable a three-year construction programme to begin which is currently expected to last until the end of 2020/21.

Feedback from our various audiences and stakeholders indicates that we have not engaged patients, the public and other stakeholders enough on how our care is evolving in order to meet new needs and how we propose to develop services further in the future. Specifically, we have not explained clearly enough what the clinical developments will mean in practical terms for our patients and local people, nor indicated the main reasons for putting our clinical strategy in place.

Future engagement around our clinical services will inform the continual development of our clinical strategy and merge into further detailed engagement and consultation about proposals for our buildings and facilities as and when we reach the relevant stage in our design and planning development timetable.

[vii] Trust response: The total number of clostridium difficile cases has since been confirmed as 79.

[viii] Appears as '*reducing avoidable infections'* (generic). Trust response: This target encompasses all healthcare associated infections.

[ix] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Healthwatch-CWL-DC-assessment-of-Hammersmith-Hospital.pdf.

[x] Trust response: This target encompasses all healthcare associated infections.

[xi] Trust response: During 2015/16, we aim to increase effective engagement with patients and local communities, especially in terms of helping us shape how our services evolve for the future and the redevelopment of our estates. This includes expanded patient engagement activity, linked to the Trust's other patient and stakeholder activities.

[xii] Trust response: In July 2014, we published our clinical strategy which sets out how our clinicians would like to connect our many different services and specialties across our sites in order to achieve the best clinical outcomes. To support this, we proposed re-developing our three main sites to have their own distinct, yet interdependent, offer. Our clinical and estates strategies reflect the wider programme for service reconfiguration agreed for North West London, led by our local clinical commissioning groups. An outline business case (OBC) for our estates redevelopment proposals is being considered at a national level within the NHS.

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enable a three-year construction programme to begin which is currently expected to last until the end of 2020/21.

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Future engagement around our clinical services will inform the continual development of our clinical strategy and merge into further detailed engagement and consultation about proposals for our buildings and facilities as and when we reach the relevant stage in our design and planning development timetable.

5

Appendices

Appendix A

National Audits reported 2014/15	Improvements made, or to be made, as a result
National Emergency Laparotomy Audit (NELA)	The Trust's current performance in regards to the recommendations of the audit is as follows: • The timely review by a senior surgeon following admission: Yes • A formal assessment of risk of death: Not formal • A pathway of defined peri-operative care: No • The prompt administration of antibiotics: Yes • The ready availability of diagnostic investigations: Yes • Prompt access to an operating theatre: Yes • Surgery performed under the direct care of a consultant surgeon and consultant anaesthetist: Yes • The admission of high-risk patients to a critical care unit following surgery: Yes • The Trust is looking at producing a care pathway as part of EPOCH which is looking at ways of improving outcomes in emergency care pathways. The initiation meeting took place on 2nd September. Action Plan • 24/7outreach team to be implemented if agreed following review and presentation of business case • Consultant handover in person – already implemented. Policy to be amended to reflect this • Explicit arrangements for review by Elderly Medicine • EPOCH trial initiated – initiation date 2/9/2014 • Design Care Pathways redesigned to incorporate risk assessment; document consultant involvement, sepsis 6 bundle
Head and Neck Cancer (DAHNO)	• Increase number of head and neck surgeons in line with competitors • Increased help/support with data collection
Lung Cancer (LUCADA)	• Complete recruitment to lung CNS team • Recruit to thoracic CNS to support surgical pathways • Increase thoracic surgical sessions
Neonatal intensive and special care (NNAP)	• Implementation of BadgerNet EPR across the 2 neonatal units to obtain robust data for national and international benchmarking • Regular validation of the data extracted by NDAU for NNAP – Monthly checking of data input by Information Manager and Consultant Lead for Data • Reducing admission hypothermia– producing guideline on "Golden Hour stabilisation". • Continue submission of validated data to NNAP through NDAU
Paediatric Intensive Care (PICANet)	St Mary's is a medium sized PICU treating patient(s) with high acuity and with good outcomes. Future PICANET audits will continue to focus on mortality as a key outcome measure but will also begin to look at compliance with the UK Paediatric Intensive Care Society Standards document (2011). On-going development and expansion of the unit will be essential to demonstrate this. • Continue to support unit expansion. • Continue to provide adequate administrative support for PICANET data collection. • Continue to improve nursing recruitment and staff retention to achieve PICS standards.
Coronary Angioplasty	• To continue to maintain our quality of data return to BCIS and MINAP • To comprehensively complete the Medcon database at time of procedure • To ensure that that individual operators, who now have their data published, are within recommended targets each year
Diabetes - Paediatric	• Reduce the percentage of patients with Hba1c > 80 Mmol/mol (> 9.5%) • Increase the percentage of patients with Hba1c <58 Mmol/mol (< 7.5%) • Continue to improve percentage of patients on insulin pump therapy.

