Imperial College Healthcare NHS
NHS Trust

Quality Account 2016/17

Contents

Glossary

We have tried to make this document as straightforward and reader-friendly as possible. A glossary of terms used throughout the document can be found on page 77.

Alternative formats

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

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Statement from the Chief Executive

We at Imperial College Healthcare NHS Trust are committed to helping the people we serve to live their lives to the fullest. We aim to do this by providing high quality care, whenever and however we are needed, and by working in partnership, supporting our patients to take an active role in their own health and wellbeing.

I am very proud of our Trust and optimistic for its future – though the whole NHS is in challenging times, we have so much to draw on in terms of the expertise, kindness and commitment of our staff. The amazing response we had to *Hospital*, the BBC2 documentary series about our organisation, provided tangible evidence of this, if it were needed.

Despite increasing financial and capacity pressures on our services, and on the NHS as a whole, we have seen some significant improvements this year. Building on our transformation programme launched in 2015/16, and supported by a re-organisation of our management structures at the beginning of this year, our staff have delivered real achievements in maintaining excellent clinical outcomes while reducing avoidable harm to patients, focusing on how we learn from mistakes and improve patient experience. I am particularly proud that we have delivered these improvements in the context of the significant challenges we have faced throughout the year to meet key national access standards and tackle long-standing pressures around demand, capacity and patient flow. Although we still have a lot more work to do, I am confident that we are starting to improve how we manage these pressures, whilst ensuring we continue to provide the best possible care to all our patients.

Most encouragingly of all, our staff are increasingly positive about working here. Our results in both our internal and the national staff engagement surveys have improved hugely and reflect our changing organisational culture; empowering staff to continuously improve the service they provide and working with our patients and communities to ensure that we are among the best healthcare providers in the country – safe, effective, caring, well led, and responsive to our patients' needs.

Our plans for 2017/18

Over the coming year, it's important that we address the immediate challenges we face but we also need to continue with the more strategic changes that will allow us to meet future health needs. We will focus on delivering the last year of our quality strategy to ensure sustainable and continuous improvement across our services, supporting the North West London Sustainability and Transformation Plan by ensuring we provide safe, high quality, sustainable acute services, while working with our partners to deliver better care across our communities.

With our staff, stakeholders and the public, we will also draw up our plans for the next three years, creating our third quality strategy which we will publish in spring 2018. This will build on the successes of our current strategy, while focusing on areas where further work is needed.

Acknowledgements

I hope that this quality account paints a clear picture of our commitment to continuous improvement, and of how important the safety and experience of our patients are to us all at Imperial College Healthcare NHS Trust.

We would like to thank everyone who helped us compile this document, including members of the public, Healthwatch, local authorities and commissioner colleagues.

Much of the work that is described in this document could not have been done without the generosity of our charity, so I would like to extend my thanks for all their support.

Finally, I would like to thank all our staff who work tirelessly every day to better the lives of patients and the community we serve.

Dr Tracey Batten
Chief executive, Imperial College Healthcare NHS Trust
May 2017

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.

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

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

We have sought to take all reasonable steps and exercised appropriate due diligence to ensure the accuracy of the data reported, but we recognise that it is nonetheless subject to the inherent limitations noted above. We are working to improve data quality across the organisation, as described on page 30. Following these steps, to the board's knowledge, the quality account is a true and fair reflection of the Trust's performance.

We have tried to make this document as straightforward and reader-friendly as possible. A glossary of terms used throughout the document can be found on page 77.

If you have any questions, would like to provide feedback on this report, or to be involved in producing it next year, please email quality@imperial.nhs.uk.

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 has been prepared in accordance with Department of Health guidance and Quality Account Amendment Regulations 2010 (as amended) and presents 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:
   - Trust board minutes and papers for the period April 2016 to May 2017
   - papers relating to Quality reported to the Trust board over the period April 2016 to May 2017
   - feedback from Clinical Commissioning Groups
   - feedback from local scrutineers, including Healthwatch and local authority overview and scrutiny committees
   - the Head of Internal Audit's Annual Opinion April 2017
   - the national inpatient survey 2016
   - the national staff survey 2016
   - the General Medical Council's National Training Survey 2016
   - mortality rates provided by external agencies (NHS Digital and Dr Foster).

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

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

The directors have reviewed the quality account at executive quality committee in May 2017 and confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality accounts. The quality account was reviewed at our Trust board meeting held on 24th May 2017, 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

About our Trust

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

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

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

Our Trust in numbers

(*DN: these will be portrayed as infographics in the designed version*)

Our services

Outpatient contacts	**Over 1 million**
Inpatient contacts	**210,000**
A&E attendees	**288,500**
Babies born	**10,500**
Operations - day	**99,000**
Operations - inpatient	**109,000**

Our staff

Number of staff, including:	**Nearly 11,000**
Doctors	**2,500**
Nurses and midwives	**4,500**
Allied health professionals	**650**
Scientists and technicians	**1,000**
Pharmacists	**125**
Undergraduate doctors in training (Health Education England)	**810**
Nurses in education, pre-reg	**500**

Our vision and objectives

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

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

- to achieve excellent patient experience and outcomes, delivered 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 clinical care.
- to pioneer integrated models of care with our partners to improve the health of the communities we serve
- to realise the organisation's potential through excellent leadership, efficient use of resources and effective governance

For an assessment of performance against our strategic objectives in 2016/17, please see our annual report (*DN: link to be added once published*).

For 2017/18, we have developed a set of corporate objectives which will be the focus of our work over the coming year. They are:

- **Improving the way we run our hospitals and services.** We will create care pathways with processes, ways of working and facilities that consistently achieve the best possible outcomes and experiences for our patients and their families, making the most of digital and other new technologies.
- **Making our care safer.** We will build a culture where all our staff feel safety is key, are able to 'speak up' and understand their responsibilities, and where patients also feel confident to raise safety concerns and believe they will be addressed.
- **Developing more patient centred approaches to care.** We will work in partnership with our patients and partner organisations to create sustainable service and organisational models that help our population stay as healthy as possible and ensure access to the most appropriate care when it is needed.
- **Making the Trust a great place to work.** We will create a shared sense of belonging across our organisation, with staff feeling supported, valued and fulfilled, and a compelling 'offer' in terms of reward and recognition, wellbeing and development.
- **Building sustainability.** We will develop an organisational culture, care models and service portfolio that enable us to move from a deficit to a surplus budget, allowing us to make greater investment in maintenance, improvement and innovation.

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

Our ethos and values

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

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

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

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

Our values are:

- **Kind** – we are considerate and thoughtful, so you feel respected and included.

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

Our Governance framework and structures

Management structure

A new organisational structure was put in place in July 2016 to devolve more authority to clinical staff providing care to patients.

Services are now organised into one of 24 clinical directorates, each with its own 'triumvirate' of lead doctor, lead nurse and lead manager, with dedicated support from finance, human resources and information and communications technology.

The clinical directorates are organised into three clinical divisions, each led by a practising clinician, they are:

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

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

The new structure also reduced the number of layers of management, to no more than five between the chief executive and frontline staff, to speed up decision-making and help the quick escalation of issues.

Imperial Private Healthcare is our private care division, offering a range of services across all of our sites. Income from our private care is invested back into supporting our NHS services.

The clinical divisions are supported by six corporate divisions:

- office of the medical director (including quality, education and research);
- nursing director's office (including patient experience, estates and quality compliance);
- finance;
- people and organisational development;
- information and communications technology;
- communications.

Governance Framework

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

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

Every month, our executive management team reviews a comprehensive set of performance indicators – our 'scorecard'.

A scorecard with a core set of indicators is also reviewed by the Trust board at its public meeting. For each indicator, we look at how we are performing against national standards and/or our own targets that flow from our various strategies.

On our website, we publish an easy-to-understand monthly performance summary taken from the scorecard as well as the full scorecard that goes to each public board meeting.

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

- quality
- finance and investment
- audit, risk and governance
- remuneration and appointments
- redevelopment

Below the board committees is the executive committee which meets on a weekly basis.

We also triangulate key quality measures, including Friends and Family test results, complaints, infection rates and patient safety incidents, at ward level through monthly 'harm free care reports' which allow wards to review their key data in one place and develop coordinated plans for improvement.

Our key strategies

Quality strategy

Our Quality Strategy 2015-2018[1] sets out our definition of quality under the domains of safe, caring, effective, responsive and well-led, and describes our vision and direction, ensuring quality is our number-one priority. Our annual quality account reports on progress with delivery of the strategy and confirms the priorities for the following year.

Our quality strategy will come to an end in March 2018. From summer 2017 we will start the consultation process to develop our new quality strategy, which will build on the progress we have made over the last three years.

Patient and public involvement strategy

Last year, we developed a strategic approach to increasing and improving patient and public involvement in the delivery and development of care and services across our organisation. This is led by our director of communications.

At the heart of the strategy[2] is the commitment to ensure patients and the public are able to help shape and input to every aspect of the Trust's work. During the year, significant progress was made on establishing new ways for patients and the public to get involved. This includes:

- establishing a strategic lay forum – made up of patients, carers and local residents
- recruiting, training and supporting an additional 22 lay partners to oversee Trust programmes and service developments as equal members of the team
- creating a patient communications group to help ensure our materials are clear and effective.

People & organisational development (P&OD) strategy

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

[1] https://www.imperial.nhs.uk/about-us/our-strategy/quality-strategy
[2] https://www.imperial.nhs.uk/get-involved/join-an-involvement-programme/about-our-involvement-strategy

continuously improving engagement of the workforce. The executive lead is our director of people and organisational development.

Clinical Strategy

Led by our medical director, our clinical strategy[3] sets out how we will develop, organise and connect our services and specialties to meet changing health needs. We are working to:

- Offer routine services locally where possible;
- Centralise specialist services where it will improve clinical outcomes and safety;
- Join up services more effectively, linking with other health and social care providers;
- Personalise care and treatment around individual needs and preferences.

In 2017 we will be refreshing our clinical strategy with a view to publishing it in 2018.

Estates strategy and redevelopment programme

We have one of the largest backlog maintenance liabilities of all trusts, mostly due to the age of our estate. We therefore have some instances where equipment is now obsolete and this means that on occasion parts have to be specifically manufactured to support this obsolete equipment – this can lead to prolonged downtime, adversely affecting patient experience, service provision, and, at times, create a risk to patient safety.

Our Estates Strategy[4] for 2016 to 2026 provides an integrated approach to the estate and supports our ambition to consolidate our place as the secondary care provider of choice within north west London. It is aligned to the strategies and needs of the wider community identified through the Sustainability and Transformation Plan. The aim of the strategy is to ensure that the Trust provides safe, secure, high-quality healthcare buildings capable of supporting current and future service needs.

Whilst the strategy is being progressed, the Trust Board has agreed increased funding to support a number of major projects, service developments and medical equipment replacement. For further information, please see our annual report (*DN: link to be added once published*).

Digital strategy

Our digital strategy is led by our chief information officer and spans five years from 2015 to 2020. The strategy is supported by our business intelligence unit, who provide data and analytics support to our teams. The strategy is driving more productive working internally and across the local health system, moving from paper records towards digital data capture and processing. This is progressing with the roll out of our electronic patient administration system, Cerner and incorporates elements such as the Care Information Exchange, a secure platform to give individuals access to information about their care held by different health and social care providers. In partnership with Chelsea and Westminster Hospital NHS Foundation Trust we were selected by NHS England to become one of 16 global digital exemplars in acute care. We aim to become an internationally recognised NHS care provider delivering exceptional care with the support of digital technology and will receive funding and support to drive this forward and create products and approaches that can be used by other organisations.