	• Introduce an insulin pump study day for healthcare and MDT professionals looking after the children on an insulin pump • Offer GPs a bespoke study day on diabetes management and carbohydrate counting with RCGP accreditation • Broaden the intake of the six study days, offer them across London and then to look at offering them nationally • Improve the adolescent service with the young person and transitional diabetes nurse specialist being the central link, looking at ways of engaging young people in their management • Develop a school policy to support education staff who take on role of supporting our patients in the school environment. This will be done in conjunction with the paediatric diabetes network for West London and the paediatric diabetes network for London and the South East coast • Procure a well-designed Diabetes Database to allow the flexible and comprehensive recording of Paediatric Diabetes data in support of the service • Recruit f a 0.2 WTE Band 6 nurse to operate the CGMS clinics for the Paediatric Short Stay Unit and Great Western Ward and work between the paediatric diabetes team and the wards as a link. • Enhance Child and Adolescent Mental Health Service (CAMHS) input for our patients • Respond to user feedback by providing individual education sessions for the Young Person User Group • Continued participation in the London and SE England paediatric diabetes network • Need to improve IT system to support continued participation with NPDA. It is also a mandatory standard to achieving the best practice tariff.
Inflammatory Bowel Disease	• New oncogeriatric service has been started for lower GI cancer patients to help with assessment before and after surgery
Sentinel Stroke National Audit Programme (SSNAP)	• Continue the door-to-needle audit to improve DTN times as set by NW London strategy group (>90% under 45 min and >50% under 30min) • Improve documentation of continence and continence planning in keeping with national stroke strategy. • Improve swallow screen times. • Improve time to first contact with all therapists and the duration of therapy that the patient is receiving while in the stroke unit. • New Strategies to improve therapy scores across all the domains. • Improve standards by discharge and the discharge process
Falls and Fragility Fractures Audit Programme (FFFAP)	• Empty bed maintained on Valentine Ellis Ward for Neck of Femur admissions; “the NoF bed” • Publishing of 36 hour “breach time” for NoF surgery on e-trauma • Open rehabilitation unit at St Marys dedicated to patients that have undergone surgery • Recruitment of second physician specialising in surgical rehabilitation • Circulation of robust weekly performance data to all key stakeholders in the pathway • Escalation process to theatre teams if additional emergency capacity required.
Intensive care national audit and research	• Delayed discharges too high/frequent – regular figures being relayed to site teams. New pathways being created and put in place. • Improve Care on Step down from ICU – coalescing of high dependency units at SMH to one facility on 9th floor. Detailed plans being worked on at present with realignment of beds and facilities. Currently benchmarking smaller units as part of business case for change. • Nursing staff retention and training. Recruitment drive overseas recently held and nursing staff coming into post. Training and orientation programme in place. • Outreach – need to expand service to 7 day model with extended working hours – Critical Care committee is currently examining future model for implementation • Implementation of electronic charting system (ICCA/ICIP) at CXH

National Cardiac Arrest Audit	• Maintain this performance with a view towards improving patient's outcomes further. • Promote the value of participation in the NCAA.
Heart Failure	• Continue nurse led HF service • Maintain MDTs
National Audit of Pulmonary Hypertension	• Local audit of first line treatment of pulmonary hypertension with sildenafil
UK Renal Registry Report	• Include co-morbidity data fields and data collection screens in Renal Unit data system • Train satellite dialysis unit and pre-dialysis clinic staff in collection and submission of co-morbidity data • Re-establish demographic data feeds from Hospital PAS system following Cerner implementation • Establish (and correct) cause of validation failure for 2012 incident patient first contact date • Job Description and Business Case for Renal Unit data manager under development