In addition to the above, we are currently developing a communications and engagement strategy for the organisation, which is being led by the director of communications. This will encompass elements such as the upgrade of our Trust intranet system.

[3] https://www.imperial.nhs.uk/about-us/our-strategy/clinical-strategy
[4] https://www.imperial.nhs.uk/about-us/our-strategy/estate-strategy

Our quality improvement plan

This section of the report describes our approach to quality improvement, and how we monitor our performance throughout the year to ensure we are continuously improving our services. It also sets out the targets and workstreams we have chosen to prioritise in 2017/18.

Our approach to quality improvement

Our quality strategy was developed following an extensive consultation with internal and external stakeholders to ensure it met national, local and trust priorities. The strategy will support the North West London Sustainability and Transformation Plan (STP), by ensuring we provide safe, high quality, sustainable acute services, while working with our partners to deliver better care. STPs have been developed by the NHS and local councils together covering all of England to make improvements to health and care. Our STP was developed by 28 NHS, local authority and voluntary sector partners, including our Trust. You can read more about it by following this link[5].

Recognising that delivering the improvements outlined in our quality strategy required a culture shift across the organisation, in autumn 2015 we launched our new quality improvement (QI) programme.

Now into its second year of building a culture of continuous improvement across the organisation, the programme:

- engages with staff to ensure everyone knows about QI and feels empowered to see improving patient care as a key part of their role
- builds improvement capability through a programme of QI education to enable staff to lead, champion and coach improvement work within their teams
- supports teams to deliver focused QI projects and programmes aligned to our strategies
- embeds rigorous improvement methods in our organisational approach to change.

In 2016/17, the QI team engaged directly with just under 3,000 staff, initiating a broad ranging education and coaching programme for 416.

To date, the QI team is actively supporting 17 strategic trust-wide initiatives as well as 45 service-led QI projects. Over 112 pieces of internal consultancy work have been completed.

You can read more about our QI programme in the annual report of the Quality Improvement team.(*DN: link to be added once published*).

Monitoring quality

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

[5] https://www.healthiernorthwestlondon.nhs.uk/news/2016/11/08/nw-london-october-stp-submission-published

In addition, we work closely with our commissioners throughout the year to monitor our performance with the quality strategy, and develop the annual quality account, acute quality schedule and priorities through the monthly clinical quality group. This ensures that our quality agenda aligns with local and national priorities. We also develop and review progress with our quality account throughout the year through the quality steering group; this group incorporates members of local councils, Healthwatch, patient representatives as well as our commissioners.

Our priorities for 2017/18

Our quality strategy is delivered through the achievement of our quality goals, which are:

- **Safe:** To eliminate avoidable harm to patients in our care as showing a reduction in the number of incidents causing severe/major harm and extreme harm/death.
- **Effective:** To ensure improvement plans are in place for all national clinical audits.
- **Caring:** 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 they needed similar care or treatment to 94 per cent
- **Responsive:** To consistently meet all national access standards
- **Well Led:** To increase the percentage of our people 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.

The original goals were developed 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 have changed the effective goal for 2017/18 due to variations in reporting of national audits and therefore difficulties in reporting performance. The goal will now be to ensure that we have improvement plans in place for every audit which reports in year.

The goals are supported by specific annual targets which are monitored and improvements driven throughout the year via the governance structure described above. The targets are focused on sustaining achievements that we have made throughout 2016/17 and on continuing to drive improvements where performance is not as good as we would wish. Each target has a

number of actions planned to ensure they can be met. Some of our targets do not currently have a defined measure; where this is the case, we will develop a trajectory for improvement and define the performance standard during the coming year.

This year, we have also developed ‘driver diagrams’ for each of our five quality domains to help provide clarity and direction for our improvement work going forward, and identify any gaps.

We use driver diagrams throughout the organisation as part of our quality improvement methodology to help teams in scoping out and planning their improvement activities and interventions. We start by developing a clear and measurable aim. The primary drivers outline a set of factors or improvement areas that we believe are collectively sufficient to achieve the aim and the desired outcome. The secondary drivers each contribute to at least one driver and lay out specific areas where we plan changes or interventions.

The driver diagrams for each domain can be found in appendix A.

Quality Domain 1: Safe

CQC Definition: People are protected from abuse and avoidable harm

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

In 2017/18 we will be focusing on achieving sustainable improvements in the target areas outlined below.

Target	Changes made to this target for 2017/18?
We will maintain our incident reporting numbers and be within the top quartile of trusts	Target changed from increase to maintain
We will have zero never events	No changes have been made to this target for 17/18
We will promote safer surgery by ensuring 100% compliance with all elements of the WHO checklist	No changes have been made to this target for 17/18
We will have no serious incidents where failure to complete the WHO checklist properly is a factor	No changes have been made to this target for 17/18
We will have a general vacancy rate of 10% or less	No changes have been made to this target for 17/18
We will have a vacancy rate for all nursing and midwifery staff of 12% or less	Target changed from band 2-6 ward staff to cover all nursing and midwifery staff and target increased from 10% to 12%
We will maintain the percentage of shifts meeting planned safe staffing levels at 90% for registered nurses and 85% for care staff	No changes have been made to this target for 17/18
We will ensure we have no avoidable MRSA BSIs and cases of *Clostridium difficile* attributed to lapse in care	No changes have been made to this target for 17/18
We will maintain 90% for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams	No changes have been made to this target for 17/18
We will reduce avoidable category 3 and 4 trust-acquired pressure ulcers by at least 10%	No changes have been made to this target for 17/18
We will assess at least 95% of all patients for risk of VTE, complete root cause analysis (RCAs) for all potentially avoidable trust acquired cases within the agreed timeframe and prevent avoidable death as a consequence	Target changed - added in 'complete RCAs for all potentially avoidable trust acquired cases within the agreed timeframe'
We will ensure that we comply with duty of candour and being open requirements for every incident graded moderate and above	New target

We are maintaining the majority of Safe targets for 2017/18. We have removed a target to reduce non-clinical transfers out of hours as it was achieved in 2016/17. We will continue to monitor this through our regular incident management processes.

We have added in a new target to support us to improve how we deliver the duty of candour requirements (see glossary on page 77 for definition).

Priority improvement worksteams

The newly developed driver diagram for Safe can be found in appendix A. From this, we have developed the safety culture programme described below as the key priority improvement workstream for this domain.

Safety Culture Programme

Safety culture is about the attitudes, values and behaviours that staff share towards safety in the organisation, often described as 'the way we do things around here to keep patients and staff safe'. Our safety culture programme is led by the Medical Director with a steering group, which includes patient representatives, in place to drive it forward. The programme is designed to ensure safety, for patients and staff, is the priority of everyone in the Trust. It will also support the Trust to develop and embed a culture in which all staff can describe their contribution to patient safety, are supported to learn from mistakes and are confident in speaking up if they have concerns.

The programme has a detailed project plan which has been informed by an analysis of incidents, intelligence gathered through listening to our staff at a number of events and pioneering the use of a staff safety attitudes questionnaire, combined with research and experience from organisations at national and international level. This programme currently consists of a number of pieces of work including:

- 'Safety streams' - Nine safety improvement priority areas identified through a review of our most frequently reported incidents, never events, and safety commitments made in previous quality accounts and the national Sign Up To Safety campaign (see glossary for definition). These are all underway:
  - safe mobility and prevention of falls with harm: supporting patients as they move around and preventing falls that cause harm
  - reducing harm from pressure ulcers: ensuring patients have the right care in place to prevent possible skin damage
  - recognising and responding to the very sick patient: spotting quickly when a patient becomes more unwell and ensuring the correct action is taken
  - safer medicines: improving safety in medicines administration and storage
  - optimising hand hygiene: preventing the spread of infection by ensuring we follow hand hygiene best practice
  - acting on abnormal results: ensuring that findings from tests and investigations are responded to appropriately
  - safer surgery: making sure best practices are applied before, during and after any invasive procedure
  - foetal monitoring: effectively monitoring babies' heart beats to identify and act early where there may be concerns
  - positive patient confirmation: ensuring we have the correct information to identify patients and that we use this to match the correct patient with the right care.
- A project to improve how we record, manage and learn from incidents and near misses.
- A project to improve how we investigate and learn from serious incidents and better involve patients in the process, including a refresh of key policies.
- A project to improve how we implement the duty of candour (see glossary on page 77 for definition).
- A review of current education and training related to safety available to staff.
- A review of the ways in which we can best communicate patient safety messages to staff.
- Promotion of a 'just culture' in which errors are discussed openly and managed in a fair way, with an emphasis on learning to better design systems that promote safe behaviours.

Quality domain 2: Effective

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

Trust Goal: To ensure improvement plans are in place for all national clinical audits.

This goal will enable us to have evidence that each of our services is effective and promotes the best outcomes for our patients.

Further assurance of this will be provided in 2017/18 by the following targets.

Target	Changes made for 2017/18
We will improve our mortality rates as measured by SHMI (summary hospital-level mortality indicator) to remain in the top five lowest-risk acute trusts	No changes have been made to this target for 17/18
We will improve our mortality rates as measured by HSMR (hospital standardised mortality ratio) to remain in the top five lowest-risk acute trusts	No changes have been made to this target for 17/18
We will ensure that palliative care is accurately coded	No changes have been made to this target for 17/18
We will ensure mortality reviews are carried out in all cases and report specified information on deaths in line with national requirements, including those that are assessed as more likely than not to be due to problems in care, and ensure learning and action as a consequence.	Target changed – amended in light of national guidance issued by NHS Improvement
We will increase PROMs participation rates to 80% with reported health gain above the national average	No changes have been made to this target for 17/18
We will review all out-of-ICU/ED and coronary care unit cardiac arrests for harm and deliver improvements as a result	Target changed – we have excluded out of coronary care unit cardiac arrests
We will ensure that 90% of clinical trials recruit their first patient within 70 days.	No changes have been made to this target for 17/18

We have removed one target from 2016/17, relating to the Dr Foster Global Comparators dataset. This is because it has not been possible to report this data since 2013 owing to changes in the way it is collected.

Priority improvement workstreams

The newly developed driver diagram for Effective can be found in appendix A. From this, we have identified the following priority improvement workstreams to ensure our services are in line with national and international best practice and by promoting excellent outcomes for our patients.

Mortality Review Programme

Since February 2016, every death which occurs in our hospitals is reviewed through our online mortality review system. Recent guidance issued by NHS Improvement requires all Trusts to report information on deaths, including those that are assessed as more likely than not to be due to problems in care. This programme will support implementation of the new national requirements ensure any learning from mortality reviews is shared and spread throughout the Trust.

Clinical Audit Programme

This is an annual comprehensive process of practice review which delivers a defined programme of priority audits to support our improvement priorities. It also ensures that we are participating in national clinical audits and that any recommendations and areas for improvement are acted upon. This programme is managed through the newly established Clinical Audit and Effectiveness Group.

Clinical Guidelines Programme

Overseeing the regular review of clinical guideline documents (recommendations of how healthcare professionals should care for people with specific conditions) to ensure they are fit for purpose and comply with current best practice. Our aim is to have no clinical guidelines that are out of date at any given time and to audit compliance.

Quality Surveillance Programme

A national programme of annual self-assessment and targeted peer review for all cancer and specialised commissioned services. Participation in this programme will support shared learning and provide assurance that improvements are being implemented.

West London Genomic Medicine Centre

We are the lead for the West London Genomic Medicine Centre, one of 13 NHS centres delivering the 100,000 Genomes Project nationally. The project aims to create a new genomic medicine service for the NHS, transforming the way people are cared for. It focuses on two main groups - patients with a rare disease and their families and patients living with common cancers.

These areas have been selected because eligible rare diseases and cancer are strongly linked to changes in the genome. By understanding these changes, there is potential to better understand how the disease develops and which treatments will be most effective. Patients may be offered a diagnosis where there wasn't one before. In time, there is the potential of new and more effective treatments.

Throughout the next year, we will be working to increase the number of patients and staff involved in the project.

Quality domain 3: Caring

CQC Definition: Staff involve and treat people with compassion, kindness, dignity and respect.

Trust 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 they needed similar care or treatment to 94%.

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 indicators outlined below will help deliver this goal and to determine whether our services are caring and patient centred in all aspects. Each of these has a number of defined actions to support delivery.

Target	Changes made for 2017/18
We will increase the percentage of outpatients who would recommend our trust to friends and family to 94% and achieve and maintain a FFT response rate of 6% in outpatient areas	No changes have been made to this target for 17/18
We will maintain the percentage of inpatients who would recommend our Trust to friends and family at 94% or higher and achieve and maintain a FFT response rate of 30% in inpatient departments	Target has been changed to say maintain rather than increase to reflect current performance
We will maintain the percentage of A&E patients who would recommend our Trust to friends and family at 94% or higher and achieve and maintain a FFT response rate of 20% in A&E	Target has been changed to say maintain rather than increase to reflect current performance
We will improve our national cancer survey scores year-on-year	No changes have been made to this target for 17/18
We will improve our score in the national inpatient survey relating to responsiveness to patients' needs	No changes have been made to this target for 17/18
We will maintain our responsiveness to complaints by responding to at least 95% within the timeframe agreed by the patient	Target changed - this has been amended to say maintain rather than increase

Priority improvement workstreams

The newly developed driver diagram for Caring can be found in appendix A. From this, we have identified the following priority improvement workstreams to improve patient experience and help ensure staff demonstrate kindness and compassion at all times.

Accessible information standard

We will continue to implement the accessible information standard within the organisation, working to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand and that they are given support so they can communicate effectively with our staff.

Schwartz rounds

These staff only meetings provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work. Research shows the positive impact that they have on individuals, teams, patient outcomes and organisational culture. We will continue to run these on a monthly basis in 2017/18.

Nursing and midwifery postgraduate education programme

This work focuses on developing and supporting our nurses and midwives through a series of education programmes, including:

- Preceptorship programme to support student nurses to make the jump to confident and qualified practitioner;
- Specialty courses to allow our staff to continue to learn, develop and deliver high quality care to our patients;
- Revalidation to support registered nursing staff to reflect upon and develop their practice.

Wayfinding strategy

Patients often report having issues with finding their way around our sites and services. This project is working to make navigation easier for patients and staff. This includes improvements to signage and physical and digital wayfinding systems, and clearer information for patients.

Experience labs

This is a one year learning and development programme that will provide training and support to improve patient and staff experience in our outpatient departments. Staff will be trained to gather patients' feedback, generate and test solutions to achieve measurable improvements in outpatient experience and reduce hospital initiated cancellations. The programme started in April 2017 with 10 multi-disciplinary teams taking part.

Improving how we use patient experience data

We routinely collect a large amount of patient feedback data through our well-developed collection systems, but need to improve ways of understanding what this is telling us and how we can better use what our patients are telling us to improve. In 2017/18 we will focus on regularly sharing patient feedback data, including complaints and compliments, with the clinical services and triangulating it with other sources of information to ensure we are using it more effectively to improve the quality of patient care.

Quality domain 4: Responsive

CQC Definition: Services are organised so that they meet people's needs

Trust Goal: To consistently meet all national access standards by the end of year three of the quality strategy.

As well as aiming to achieve the national access standards, we will focus on the following targets to improve our responsiveness as a Trust. Each of these has a number of defined actions to support delivery.

Target	Changes made to this target for 2017/18?
We will reduce the unplanned readmission rates for patients aged 0-15 and be below the national average	No changes have been made to this target for 17/18
We will reduce the unplanned readmission rates for patients aged 16 or over and be below the national average	No changes have been made to this target for 17/18
We will have no inpatients waiting over 52 weeks for elective surgery, and reduce the number of patients waiting over 40 weeks and implement our agreed clinical validation process	Target changed from 'ensure a clinical validation process is in place for each patient who waits over 18 weeks' to 'implement our agreed clinical validation process'
We will reduce the proportion of outpatient appointments cancelled by the trust with less than 6 weeks' notice to 7.5% or lower	Target changed from 8.5% to 7.5%
We will ensure 95% of outpatient appointments are made within 5 working days of receipt of referral	No changes have been made to this target for 17/18
We will reduce the proportion of patients who do not attend outpatient appointments to 10%	No changes have been made to this target for 17/18
We will improve our PLACE scores year-on-year; aiming to maintain our score above national average for cleanliness; meet the national average for food; be above the bottom 20% for condition, appearance and maintenance and for privacy and dignity; and improve our scores compared to last year for dementia and disability	Target changed to specify degree of improvement for each element of PLACE
We will discharge at least 35% of our patients on relevant pathways before noon	No changes have been made to this target for 17/18
We will ensure 98% of admissions to an intensive care bed occur within 2 hours of the decision to admit/completion of surgery	New target

We have removed the target related to outpatients waiting no more than 45 minutes past their allotted appointment time as we have been unable to report data against it throughout 2016/17.

We have added a new target to reduce delayed admissions to intensive care beds, which will support improved care for ITU patients and reduce the possibility of harm caused by delays.

Priority improvement workstreams

The newly developed driver diagram for Responsive can be found in appendix A. From this, we have identified the following priority improvement workstreams to drive efficiency in pathways which meet the needs of the individual patient.

Specialty review programme (SPR)

In early 2017/18 we launched a programme to develop local clinical strategies for each clinical speciality, which will in turn feed in to the Trust clinical strategy. The programme started in April, with each specialty participating in an event led by the Medical Director.

Telemedicine

This project is looking at opportunities across the organisation to connect people who use our services with healthcare practitioners using technology such as video consultation to speed up decision-making and treatment and improve patient experience.

Outpatient improvement programme

We will continue our work to improve our outpatient departments and develop new innovations and improvements in response to the findings of the CQC inspection in November once the report is published in May 2017.

Patient flow programme

We are participating in an innovative coaching programme, run by Sheffield Microsystem Coaching Academy, which aims to improve how patients flow through a specific care pathway (see glossary on page 77 for definitions) with positive impacts on patient experience, safety and efficiency. Three pathways are currently participating in this programme: diabetic foot, sepsis, and acute wheeze and asthma in children and young people. Through weekly ‘big room’ meetings, staff and stakeholders from all specialties and professions which impact on the care provided in each pathway will work together alongside patients and members of the community to develop, implement and monitor small tests of change. These changes will ultimately deliver improvements to care – making it safer, more effective, more efficient and providing a better experience for both patients and staff. We plan to run our own flow coaching programme in 2018/19, which will involve twelve new clinical pathways.

Waiting list improvement programme

We will continue the work of our waiting list improvement programme which is making good progress in cleaning up our waiting list data and ensuring delays in treatment are minimised. We have developed a clinical review process to ensure that patients are not coming to harm due to long waits, which we will embed and further refine in the coming year.

Quality domain 5: Well led

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

Trust 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. This will be delivered by the targets outlined below. Each of these has a number of defined actions to support delivery.

Target	Changes made to this target for 2017/18?
We will achieve a voluntary turnover rate of 10%	No changes have been made to this target for 17/18
We will maintain our sickness absence rate at below 3.10%	Target changed - We have achieved this target, so have changed the narrative to say 'maintain' rather than 'achieve'
We will have a departmental safety coordinator in 60% of clinical wards, clinical departments and corporate departments (TBC)	Target being confirmed
We will ensure at least 10% of our staff are trained as fire wardens (TBC)	Target being confirmed
We will achieve a performance development review rate of 95%	No changes have been made to this target for 17/18
We will achieve a non-training grade doctor appraisal rate of 95%	No changes have been made to this target for 17/18
We will achieve compliance of 90% with core skills training	No changes have been made to this target for 17/18
We will further develop our ward accreditation programme to ensure it links with other quality initiatives and has quality improvement at its heart	Target re-phrased
We will reduce the number of programmes with red flags in the GMC's national trainee survey by 5%	No changes have been made to this target for 17/18
We will increase the overall number of green flags in the GMC's national trainee survey by 5%	Target changed – added an increase of 5%
We will obtain a minimum score of 0.5 for placement satisfaction for all student placements as measured by SOLE	No changes have been made to this target for 17/18
We will ensure we respond to all exception reports from junior doctors within 14 days of an application being made and that we deliver improvements as a result	New target

We have included a new target, which is to respond to exception reports within 14 days and ensure improvements are delivered as a result. Exception reports were introduced in 2016 with the new junior doctor contract to enable trainees to quickly and easily flag up if their actual work has varied from their agreed work schedule and to allow the Trust to take action as a result.

Targets for departmental safety co-ordinators and fire wardens, which are included to drive improvements in health and safety, are awaiting final confirmation.

Priority Improvement workstreams

The newly developed driver diagram for Well-led can be found in appendix A. From this, we have identified the following priority improvement workstreams to empower staff to make changes, encourage their development and improve engagement:

Leadership development programme

Building on our existing award winning schemes, we are further developing training programmes which focus on specific needs identified by our staff, including management skills, financial management, digital learning, data and analytics. We will also be looking at piloting management and leadership apprenticeship programmes.

Retention strategy

We have developed a recruitment and retention plan for bands 2-6 nursing and midwifery staff which will fully launch in 2017. This features a development programme, careers clinics which will run in summer 2017, automatic recruitment offers for student nurses working in the Trust, and a workshop for managers on how to engage and retain their staff. We are also one of eleven pilot sites training new band 4 associate nurses; a new role that will sit alongside existing nursing care support workers and fully-qualified registered nurses to deliver hands-on care for patients. We have recruited 13 staff members to this programme which started in April 2017.

Occupational Health Service review

Our Occupational Health team ensures the health and safety of patients, staff and contractors and other users of our services. We are currently reviewing the service to ensure it is set up in the most appropriate way to deliver an effective and high quality service for our staff.

Engagement programme

We will continue to develop the way we monitor and measure staff engagement and ensure the development of plans to improve based on what our staff tell us. The initial focus will be on driving improvements in the areas where we did not perform as well as we would wish in our staff engagement surveys in 2016/17, particularly around developing management skills in addressing poor performance, reducing staff experience of violence, bullying and harassment and ensuring equality opportunities for career progression.