Appendix B

Local Audits reported 2014/15	Improvements made, or to be made, as a result
Nasogastric Tube Placement Audit	NG Tube Placement Audit initial results demonstrated that out of the 27 actions from the Never Event/Serious Incident investigations, 17 (63%) were fully implemented and 9 (33%) required further evidence of implementation Re-audit scheduled for Q1 2015/16.
Paediatric Pain Management	The following trust guidelines are under amendment: • Changes to ward documentation in order to allow thorough recording of pain scores. • More thorough implementation of guidance on naloxone prescribing.
What percentage of medication orders are prescribers identifiable across Imperial College Hospital NHS Trust	• Implement prescriber education through trust-wide publication of audit results. This is achieved via a “Prescribing Tip” e-mail.
Appropriate prescribing of anti-microbial on the post natal wards	• Antimicrobial education session with new rotational doctors at the start of their rotations is on-going; both neonatal and obstetric.
Audit of CIWA protocol for chlordiazepoxide dosing in alcohol withdrawal following its implementation in the CDU	• Further education to both nursing staff and doctors regarding symptom triggered chlordiazepoxide prescribing and alcohol history taking. • Implementing CIWA in the emergency department.
Dementia Care and CQUIN at Imperial – Supporting Carers of Patients with Dementia	• A Carer’s Pack consisting of useful information for carers of people with dementia made available on The Source and Trust’s Website. • Dementia Care Team will liaise with Ward Managers and Therapists, to increase the amount of Carers Questionnaires collected.
Development of a Local Protocol for Maintaining high standards of nutritional support in acute stroke	• Development of trust PEG Insertion Pathway. • Development of local Stroke Unit PEG Referral Pathway.
Auditing patient understanding of abbreviations used on the consent form for Surgery	• Education and awareness to surgeons seeking written consent from patients. • Distribution of audit ‘one pager’ to key players via the Major Trauma Governance Lead
Re-audit of understanding of pre-operative fasting rules amongst nursing staff working on surgical wards	• Pre-operative fasting rules documents are present in all surgical wards to provide easy reference.
Routine Pre-Procedural coagulation screen for Elective angiography patients at Imperial College Healthcare NHS Trust	• Clotting Screens are not to be routinely performed prior to elective angiography unless the patient is on anticoagulants or has a relevant co-morbidity (as determined by the ordering clinicians). • Information leaflet is available for the vascular junior doctors for awareness of the clinical audit outcomes.
STEMI: Incidence of arrhythmias & vascular complications within 24hr post primary angioplasty	• Local policies and guidelines regarding CCU monitoring time are being updated to show that patients with STEMI after successful and complication free primary angioplasty can be stepped down as early as 6 hours after the procedure and minimum of 24 hours CCU monitoring is not an absolute necessity. • Further audit/observational study with larger sample size is due to confirm the findings from current study.
Admissions to Angiogram for NSTEACSPTS at Charing Cross	• HAC coordinator appointed for delegation of responsibility and ease of follow up to ‘chase’ transfer.

Hospital	• Dual referral system: IHT (web), phone-call to HAC coordinator for manual listing. • Repeat cycles are in place to monitor the maintenance of results, and consider further intervention to improve.
Audit on the online referral pathway (imperialspine.com) for acute spinal pathologies	• Electronic referral systems are rolled out for other specialities. • Re-audit with larger sample size.
Pre-op Fasting – An Audit on current Staff knowledge	• Posters are present in wards as a staff reminder. • Teaching junior doctors and nursing staff during induction and when in orthopaedic staff. • Patient information leaflet available.
Standards of Documentation on the ENT Ward Round	• Daily "board round" before leaving the ward.
The impact of Bariatric surgery on patient mobility using a novel ambulation scoring system (BARS Score)	• All bariatric patients are ensured to receive a complete Alwyn and BARS score at every pre and post-operative consultation. • The three named validation studies for the Imperial Bariatric Restriction Severity index are also to be completed in order to support its clinical implementation and interpretation.
The Use and Documentation of Chaperones during Intimate Examinations	The following actions are awaiting approval: • Employing a floating member of staff to take on administrative roles and act as a chaperone when necessary. • Reminder posters to be placed in clinic rooms; an enlarged version of the stamp to be placed on the wall in front of the clinician. • Introduction of a self-inking stamp into the top of the clinic notes beneath the name of the consultant.
The use of Premedication for Neonatal Intubations	• Medication table / Dosing table re-designed to simplify the dosing and drawing of premedications. • Frequent intubation simulation training for Doctors. • Frequent drug preparation simulation training for Nurses. • Weekly updated charges with exact doses for each baby, with pre-filled syringes prepared.
Audit of the names listed for Child Protection Plans in Cerner and Symphony Systems	• Audits to be completed on the Trust Alert System to ascertain that documented evidence is available to inform Social Care of the child's attendance. • The Trust is considering an electronic system to enable electronic uploading of the Child protection alerts to our systems to avoid manual error. • At least one administrative staff will continually manage all systems to ensure that the information is up to date.
Assessment of the Quantitative and Qualitative data included on the Trust's interagency referral form that is sent to Children's Social Care, evidence of the referral form in the medical records along with documented evidence of feedback from Social Care	• Training on the completion of interagency referrals forms to be offered to all staff working in the A&E Departments. • A review of the process of sending referrals to CSC regarding the timeliness of referrals must be undertaken at Charing Cross Hospital A&E. • Assurance that there are appropriate systems and processes in place to ensure that the interagency form and other records are scanned on the Symphony system.
Early Onset Sepsis	• EOS audit for postnatal infants in place. • Indications for starting first line antibiotics are clearly documented on admission in the notes. • EOS documentation sheet are part of the admission pack. • Document rationale for stopping antibiotics at 36 hours or continuing course in the notes.
Formula Milk on the Postnatal Ward	• Education in formula Prescription is available in E-learning.
Golden hour Guidelines - Effectiveness of Stabilisation of	• Increase consultant presence, where it is suggested that at delivery of babies <26 weeks consultant presence to become mandatory.