Ward Accreditation Programme

Ward accreditation programmes (WAP) are designed to support ward, unit and department managers to understand how they deliver care, identify what works well and where further improvements are needed. We plan to run our ward accreditation programme for the third time in 2017/18, and will be implementing a number of changes to improve the process, such as live on-line dashboards of the results to facilitate immediate improvements and changes to the review team structure to ensure consistency and fairness.

Statements of assurance from the Trust board

In this section of the quality account, we are required to present mandatory statements about the quality of services that we provide, relating to financial year 2016/17. 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 2016/17, Imperial College Healthcare NHS Trust provided and/or sub-contracted 86 NHS services.

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

The income generated by the NHS services reviewed in 2016/17 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2016/17.

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.

The table below shows all national clinical audits and confidential enquiries which were mandated during 2016/17. Of these, two were not collecting data during 2016/17, and we were not eligible to participate in seven. Therefore, during 2016/17, the NHS services that we provide were covered by 49 national clinical audits and 13 national confidential enquiries.

During that period we took part in 98 per cent of national clinical audits (48 out of 49) and 100 per cent of national confidential enquiries (13 out of 13) in which we were eligible to participate.

The national clinical audits and national confidential enquiries that we participated in during 2016/17 are included in the table below alongside the number of cases submitted to each audit or enquiry as a percentage where this is available.

Title	Eligible	Participated	Per cent Submitted
NATIONAL CLINICAL AUDITS			
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	✓	100%
Adult Asthma	✓	✓	100%
Adult Cardiac Surgery	✓	✓	100%
BAUS Urology Audits - Female Stress Urinary Incontinence Audit	✓	✓	100% (N.B. the number of procedures performed was not sufficient to be published)
BAUS Urology Audits - Radical Prostatectomy Audit	✓	✓	75.5%
BAUS Urology Audits - Nephrectomy audit	✓	✓	75.3%
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	✓	✓	100%
Bowel Cancer (NBOCAP)	✓	✓	100%
Cardiac Rhythm Management (CRM)	✓	✓	Submission rate not available
Case Mix Programme (CMP)	✓	✓	100%
Chronic Kidney Disease in primary care	**x**	**N/A**	Primary care service only
Congenital Heart Disease (CHD)	**x**	**N/A**	Service decommissioned
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	✓	✓	100%
Diabetes (Paediatric) (NPDA)	✓	✓	100%
Elective Surgery (National PROMs Programme)	✓	✓	On-going data collection
Endocrine and Thyroid National Audit	✓	✓	100%
Falls and Fragility Fractures Audit programme (FFFAP):			
Fracture Liaison Service Database	**x**	**N/A**	Only for Trusts with a Fracture Liaison Service
Inpatient Falls	✓	✓	100%
National Hip Fracture Database	✓	✓	83.1%
Head and Neck Cancer Audit	✓	✓	On-going data collection
Inflammatory Bowel Disease (IBD) programme / IBD Registry	✓	✓	100%
Learning Disability Mortality Review Programme (LeDeR)	✓	✓	On-going data collection
Major Trauma Audit	✓	✓	97.2%
Mental Health Clinical Outcome Review Programme	**x**	**N/A**	For mental health trusts only
Moderate & Acute Severe Asthma - adult and paediatric (care in emergency departments)	✓	✓	100%
National Audit of Dementia	✓	✓	100%
National Audit of Pulmonary Hypertension	✓	✓	100%
National Cardiac Arrest Audit (NCAA)	✓	✓	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme:			
Pulmonary rehabilitation	✓	✓	On-going data collection
Secondary Care	✓	✓	On-going data collection
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	✓	**N/A**	Not collecting data in 2016/17
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	✓	**N/A**	Not collecting data in 2016/17
National Comparative Audit of Blood Transfusion programme:			

Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	✓	✓	Not yet started
2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	✓	✓	On-going data collection
Audit of Patient Blood Management in Scheduled Surgery - Re-audit September 2016	**x**	**N/A**	ICHT not eligible (re-audit of pilot sites)
Audit of the use of blood in Lower GI bleeding (audit will not be repeated)	✓	**x**	ICHT did not participate
National Diabetes Audit – Adults:			
National Diabetes Foot Care Audit	✓	✓	99%
National Diabetes Inpatient Audit (NaDia) - reporting data on services in England and Wales	✓	✓	100%
National Pregnancy in Diabetes Audit	✓	✓	SMH - 100% QCCH – submission in progress
National Diabetes Transition	✓	✓	100%
National Core Diabetes Audit	✓	✓	Not yet started
National Emergency Laparotomy Audit (NELA)	✓	✓	SMH = 30% CXH = 60%
National Heart Failure Audit	✓	✓	58%
National Joint Registry (NJR)	✓	✓	On-going data collection
National Lung Cancer Audit (NLCA)	✓	✓	91.1%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	✓	✓	100%
National Ophthalmology Audit	✓	✓	On-going data collection
National Prostate Cancer Audit	✓	✓	100%
National Vascular Registry	✓	✓	79%
Neurosurgical National Audit Programme	✓	✓	Submission rate not yet available
Oesophago-gastric Cancer (NAOGC)	✓	✓	100%
Paediatric Intensive Care (PICANet)	✓	✓	Submission rate not yet available
Paediatric Pneumonia	✓	✓	Submission rate not yet available
Prescribing Observatory for Mental Health (POMH-UK)	**x**	**N/A**	For mental health trusts only
Renal Replacement Therapy (Renal Registry)	✓	✓	100%
Sentinel Stroke National Audit programme (SSNAP)	✓	✓	100%
Severe Sepsis and Septic Shock (care in emergency departments)	✓	✓	100%
UK Cystic Fibrosis Registry	**x**	**N/A**	Service not offered
NATIONAL CONFIDENTIAL ENQUIRIES			
Medical and Surgical Clinical Outcome Review Programme (NCEPOD):			
Perioperative diabetes	✓	✓	Data collection not yet commenced
Cancer in Children, Teens and Young Adults	✓	✓	On-going data collection
Heart Failure	✓	✓	Data collection not yet commenced
Acute Pancreatitis	✓	✓	85%
Non-invasive ventilation	✓	✓	75%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE):			
Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity	✓	✓	100%
Perinatal Mortality Surveillance	✓	✓	100%
Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal	✓	✓	100%

deaths)			
Confidential enquiry into serious maternal morbidity	✓	✓	100%
Maternal mortality surveillance	✓	✓	100%
Maternal morbidity and mortality confidential enquiries (cardiac plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	✓	✓	100%
Child Health Clinical Outcome Review Programme (NCEPOD):			
Chronic Neurodisability	✓	✓	On-going data collection
Young People's Mental Health	✓	✓	On-going data collection

There were a total of 33 national clinical audit reports issued in the period April 2016 to March 2017 in which the Trust participated. We reviewed the reports of 32 national clinical audits in 2016/17. The outstanding report (national comparative audit of blood transfusion) remains under review by the service.

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. The actions we intend to take to improve the quality of healthcare provided can be found in appendix B

The reports of 41 local clinical audits were reviewed by the provider (out of 41 local audits registered and completed in 2016/17) and the actions we intend to take to improve the quality of healthcare provided can be found in appendix C (see appendix C for a selection of the local audits and actions/recommendations).

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 21,611.

14,023 patients have been recruited into 438 Portfolio studies in 2016-17. This included 439 patients within 80 studies sponsored by commercial clinical Research and Development organisations.

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 2016/17 and to attract further new investment to support clinical research and development (R&D), including the following:

- **NIHR Imperial Biomedical Research Centre (BRC)** – this major programme of experimental medicine was renewed and awarded £90m over the next 5 years. This new funding will allow the BRC to continue its world-class research into cancer, heart disease, brain sciences, immunology, gut health, infection, surgery and metabolic disorders. It will also support cross-cutting research and technology development in areas such as genomics, imaging, molecular phenotyping and the use and storage of biomedical data and samples.
- **NIHR Imperial Clinical Research Facility (CRF) –** our experimental medicine CRF was awarded £10.9m over the next 5 years. This award will continue to provide dedicated bed space for up to 25 patients participating in research. It will also support a team of 40 dedicated healthcare professionals specialising in clinical research. The award will allow

us to continue to support experimental medicine clinical research studies in patients and healthy volunteers across a wide range of conditions.

- **NIHR Imperial Patient Safety Translational Research Centre (PSTRC)** – also renewed at £7m over the next 5 years. The investment will be spent on patient safety research across numerous clinical areas with the aim to turn patient safety discoveries into practice and impact NHS frontline services.

Our CQUIN performance – CQUIN framework

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

A proportion of Imperial College Healthcare NHS Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals through the CQUIN framework.

In 2016/17 the value of the schemes was 2.8% of the contract value for NHS acute healthcare services as agreed with NHS England. This equated to £5.64 million of our planned income from NHS England.

A summary of the 2016/17 CQUIN goals and achievement is provided in the table below. The figures are based on our projected year end and are subject to final agreement.

CQUIN scheme	**Description of scheme**	**Full year Plan value £**	**Achieved £ projected year end**	**Achieved % projected year end**
BI1 HCV Improving Treatment Pathways through ODNs	To support providers to deliver the infrastructure, governance and partnership working across Hepatitis C virus operational delivery networks	£3,222,450	£3,381,937	100%
GE1 *Clinical Utilisation Review Tool*	To reduce numbers of bed days (and emergency admissions) that do not meet criteria of clinical appropriateness.	*£664,630*	£0	0%
TR1 Adult Critical Care (ACC) Timely Discharge	To reduce delayed discharges from ACC to ward level care by improving bed management	£463,227	£291,692	60%
CA2 Nationally Standardised Dose Banding Adult Intravenous SACT	To standardise the doses of Systemic Anti-Cancer Therapy (SACT) in all units across England	£483,368	£507,290	100%
QIPP Telemedicine	To reduce or replace physical outpatient attendances, where appropriate, with virtual contact through phone calls or other technological methods.	£342,385	£359,331	100%
QIPP Ventilator acquired pneumonia	To support providers in procuring the appropriate product that demonstrates effective ventilator prevention measures against infection and potential pneumonia rates.	£201,403	£211,371	100%
QIPP ARV Switch	To ensure the appropriate and cost effective use of antiretroviral drugs and switching patients to newer regimens where clinically appropriate	£261,824	£274,782	100%

We were unable to implement the CUR CQUIN in its current format as it required another IT system to be put in place which would have needed our staff to do double data entry. We are hoping to work with the national team to look at how we can implement this scheme using our existing electronic patient record.

In addition to these national schemes, we also agreed two CQUINs locally with our commissioners, which were focused on our outpatient transformation programme and improving communication with primary care. We are expecting to achieve 100% of the value of these schemes.

Care Quality Commission registration status

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

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

The CQC has not taken enforcement action against Imperial College Healthcare NHS Trust during 2016/17.

We have participated in one review by the CQC related to the following area during 2016/17:

- *Learning, candour and accountability*: A review of the way NHS trusts review and investigate the deaths of patients in England (published December 2016). This involved filling out a questionnaire with data about how the Trust has investigated deaths only.

We intend to take the following action to address the conclusions or requirements reported by the CQC:

- We have undertaken a review of the report and a gap analysis against our current mortality review process. We have developed an action plan to ensure we are fully implementing the recommendations in line with the national requirements.

In September 2014, the CQC inspected the Trust by visiting four of our main sites. We received an overall rating of 'requires improvement'. A summary of our overall ratings can be found below with a full report available on the CQC website:

Safe	Effective	Caring	Responsive	Well led	**Overall**
Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

The action plan developed following the Trust's CQC inspection in September 2014 was completed in March 2016.

In November 2016, the CQC carried out a re-inspection of the core service of Outpatients and diagnostic imaging. This was the only service at the Trust to be rated overall as 'Inadequate' following the September 2014 inspection.

The draft inspection reports were received on 18 April 2017 for a factual accuracy check. The reports are expected to be finalised and published on the CQC's website, including all ratings, by late May 2017. Once the inspection reports are finalised, we will be required to submit to the CQC an action plan for how we will address any areas of concern.

On 7 March 2017, the CQC arrived unannounced at the Trust to carry out a three day focused inspections of two core services:

- Maternity at St Mary's Hospital
- Medical Care at St Mary's, Charing Cross and Hammersmith hospitals.

The draft inspection reports are due between July and September 2017.

Our data quality

High quality information leads to improved decision making which in turn results in better patient care, wellbeing and safety. There are potentially serious consequences if information is not correct, secure and up to date.
We continued to experience some challenges with data quality in 2016/17 which we are working to improve through our data quality assurance framework which we introduced in 2016.
Key data quality indicators are reported every week and are also included within our monthly performance scorecards to ensure data quality governance is aligned with our Performance Management Framework.

An executive-led Data Quality Steering Group has been established and meets every month. It provides leadership and oversight of the development and delivery of all aspects of our Data Quality Framework.

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

NHS number and general medical practice code validity

The Trust submitted records during 2016/17 to the Secondary Users Service for inclusion in the Hospital Episode Statistics (see glossary on page 77 for definitions) which are included in the latest published data. The percentage of records in the published data to month 9 2016/17 (most recent available) which included the patient's valid NHS number was:

- 96.9 per cent for admitted patient care
- 98.7 per cent for outpatient care
- 90.2 per cent for accident and emergency care

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

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

Information governance toolkit scoring

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

Our information governance assessment report overall score for 2016/17 was 67 per cent and was graded 'satisfactory'. The satisfactory rating was achieved by a minimum level 2 assessment against all standards. The information governance toolkit return was subject to an independent audit conducted in October 2016 and in March 2017. The final audit report gave the Trust 'reasonable assurance' of the self-assessment.

Clinical coding quality

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

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

The Trust was not subject to the Payment by Results clinical coding audit by Monitor during 2016/17. There are no Payment by Results audits currently planned.

National Outcomes framework indicators 2016/17

For full information about our performance

The NHS Outcomes Framework 2016/17 sets out high level national outcomes which the NHS should be aiming to improve. For full information about our performance, please see pages 61-66.

A review of our quality progress 16/17

This part of the report shares the quality improvement priorities that we set ourselves for 2016/17 and reports our progress against each of these. It also outlines our performance against the NHS Outcomes Framework 2015/16, the Quality Schedule agreed with our commissioners and national targets and regulatory requirements.

Our quality account improvement priorities for 2016/17 reflected the goals and targets defined in our quality strategy. They were outlined in our quality account last year following consultation with our clinical and management teams and with our external stakeholders, through the quality steering group.

Our progress with these goals and targets is described below under each quality domain.

As part of our quality strategy, we also developed measurable and structured improvement projects which were assessed for their potential to positively impact on the goals and targets we set. These are featured throughout the following sections.

Following feedback from both internal and external stakeholders and a review of the quality accounts produced by other providers, we have simplified and shortened this section of the quality account to help ensure it is clearer and more focused, highlighting areas of good work as well as areas where we have not performed as well as we would wish.

Safe

This section describes our progress with the targets under the Safe domain during 2016/17.

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

Goal/Target	National Target / National Average	Performance in 15/16	Target for 16/17	Outcome in 16/17	Target achieved?
To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing severe/major harm	0.3% (April-Sept 2016)	0.1% (8 incidents) (April-Sept 2015)	below national average (0.3%)	0.1% (7 incidents) (April-Sept 2016)	Yes
To eliminate avoidable harm to patients in our care as shown through a reduction in the number of incidents causing extreme harm/death	0.1% (April-Sept 2016)	0.1% (5 incidents) (April- Sept 2015)	below national average (0.1%)	0.0% (2 incidents) (April-Sept 2016)	Yes
We will increase our incident reporting numbers and be within the top quartile of trusts	40.02 (April-Sept 2016)	41.38 (April-Sept 2015)	Over 44.89	42.3 (April-Sept 2016 as published by NRLS) 44.85 (full year)	No
We will have zero never events	0 never events	6 never events	0 never events	4 never events	No
We will promote safer surgery by ensuring 100% compliance with all elements of the WHO checklist in all relevant areas	N/A	Element 1: 100% Element 2: 100% Element 3: 100% Element 4: 100% Element 5: 72%	100% compliance	Element 1: 100% Element 2: 100% Element 3: 100% Element 4: 100% Element 5: 92%	No
We will have no SIs where failure to follow the WHO checklist properly is a factor	N/A	New reporting criteria – data not reported in this way	0	2	No
We will ensure we have no avoidable MRSA BSIs and cases of *C. difficile* attributed to potential lapse in care	N/A	13 (7 MRSA BSIs, 6 *C. difficile* lapses in care)	0 avoidable infections	12 (3 MRSA BSIs, 9 *C. difficile* lapses in care)	No
We will maintain 90% for anti-infectives prescribed in line with our antibiotic policy or approved by specialists from within our infection teams	N/A	89%	At least 90%	89%	No
We will reduce avoidable category 3 and 4 trust-acquired pressure ulcers by at least 10%	N/A	25 (42% reduction)	Less than 22 (at least 10% reduction)	27	No
We will assess at least 95% of all patients for risk of VTE and prevent avoidable death as a consequence	over 95%	96.43%	over 95% 0 avoidable deaths	95.33% 0 avoidable deaths	Yes
We will stop non-clinical inter-site transfers of patients out-of-hours without clinical agreement and prevent avoidable harm	N/A	New reporting criteria – data not reported in this way	0	0 cases without clinical agreement	Yes

We will have a general vacancy rate of 10% or less	N/A	10.21%	10% or less	11.57%	No
We will have a band 2-6 ward vacancy rate of 10% or less	N/A	14.69%	10% or less	19%	No
We will maintain the percentage of shifts meeting planned safe staffing levels at 90% for registered nurses and 85% for care staff	90% for registered nurses 85% for care staff	95.16% for registered nurses 92.81% for care staff	90% for registered nurses 85% for care staff	98.01% for registered nurses 94.26% for care staff	Yes

We want to ensure our patients are as safe as possible while under our care and that they are protected from avoidable harm.

Areas where we are proud of the improvements we have made or sustained in our Safe domain are outlined below under 'quality highlights', areas where we have not performed as well as we would wish are summarised under 'quality challenges'.

Safe quality highlights

We remain below average for incidents causing severe or extreme harm to patients: A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. Incidents are categorised by degree of harm, from near miss and no harm up to extreme harm (for definitions, please see the glossary on page 77).

Reporting incidents allows us to investigate and learn from errors so we can prevent them from happening again. We investigate all patient safety incidents which are reported on our incident reporting system, Datix. In addition, all patient safety incidents graded moderate and above are reviewed at a weekly panel chaired by the medical director. Each incident is reviewed when it is first reported on Datix, and then again each week until the investigation has been completed and it is closed from a Trust perspective. Incidents that are deemed to be Serious Incidents (SIs) or never events also undergo an investigation which involves root cause analysis (see glossary on page 77 for definitions).

According to the latest data published by the National Reporting and Learning Service (NRLS) we have reported fewer of the incidents which cause the most harm to patients compared to our peers. Our internal data for the full year also shows a decrease in these incidents, with 28 reported in 2016/17 compared to 31 last year.

To support this, we have identified nine safety improvement priority streams for the trust, which are described in more detail on page 15. These are:

- safe mobility and prevention of falls with harm
- reducing harm from pressure ulcers
- recognising and responding to the very sick patient
- safer medicines
- optimising hand hygiene
- acting on abnormal results
- safer surgery
- foetal monitoring
- positive patient confirmation.

Work is progressing at different stages in each of these areas, with some safety streams only recently commenced. For those which are further developed, improvements are starting to be seen – you can read more about these in the rest of this section. The projects will continue into 2017/18 and progress will be reported in next year's quality account.

We increased our incident reporting rate: An important measure of an organisation's safety culture is its willingness to report incidents affecting patient safety, learn from them and deliver

improved care. A high reporting rate reflects a positive reporting culture, as staff feel able to report incidents that occur.

The data for April to September 2016 published by the NRLS in March 2017 shows that we succeeded in increasing our incident reporting rate compared to last year, although we remained below the top quartile. Our internal data, which we use to monitor our incident reporting rate each month, shows an improvement in our performance since September 2016, and we have been above the top quartile for all months except February 2017 since then.

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

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

Our divisional nurse directors regularly review staffing at ward level alongside local quality metrics to ensure there are no quality or safety concerns regarding safe staffing levels. We have also developed a recruitment and retention plan for bands 2-6 nursing and midwifery staff which will fully launch in 2017. For more information, please see page 23.

We have reduced the number of non-clinical inter-site transfers of patients out-of-hours and have reported no cases which occurred without clinical agreement: The move of general acute medicine from Hammersmith Hospital to the Trust's other main sites has supported a decrease in the number of inter-site transfers out-of-hours occurring for capacity reasons, with none occurring in December 2016 (latest available data). In addition, since the beginning of the year, none of these transfers have occurred without clinical agreement, the requirement for which was put in place last year to minimise risk to patients and still allow flow through our hospitals. For the second year in a row, we have not reported any serious incidents where a non-clinical OOH transfer out-of-hours was a contributory factor.

We have achieved a 50 per cent reduction in the number of grade 3 and 4 pressure ulcers since 2014: A pressure ulcer is a type of injury that affects areas of the skin and underlying tissue when the area is placed under too much pressure. These 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 one to four to indicate their severity, with one indicating less damage and four indicating serious damage. All category three and four pressure ulcers are subject to an internal process of root cause analysis and are reported as serious incidents. Although we have not achieved our target of a 10 per cent decrease compared to last year, we are proud that we have reduced the occurrence of these types of pressure ulcer by nearly 50 per cent in three years and that we have not had a grade four pressure ulcer since 2013.

We continue to work to reduce pressure ulcers through our five year strategy and associated action plan and collaborate with our partners in the community to adopt a whole systems approach to reducing harm from pressure damage. Actions we are currently undertaking include: development of the SKIN champion roles, a review of our mattress contract, and a communications campaign to improve the use of the pressure ulcer prevention app amongst our patients, carers and families.

Safe quality challenges

We reported four surgical related never events and two SIs due to a failure to follow the WHO checklist: Never events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The Trust reported four never events in 2016/17, each related to practice in surgery. We also reported two serious incidents due to a failure to follow the WHO safer surgery checklist, which is an intervention introduced by the World Health Organization to improve safety in theatres (see glossary on page 77 for full definition). Each of these incidents has individual actions in place to reduce the risk of recurrence, however the investigations highlighted similar issues with leadership and teamwork, the application of the WHO checklist, and Trust policies and procedures either not being followed or not complying with best practice. A safer surgery task and finish group was established in July 2016 to review how we were conducting interventional procedures across the Trust and to ensure we were providing the safest possible care for our patients. The work of this group has included:

- a baseline information collection, audit and observation process to bring to light any safe practice concerns;
- a review of all policies to ensure they are compliant with the national standards;
- Standardisation of all local checklists to ensure consistency;
- the introduction of 'no brief, no start' which means that both the senior surgeon and anaesthetist must be present for the team brief to promote teamwork and ensure the safest possible start to surgery;
- Development of driver diagram for safer surgery to focus our improvement work

As a result of this work, we are starting to see improvements in compliance with the five steps to safer surgery, with all five elements met by March 2017.