Preterm Babies < 32 wks on early CPAP by implementing the Golden Hour Guideline	• Intensified simulation-based training on logistics and communication. • Intensified teaching of Golden Hour guideline to new doctors. • Better pre-preparation, resuscitaire checked canulation equipment available in all situations.
Postnatal Ward Observations and Transitional Care Activity Audit	• Implementation of a more structured neonatal observation chart is in development.
Quality of neonatal discharges- retrospective and prospective audit	• All Discharge Summaries are to be checked by parents and the attending consultants. • For all inpatients, update on discharge summaries should be done on weekly basis and supervised by attending consultants.
Postnatal neonatal jaundice management– comparison with local/NICE guidelines	• A patient information leaflet for jaundice in babies to be made available for parents of babies requiring phototherapy. • Management of jaundice in babies occurring at more than 24 hours of age - repeat bilirubin once phototherapy has started needs to be performed within the recommended time frame.
Prevention of hypoglycaema by implementing the 'Golden Hour' guideline	• Continued simulation teaching run with each new set of doctors every 6 months • Gel Mattresses used to keep babies warm.
Obstetric Chloestasis	• All women with OC are referred to OC Research Midwife for data capture and follow-up. • All postnatal ward rounds are to include everyone who has had an obstetric condition, regardless of birth outcome.
Rolling audit on the Status of Case notes in Paediatric Haematology Daycare Unit	• Staff are continually informed of procedures required when handling case notes • Ward clerks and admin team are reminded to track notes when they are moved between areas. • Ward clerks are shown where/how to print missing barcodes in POPD.
Controlled Drug audit	• Ward managers to raise awareness and importance of all of these aspects of controlled drug management locally and complete local audit to identify persistent failings and to ensure that progress is being made before the next pharmacy-led audit. • For those areas with less than 90% overall compliance, Pharmacy will provide ward managers with an audit checklist and notes for completion.
Transitional Care Activity and Postnatal Ward Observations	• On-going training occurring for midwives as part of Baby Friendly Initiative. • Re-audit to establish trend in readmission rates and include data on reason for readmission e.g. poor feeding / weight loss / jaundice.
Safeguarding supervision children and young people in the Children's Department	• All safeguarding supervision is documented in Patient Records. • Strategy for supervision of young people with complex health needs to be developed.

Glossary

Glossary

1,000,000 Genomes Project – the project will sequence 100,000 genomes from around 70,000 people. Participants are NHS patients with a rare disease, plus their families, and patients with cancer. The aim is to create a new genomic medicine service for the NHS – transforming the way people are cared for. Patients may be offered a diagnosis where there wasn't one before. In time, there is the potential of new and more effective treatments.

Anti-infectives – drugs that are capable of acting against infection.

Aseptic Non-Touch Technique (ANTT) – how staff perform a number of clinical procedures, this involves correct hand washing, wearing of gloves and aprons at appropriate time to maintain sterility of key parts to prevent infections by not touching them.

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

Care Quality Commission (CQC) - the CQC is the independent regulator of health and social care in England. It makes sure health and social care services provide people with safe, effective, caring, well-led and responsive care, and encourages care services to improve.

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

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

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

Hospital Episode Statistics (HES) - HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England. This data is collected during a patient's time at hospital and is submitted to allow hospitals to be paid for the care they deliver. HES data is designed to enable secondary use, that is use for non-clinical purposes, of this administrative data.

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

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

Methicillin-resistant *Staphylococcus aureus* (MRSA) – a bacterium that is found on the skin and in the nostrils of many healthy people without causing problems.

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

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

Patient safety incident – any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care as defined by the National Patient Safety Agency.

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

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

Root Cause Analysis (RCA) – a systematic investigation that looks beyond the people concerned to try and understand the underlying causes and environmental context in which the incident happened (NPSA 2004).