The group will continue to deliver improvements into 2017/18, including:

- the development of a long-term audit programme which provides sufficient assurance;
- Co-designing an education model with staff and patients, for all theatre staff with patient stories at its heart;
- Developing a revised simulation training programme in interventional areas;
- Evaluating the impact of our interventions through re-auditing and a review of key measures e.g. staff engagement and patient safety indicators.

Feedback from staff and patients, and a review of how we meet the duty of candour requirements for SIs, has identified areas of improvement in how we manage and investigate SIs and never events. In addition, although our mortality rates are consistently excellent and our incident reporting rates are improving, patients continue to experience avoidable harms whilst in our care. Recognising that we have work to do to improve the safety culture at our Trust, in June 2016 we started a programme of work to develop, create and embed a culture in which all staff can describe their contribution to patient safety, feel confident in raising safety concerns and know how to address such issues within their place of work.

The initial focus has been purposely given to gaining intelligence, and communication and engagement with our teams, this has included a number of well-attended workshops and a questionnaire focused on staff attitudes to safety, to which over 1,500 staff members have responded. This intelligence is informing the development of a detailed project plan. Work so far includes:

- Improving staff experience of reporting incidents which will include a re-design of the Datix incident reporting system so that logging incidents is quicker and more straightforward, feedback takes place more quickly and themes can be spotted more swiftly, and escalated for prompt action.
- Improving the process for and quality of incident investigation, including training for staff and a more rigorous quality assurance process; clarification around timelines, roles and responsibilities of those involved in the investigation process; and improvements in practice regarding how we involve patients and families.
- Improving how we implement the duty of candour, providing staff with a summary of the requirements and FAQs to help clarify their responsibilities. We have also developed an online training package for staff which was rolled out in May. In addition, we will create a

patient information sheet so patients are fully aware what they should expect from their healthcare workers.

We believe these actions will improve both staff and patients' experience when things go wrong, support open and honest communication and ultimately deliver better outcomes.

We reported 12 avoidable infections: In 2015 we began to report 'avoidable' infections of MRSA blood stream infections (BSI) and *Clostridium difficile* infections. For how we define 'avoidable infections' please see the glossary on page 77. Although we did not meet our target, we had a slight decrease in avoidable infections in 2016/17, reporting 12 compared to 13 last year. We have also seen a reduction in total cases of both infections when compared to last year:

- Three trust-attributable cases of MRSA BSI compared to seven last year (see glossary on page 77 for definition).
- 63 cases of *Clostridium difficile* have been allocated to the Trust compared to 73 last year (see glossary on page 77 for definition).

There are two key elements to reducing the risk of infections occurring in hospital, which we will continue to work on into 2017/18:

1. Reducing the use of anti-infectives (antibiotics) – 89 per cent of anti-infectives were prescribed in line with our antibiotic policy this year; we will continue to work to improve this.
2. Improving hand hygiene – we have recently developed a new audit of hand hygiene which will allow us to monitor compliance for all of the five moments of hand hygiene.

We have not met the VTE assessment target since December 2016: Venous thromboembolism (VTE) is a blood clot within a blood vessel that blocks a vein, obstructing or stopping the flow of blood. The risk of hospital acquired VTE can be reduced by assessing patients on admission. Last year, an internal audit conducted raised concern that recording of compliance with VTE assessment was being completed on patients' discharge summaries and evidence was not consistently available in their medical records that this assessment had been completed. We have been working all year to transfer recording of this assessment to the Cerner electronic record on admission to ensure that adequate assessment is taking place; this was completed in March.

Our performance dropped below the 95 per cent target for the first time in December and remained below target at 94.78% in March 2017. This dip coincided with pilots testing the use of the Cerner discharge process and stopping recording VTE assessment on the electronic discharge summary. Once the assessment process is fully embedded in Cerner, we expect to return to reporting above target. An action plan is in place, led by the deputy medical director to deliver the required improvements to meet the target.

Effective

The following section describes the progress we have made with the targets we set ourselves this year under the Effective domain.

The table below sets out our performance in 2016/17. Where applicable, it presents national targets and averages and information relating to our performance against these indicators in 2015/16. Site level data is described where available and appropriate.

Goal/Target	National Target / National Average	Performance in 15/16	Target for 16/17	Outcome in 16/17	Target achieved?
To show continuous improvement in national clinical audits with no negative outcomes	N/A	Unknown	All show continuous improvement No negative outcomes	We have not been able to fully report against this goal	Not available
We will improve our mortality rates as measured by SHMI (summary hospital-level mortality indicator) to remain in the top five lowest-risk acute trusts	100	73.8 (Oct 2014 – Sept 2015) 3rd lowest risk	Top 5	78.05 Fourth lowest risk (Oct 2015 – Sept 2016)	Yes
We will improve our mortality rates as measured by HSMR (hospital standardised mortality ratio) to remain in the top five lowest-risk acute trusts	100	69.62 lowest risk (December 2014 –Nov 2015)	Top 5	65.42 Second lowest risk (Jan-Dec 2016)	Yes
We will improve our position annually in comparison to the Dr Foster Global Comparators data set to be in the top third	100	Not available	To be in the top quarter	Not available*	Not available
We will ensure that palliative care is accurately coded	N/A	New target not previously measured	100%	100% (for all reviewed deaths)	Yes
We will ensure mortality reviews are carried out in all cases	N/A	Not available	100%	91% (Feb 2016 – March 2017)	No
We will increase PROMs participation rates to 80%	Groin hernia: 56.6% Hip replacement: 87.4% Knee replacement: 96.4% Varicose vein: 33.8% (national average April 2016 – Sept 2016)	Groin hernia: 30.1% Hip replacement: 71.4% Knee replacement: 168.9% Varicose vein: 34.3%	80%	Groin hernia: 9.4% Hip replacement: 87% Knee replacement: 119.8%** Varicose vein: 63.7% (April 2016 – Sept 2016)	No
We will improve PROMs reported health gain to be better than national average	See table on page 61 for full results	See table on page 61 for results	Over national average	Health gain unable to be calculated	No

				for groin hernia, hip and knee replacement as insufficient forms returned Varicose Veins: EQ-5D: 0.083 (below average) EQ-VAS: 0.3 (below average) Aberdeen : -0.1 (above average)	
We will review all out-of-ICU/ED cardiac arrests for harm and deliver improvements as a result	N/A	N/A	All cases reviewed	Cases reviewed from December 2016	No
We will discharge at least 35% of our patients on relevant pathways before noon	N/A	28%	35% of patients discharged before noon	17.5%	No
We will ensure that 90% of clinical trials recruit their first patient within 70 days	70%	97.5% (Q2 2015/16)	More than 90%	85.1% (Q3 2016/17)	No

**We have not included data relating to the following target: "We will improve our position annually in comparison to the Dr Foster Global Comparators data set to be in the top third'. This is because it has not been possible to report this data since 2013 owing to changes in the way it is now collected.*
***Data from completed part A (pre-surgery) forms can sometimes arrive with 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%*

The goal and targets in our Effective domain are designed to drive improvements to support good practice in our services and ensure the best possible outcomes for our patients. Areas where we are proud of the improvements we have made or sustained in our Effective domain are outlined below under 'quality highlights', areas where we have not performed as well as we would wish are summarised under 'quality challenges'.

Effective quality highlights

Our mortality rates remain consistently low and we have a system in place to review all deaths that occur in the Trust: As part of our drive to deliver good outcomes for our patients we closely monitor our mortality rates, using two indicators, HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator), which enable us to compare our mortality rates with our peers. Both of these have remained low, with our Trust being amongst the top five lowest risk acute Trusts in the country throughout the year. As part of this, we also monitor the percentage of deaths with palliative care coded as this may affect the data (for definitions see glossary on page 77). Although our palliative care coding rates are high, we are confident that they are accurate as we have a robust clinical coding review process in place.

In February 2016, we introduced an online mortality review process to standardise the way all deaths are reported and reviewed across the Trust. Reviewing every death which occurs in our hospitals enables us to learn from any errors and pick up quickly on potential issues which could result in harm to other patients. This new process is starting to embed, with 91 per cent of

deaths reported between February 2016 and March 2017 reviewed and plans in place to improve compliance in areas where reviews are overdue.

A large retrospective note review exercise conducted across the NHS and published in the BMJ in 2015 concluded that 3.6 per cent of deaths across the NHS were avoidable; in an organisation our size that equates to 55 deaths a year. Of the 1,897 deaths which have so far been reviewed through our new system, five of them have been confirmed as avoidable deaths. These have all been investigated as serious incidents and the actions and learning shared across the Trust through the Mortality Review Group. An additional thirteen cases of potential avoidable death currently remain under review. In 2017/18, we will publish information on avoidable deaths in line with national requirements set out in the CQC's review 'Learning, Candour and Accountability: a review of the way NHS trusts review and investigate the deaths of patients in England'[6].

We developed a process to review all out-of-ICU/ED cardiac arrests for harm: Our initial target for the first year of the quality strategy was to reduce the number of cardiac arrests (see glossary on page 77 for definition) occurring outside our intensive care units and emergency departments. This is because when a cardiac arrest happens outside these two areas, it is often due to patients not being monitored properly or staff failing to recognise and act on deterioration in their condition. We achieved this target last year, and have reduced the number further this year (from 277 in 2015/16 to 241 in 2016/17). In December 2016 we introduced a robust system to enable us to review all out-of-ICU/ED arrests for harm, with all cases being reported on the Trust's incident reporting system to enable further review and root cause analysis. Any incidents where harm has been found are now able to be properly investigated and learning shared. Since this process was implemented, one case has been found to have resulted in harm.

Effective quality challenges:

We have not been able to fully report against our goal to show continuous improvement in national clinical audits with no negative outcomes: Clinical audit is a key improvement tool through which we can monitor and improve the quality of care that we provide. By taking part in national clinical audit programmes, we are able to benchmark our performance and measure improvements on a year-by-year basis. Action plans are developed in response to recommendations and areas for improvement. We review all national clinical audit reports in which we participate through our divisional governance structures and through the newly established Clinical Audit and Effectiveness Group. This group was introduced to improve how we manage clinical audit, but also to improve how we learn from the outputs and deliver improvements to patient care as a result. We have further work to do into 2017/18 to fully embed this effectively.

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

National clinical audits all report in different ways and have different rates of recurrence (e.g. some happen every year, some only once, and some every two or three years). Unfortunately this means we have struggled to demonstrate which audit reports show continuous improvement as we are not always able to compare them effectively with previous performance. In addition, not all audit reports provide trust level data, or a comparison to enable us to determine whether they represent a negative outcome. We will change our goal next year so that we are able to measure our performance more effectively.