Safety thermometer – a local improvement tool for measuring, monitoring and analysing patient harms and harm free care. It provides a quick and simple method for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm free care over time. The safety thermometer records pressure ulcers, falls, catheters with urinary tract Infections and venous thromboembolisms (VTEs).

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

Standardised hospital mortality indicator (**SHMI)** – a national way of measuring mortality. It includes deaths related to all admitted patients that occur in all settings – including those in hospitals and those that happen 30 days after discharge. This measurement takes into account factors that may be outside of a hospitals control, such as those patients receiving palliative care.

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

Urinary tract infection (UTI) – an infection that can happen anywhere along the urinary tract. Urinary tract infections have different names, depending on what part of the urinary tract is infected. They are caused by bacteria entering the urethra and then the bladder which can lead to infection.

Venous thromboembolism (VTE) – a blood clot within a blood vessel that blocks a vein or an artery, obstructing or stopping the flow of blood. A blood clot can occur anywhere in the body's bloodstream. There are two main types; venous thromboembolism (VTE) which is a blood clot that develops in a vein; and arterial thrombosis which is a blood clot that develops in an artery.

WHO checklist – The World Health Organization Surgical Safety Checklist was introduced in 2008 to increase the safety of patients undergoing surgery. The checklist ensures that surgical teams have completed the necessary listed tasks to ensure patient safety before proceeding with surgery.

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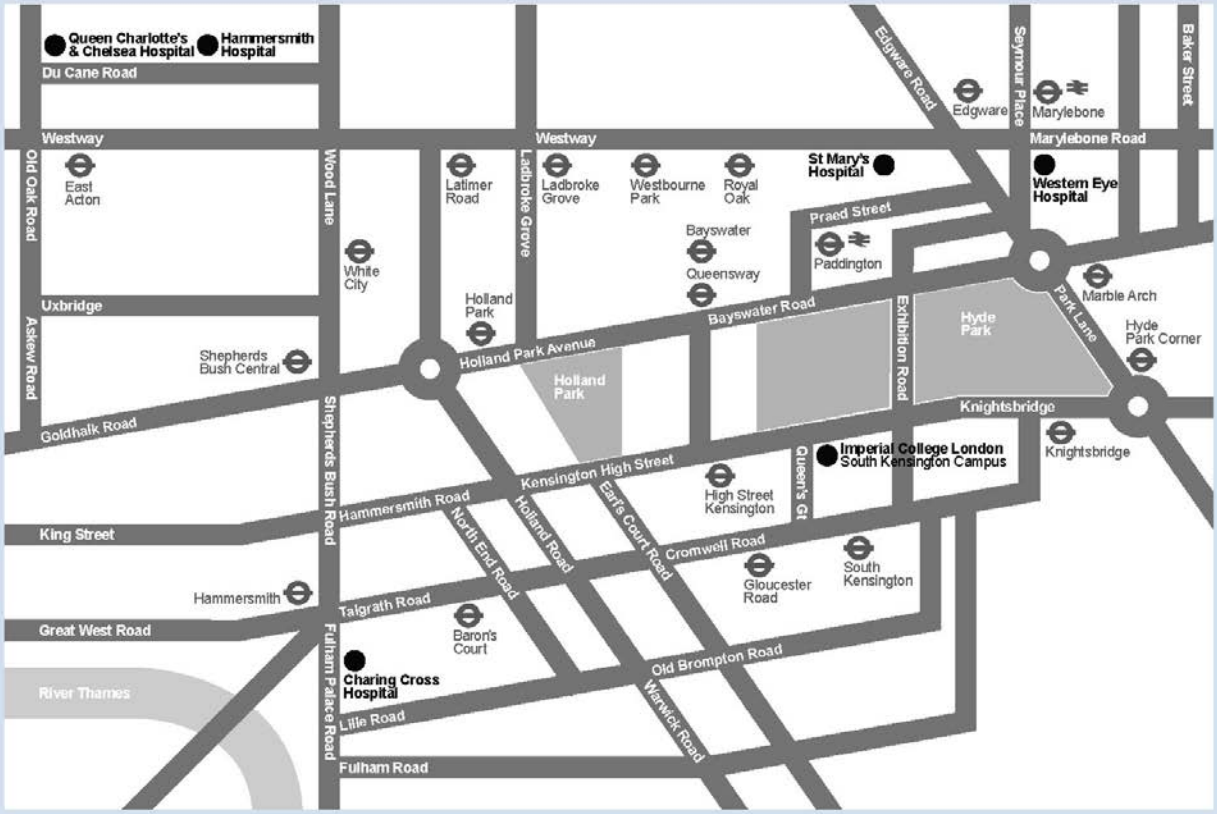

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