Our PROMs health gain was unable to be measured for all procedures due to insufficient numbers of forms being returned: Patient Reported Outcome Measures (PROMs) measure

[6] https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

quality from the patient perspective and seek to calculate the health gain experienced following four surgical procedures: surgery for groin hernia, varicose veins, hip replacement and knee replacement.

Patients who have these procedures are asked to complete the same short questionnaire both before and after surgery. We are responsible for ensuring completion of the first questionnaire (part A). The number of pre-surgery forms sent into NHS Digital by us is compared to the number for surgical procedures carried out on our hospital information system; it is this figure which is used to calculate the Trust's participation rate.

An external agency, Capita, is responsible for posting out the second (part B) PROMs questionnaire to patients. The patient completes the form and returns it to Capita. It is the difference between the part A and part B forms which is used to calculate health gain. If insufficient Part B forms are returned, then NHS Digital, who publish the results, will supress an organisation's health gain score to protect patient confidentiality.

The most recent PROMs results were published by NHS digital in February 2017 for the data period April – September 2016. Although our participation rates are on or above average for all but one procedure (groin hernia), insufficient part B questionnaires were either sent out by Capita or returned by patients to allow health gain to be calculated for three out of the four procedures (hip and knee replacement and groin hernia) during this time period. We are working with Capita to resolve these issues.

PROMs data for this time period shows that our patients undergoing varicose vein surgery reported below average health gain. We believe the reason for this is that we had two different treatment pathways for patients with varicose veins depending on whether they are seen at St Mary's or Charing Cross Hospital, due to facility constraints. A new centralised varicose vein unit is now up and running, meaning all our patients will benefit from being offered treatment for varicose veins in one operation, rather than two. We expect that the change in practice will result in an improvement in PROMs reported health gain, and allow new innovative strategies of care and new technologies to be implemented for all varicose vein patients being cared for by the Trust.

We have not achieved our target to discharge at least 35 per cent of our patients on relevant pathways before noon: Untimely discharge has been identified as one of the most common reasons why A&E departments fill and patients have long waits to be seen and admitted or discharged. Planning discharges before the peak in admissions is an effective way to smooth the total demand for beds and run safer, more effective services.

By discharging patients earlier where clinically appropriate, we are in a better position to place all patients appropriately in the right ward, in the right bed and at the right time. Despite improvements made to our discharge processes we have not met our target this year, with 19% of patients being discharged from downstream wards by noon. This is partly due to issues such as patients being unable to be discharged as they are waiting for a bed at a care home. We are working with our partners in the community to solve this issue, including with Ealing, Brent and Hounslow through a north west London collaboration to deliver integrated adult social care services and with Central North West London to deliver an integrated community independence service.

In the meantime, we continue to make improvements to our discharge processes, such as:

- Development of the 'discharge to assess model' with Community Care UK to ensure speedy discharge from hospital to home. Comprehensive assessment is undertaken in the patient's own home, instead of in hospital, where it is more comfortable and the patient's needs are clearer.

- Introduction of training for staff following implementation of the new discharge policy in February 2017.
- Development of a process for improved discharge review which includes follow up calls 24 hours after discharge for complex cases.

We did not meet our target to ensure that 90 per cent of clinical trials recruit their first patient within 70 days in quarter two or quarter three this year: As one of the UK's six Academic Health Science Centres we are committed to encouraging innovation in everything that we do. Part of this involves carrying out pioneering research into diagnostic methods and treatments across a broad spectrum of specialities and for some of the most complex illnesses, with benefits for patients everywhere.

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

Since 2014, up until quarter one this year, we have consistently reported above 90 per cent against this target. This is the result of having a robust feasibility assessment in place for every clinical trial. This ensures that everything is in place in advance, meaning patients are recruited to a fully operational trial that can be commenced in a timely manner. However, our results fell below target in quarter two, reflecting the impact of the full implementation of the new Health Research Authority (HRA) approvals process. The main reason for longer approval times in the new system is that the full duration of contract negotiation must now be included within the strictly-defined study initiation window of 70 days. The contracts team only receives legal agreements for review on the date when the HRA clock starts; no initial review or assessment can take place prior to that date (which was the practice previously). The average approval times have increased nationally as well as locally in the last two quarters, according to the NIHR reports. ICHT are reviewing processes for contractual review and negotiation, to identify ways of shortening these approval times and coming back within our target metric. This is likely to take another two quarters to achieve given the inherent lag involved in the clinical trials submission and set-up process.

Caring

The following section describes the progress we have made with the targets we set ourselves this year under the Caring domain.

The table below sets out our performance in 2016/17 as a trust. Where applicable, it presents national targets and averages and information about our performance in 2015/16. Site level data is described where available and appropriate.

Goal/Target	National Target / National Average	Performance in 15/16	Target for 16/17	Outcome 16/17	Target achieved?
To increase the percentage of inpatients who would recommend our trust to friends and family to 94%	96%	96%	94%	97%	Yes
To increase the percentage of A&E patients who would recommend our trust to friends and family to 94%	86%	92%	94%	95%	Yes
To increase the percentage of Outpatients who would recommend our trust to friends and family to 94%	93% (as of January 2017)	94%	94%	91%	No
We will achieve and maintain a FFT response rate of 30% in inpatient departments	23.1% (as of January 2017)	28%	30%	30%	Yes
We will achieve and maintain a FFT response rate of 20% in A&E	12% (as of January 2017)	11%	20%	15%	No
We will achieve and maintain a FFT response rate of 6% in Outpatients	Not reported	5%	6%	10%	Yes
We will improve our national cancer survey scores year-on-year	) N/A	72% (annual results from 2014 survey published in 2015	72%	8.6/10 (average rating of care) (annual result from 2015 survey published June 2016)	Yes – although it is not possible to compare scores directly, due to changes to the survey, our results show an improvement on last year
We will improve our score in the national inpatient survey relating to responsiveness to patients' needs	N/A	6.82 (annual result from 2014 survey published in 2015)	Over 6.85	6.74 (annual result from 2015 survey published June 2016)	No
We will increase our responsiveness to complaints - 95% of complaints responded to within the timeframe agreed with the patient (nominally 25 working days)	N/A	100% by March 2016	95%	100% (March 2017)	Yes

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 ensure that we listen to our patients, their families and carers, and respond to their feedback.

Areas where we are proud of the improvements we have made or sustained in our Caring domain are outlined below under 'quality highlights', areas where we have not performed as well as we would wish are summarised under 'quality challenges'.

Caring quality highlights

We have exceeded our target for the percentage of our inpatients who would recommend us to friends and family and have maintained our performance in the national inpatient survey published in July 2016, with results very similar to our peers:

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. This system also means we can accurately track key protected characteristics (gender, age, ethnic group and disability) of those who respond, enabling us to compare experiences across these characteristics. We have continued to work to implement improvements based on any concerns that impact on one group more than another.

For patients reporting a positive experience, interaction with staff is usually the most significant factor. Work we have undertaken to support this includes:

- Providing patient feedback reports to every ward and department, and reviewing patient experience data alongside key safety metrics at local level to support the identification of quality improvement projects.
- Making sure we are compliant with the accessible information standard (see glossary on page 77 for definition) by providing information in a range of formats and languages, training our staff, undertaking promotional work to raise awareness about the need to ask patients if they have any specific communication needs and adding hearing loops in rooms where public meetings are held. We have also introduced an assessment process through our electronic patient record which enables automatic flagging of specific communication requirements.
- A new pathway for patients with learning disabilities who use our services. Known as the purple pathway, because of the flow chart colouring, it clearly lays out the pathways which patients will follow during their contact with the trust be it in A&E, as an outpatient or inpatient. It also covers the discharge process. A number of staff have been through a bespoke learning disabilities training programme in collaboration with Mencap and are now identified as learning disability champions in their departments.
- Continuing to improve care for our patients with dementia and consistently meeting the national standards for dementia screening and assessment throughout the year. On average, twenty five per cent of our beds are occupied by a person with dementia or cognitive impairment. Recognising the risks and concerns surrounding hospital admissions and dementia, our Dementia Care Team continues to provide tailored support, including:
  - twice weekly drop in sessions for patients and carers;
  - redevelopment of the Trust dementia champion role;
  - creation of a nutritional support pathway with three designated levels of support a patient can receive depending on what level their nutrition is affected.
  - implementation of 'My Improvement Network' technology, funded by the Charity, which provides activities including games, music, physical exercises and opportunities for social interaction all contained within a portable unit.

In 2017, we will be re-launching the carer's passport to raise the profile and provide additional support to carers, focusing on those who provide voluntary care for those with learning disabilities or dementia.

When patients report a negative experience, the cause is usually due to ineffective systems and processes. We continue to take steps to improve and to ensure that waiting and delays are kept

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

Changes we are making to improve include:

- A strategy to improve wayfinding across all of our sites (see page 19 for further information).
- Patient transport – Patient transport is another key issue for those who are not able to travel to appointments independently. Our FFT results for patient transport have been consistently below target this year. We reviewed our patient transport service, recruited an additional 28 drivers and introduced a new system that can match short notice requests to the earliest available vehicle. Once these are embedded we anticipate seeing an increase in the percentage of patients who would recommend the service. A Transport Working Group, comprising of members of Healthwatch as well as Trust staff, has been established to develop the collaborative approach to improving transport and travel to and across our sites with key stakeholders. Our current non-emergency patient transport contract will come to an end in 2018 so we will be re-tendering the service this year, focusing on creating a contract which will continue to deliver quality improvements for our patients.
- Discharge improvement - In the national inpatient survey, the Trust performed better than or about the same as most other Trusts for all questions except two which were: 'Did hospital staff take your family or home situation into account when planning your discharge?' and 'Did hospital staff discuss whether additional equipment or adaptions were needed in your home?'. Steps we are taking to improve the discharge process can be found on page 40.

The percentage of our A&E patients who would recommend us is over our target and significantly above national average: Like many NHS trusts, we continue to struggle to meet the national standard for A&E patients waiting under four hours to be treated and discharged or admitted. Despite this, we are pleased that over 94 per cent of our patients would still recommend our A&E services. We have detailed plans in place to improve performance in our A&E departments – please see page 48-49 for more information.

Our results in the national cancer patient experience survey (NPES) show significant improvement: We have previously performed poorly in this survey, particularly in 2013 when we were ranked the worst in the country according to the Macmillan league table, so we are delighted to see a continuous year on year improvement in our results. Considerable work has been undertaken to improve the experience of patients with cancer since the 2013 results, most notably through our partnership with Macmillan Cancer Support, which has led to developments such as a Macmillan navigator function (see glossary on page 77 for definition) to support patients through the cancer pathway and the expansion of our nurse specialist service. We have also strengthened the functioning of our multi-disciplinary team meetings and run an internal programme centred around improving communicating with patients (*SMILE*). The latest results demonstrate the positive impact of that work; they are the best set of results that we have returned in the 5 years that the survey has been running.

There were improvements in 22 out of 50 questions in the survey; we also scored above or within the expected range for 38 questions, with the number of questions which scored in the lowest range decreasing significantly (12 compared to 46 last year).

Whilst there is clearly more to do, we are confident that we will continue to see improvements in our results. Since the survey was published in early 2016, we have been working to embed the improvements we've made, including rolling out the navigator service to all tumour groups, and have launched phase two of our partnership with Macmillan, focusing on improving the quality of

life for the increasing number of people living with and beyond cancer. Phase two of our partnership specifically aims to:

- develop a deeper understanding of what enables people to live well with and beyond cancer, or stops them from doing so, by way of an in-depth research project
- deliver services which enable people to access timely support and information to help them manage their condition.

Central to the ethos of the programme is strengthening the links between the Trust and the wide range of community-based services in north west London, including GP and primary care services and community and charitable groups.

We have exceeded our target to respond to 95 per cent of complaints within the timeframe agreed with the patient: In 2015/16 we restructured the complaints service and process following feedback to create a more responsive and caring service for our patients and identify learning for our staff. We adopted a new approach, shifting the focus from providing a response letter to resolving the concern.

We have continued to build on the improvements we made last year, embedding the new processes into practice. We are focusing on learning from and analysing themes from complaints, and are now providing monthly reports to each division, including trends and a weekly update of live complaints and received compliments to enable them to focus quality improvement based on what our patients are telling us. Appointments (including delays and cancellations) continue to account for the highest volume of complaints; work to improve this continues as part of the outpatient improvement programme (see page 48 for further detail).

We are one of a group of trusts working with Picker Europe to pilot a post complaint survey to understand complainants' experience of the process. 160 questionnaires have been sent out so far, with 20 responses received. Initial feedback suggests that they found the process satisfactory. One theme emerging is that complainants want the opportunity for more telephone contact and the option of having another nominated person to talk to if their designated point of contact is not available. The complaints team have therefore introduced a system of cover to ensure that there will be an alternative available.

We have also started to capture videos of patient stories arising out of complaints, with the first being shown at the Board meeting in January, supporting board decision making by illustrating the personal and emotional consequences of failing to deliver quality services.

Caring quality challenges

The percentage of outpatients who would recommend our Trust is below average and has dropped since last year: This drop coincided with the introduction of online completion of the survey. Although we are disappointed that our outpatient FFT rate has declined, we are confident that the changes we are making as part of our outpatient improvement programme will significantly improve outpatient experience in the long run. Work we are doing includes improving the content of appointment and follow-up letters, improving the clinic environment, delivering customer care training for staff, and increasing the use of digital technologies to support a better patient experience, such as patient kiosks and patient calling screens. You can read more about our outpatient improvement programme on page 48.

Responsive

The following section describes the progress we have made with the targets we set ourselves this year under the responsive domain.

The table below sets out our performance in 2016/17 as a trust. Where applicable, it presents national targets and averages, and information about our performance in 2015/16. Site level data is described where available and appropriate.

Target	National Target / National Average	Performance in 15/16	Target for 16/17	Outcome in 16/17	Target achieved?
To consistently meet all relevant national access standards	N/A	5 out of 12 met in all 4 quarters	All targets met in all 4 quarters	4 out of 12 met in all 4 quarters	No
We will reduce the unplanned readmission rates for patients aged 0-15 and be below the national average	8.97% (Oct 15 – Sept 16)	4.81% (Jan-Dec 2015)	Below national average (8.97%)	5.15% (Oct 15 – Sept 16)	Yes
We will reduce the unplanned readmission rates for patients aged over 16 and be below the national average	7.98% (Oct 15 – Sept 16)	7.39% (Jan – Dec 2015)	Below national average (7.98%)	6.64% (Oct 15 – Sept 16)	Yes
We will have no inpatients waiting over 52 weeks for elective surgery, reduce the number of patients waiting over 40 weeks, and ensure a clinical validation is in place for each patient who waits over 18 weeks	N/A	52 week waits: 47 (month 12 performance)	0	52 week waits: 1,578 (16/17 total) Clinical validation process described on pages 51-52	No
We will reduce the proportion of outpatient clinics cancelled by the trust with less than 6 weeks' notice	N/A	9.5%	8.5%	8%	Yes
We will reduce the proportion of patients who do not attend outpatient appointments to 10%	N/A	N/A – new target for 16/17	10%	11.8%	No
We will ensure 95% of outpatient appointments are made within 5 working days of receipt of referral	N/A	N/A – new target for 16/17	95%	77%	No
We will reduce the proportion of outpatients who wait more than 45 minutes past their allotted appointment time	N/A	N/A	N/A	Unable to be reported	Unable to be reported
We will improve our PLACE scores annually to be in the top 25% nationally where possible	Cleanliness – 98.1% Food – 88.2% Privacy etc. – 84.2% Condition etc. – 93.4% Dementia – 75.3% Disability – 78.8%	Cleanliness: 98.60% (above average) Food: 86.07% (below average) Privacy etc. 78.39% (below average) Condition etc. – 86.76% (below average)	All scores above national average, except for condition where we will maintain current performance	Cleanliness: 98.73% (above average) Food: 87.1% (below average) Privacy: 71.77% (bottom 20%) Condition:91 .02% (below average) Dementia:	No

				62.62% (bottom 20%) Disability: 64.82% (bottom 20%)	

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

The table below shows our performance against the national access standards throughout 2016/17. We have consistently met four out of the12 standards however performance was challenged in the others.

National Targets and Minimum Standards	Measure	Threshold	Q1	Q2	Q3	Q4	Target achieved in all quarters
Access to treatment	18 weeks referral to treatment - incomplete pathway	92.00%	88.16%	84.57%	82.92%	82.48%	No
Access to Cancer Services	2 week wait from referral to date first seen all urgent referrals	93.00%	90.70%	92.40%	93.30%	90.16%	No
	2 week wait from referral to date first seen breast cancer	93.00%	92.00%	93.30%	95.30%	93.21%	No
	31 days standard from diagnosis to first treatment	96.00%	97.00%	96.70%	97.60%	96.15%	Yes
	31 days standard to subsequent Cancer Treatment - Drug	98.00%	100%	100%	100%	99.16%	Yes
	31 days standard to subsequent Cancer Treatment - Radiotherapy	94.00%	99.50%	98.20%	99.30%	97.95%	Yes
	31 days standard to subsequent Cancer Treatment - Surgery	94.00%	95.50%	97.50%	95.70%	96.75%	Yes
	62 day wait for first treatment from urgent GP referral	85.00%	70.20%	80.10%	82.00%	74.70%	No
	62 day wait for first treatment from NHS Screening Services referral	90.00%	92.80%	87.70%	90.80%	92.94%	No
A&E Performance	A&E maximum waiting times 4 hours	95.00%	90.86%	90.83%	87.67%	88.97%	No
Cancelled Operations	Cancelled operations for non-clinical reasons	0.80%	0.99%	0.73%	0.69%	0.88%	No
	Rebooking non-clinical cancellations within 28 days	<5%	9.82%	12.14%	13.40%	11.9%	No

We know we have much work to do to tackle long-standing pressures around demand, capacity and patient flow (see glossary on page 77 for definition) to enable us to meet these targets. Areas where we are proud of the improvements we have made or sustained in our Responsive domain are outlined below under 'quality highlights', areas where we have not performed as well as we would wish are summarised under 'quality challenges'.

Responsive quality highlights

We continue to deliver our outpatient improvement programme and are seeing improvements as a result: Around a million people come to the Trust's hospitals as outpatients every year and we have been running a major programme to improve the quality of their experience. This includes:

- £3 million of refurbishment works, creating a more patient-friendly environment at our clinics at Charing Cross and Hammersmith hospitals, funded by Imperial Health Charity who also gave £4m for a centralised patient services centre at Charing Cross and committed nearly £300,000 to update the outpatient department at Western Eye Hospital.
- Tackling issues with appointment letters, patients being rescheduled at short notice and long waiting times in some clinics with high demand – with outpatient staff winning a Trust award by keeping patients informed of any delays to their clinic.
- Improving how patients get their appointment details – 90,000 patients have now opted to receive email correspondence. For those who prefer having their appointments sent by post, we switched to a new postal service in June 2016 that is faster and more reliable. We also made the appointment letters clearer and more informative.
- Creating a single patient service centre at Charing Cross, .Here, all of the outpatient administration teams are coming together to manage all calls and put in place new ways of working to make sure we get things right for patients and GPs, first time.
- Introducing appointment reminders by voicemail and expanded text reminders, with more than half of patients contacted now confirming their attendance. All of the improved communication has meant that fewer people are missing their appointment – down from 17 per cent in 2014 to just over 11 per cent in 2017.
- Improving the availability of patient records, which are held electronically on a secure system ensuring when a doctor sees a patient in clinic, they have their key details to hand and there aren't delays waiting for paper records. Furthermore, GPs now receive 96 per cent of documentation, including patient discharge summaries, electronically.
- Increasing the percentage of GP electronic referrals to 50 per cent.

As a result of this work, we have seen improvements in some of our key targets, including reducing the amount of outpatient clinics cancelled by the trust and increasing the number of appointments made within five working days of receipt of referral from 70.70 per cent in August to 78.9 per cent in March 2017.

Our main outpatient departments were inspected again by the CQC in November 2016. We are due to receive the final reports of their findings in May 2017; this will then inform further plans for improvement.

Responsive quality challenges

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

- The main Emergency Departments (Type 1)
- Western Eye Hospital (Type 2)
- The Urgent Care Centres at our three main sites (Type 3).

Like many NHS trusts, we struggled to meet the 95 per cent standard for A&E patients to be treated and discharged or admitted in under four hours. Pressures on A&E are complex and include pressures on the entire urgent and emergency care system, with acute trusts, ambulance services, mental health and social services all reporting major challenges to delivery.

We saw a three per cent increase in A&E attendances and a five per cent increase in emergency admissions in 2016/17.

We have been rolling out a range of improvements to enable a better 'flow' through of patients through our urgent and emergency care pathways, working to ensure patients receive care in the right place at the right time by the right healthcare professional, from their first contact with us, through assessment, diagnosis and treatment, to ensuring a safe and timely discharge. This includes:

- Refurbishing St Mary's A&E and co-locating services for patients requiring urgent and emergency care on the ground floor at Charing Cross to improve the environment and increase capacity. For further detail, please see the annual report.
- Working with commissioners and local mental health trusts to improve the pathway for patients. We have increased the number of registered mental health nurses and established a dedicated consultant lead in both emergency departments.
- Extending the opening hours of the ambulatory emergency care (AEC) service at St Mary's and Charing Cross hospitals, including weekends. The AEC service provides specialist diagnostics and treatment for patients who have urgent needs but are well enough to go home in between procedures or consultations and, essentially, to be cared for on an urgent outpatient basis. See glossary on page 77 for further information.
- Opening a 12-space surgical assessment unit at St Mary's in January 2017 to enable faster access to a specialist surgical opinion where required.
- Promoting discharges before noon, streamlining and improving our discharge processes (see page 40 for further information).

Despite not achieving the national standard, reported patient experience in A&E has been above our target of 94 per cent for every month throughout the year except August 2016. We have also maintained low emergency readmission rates for both adult and paediatric patients, with both rates remaining below national average throughout the year. This a good measure of the effectiveness of our care, as if a patient is treated and discharged appropriately they should not require unplanned readmission.

We have not met the national performance targets for referral to treatment (RTT):

With increasing demand for our services, keeping waiting times down for planned care has been a particular challenge. In early 2016, the Trust also identified some issues with how we were managing our waiting lists as well as underlying capacity problems in some areas. We have not met the standard of 92 per cent of patients treated within 18 weeks of referral this year, reporting 83.24 per cent at the end of March 2017.

We invited NHS Improvement's Elective Care Intensive Support Team (IST) to review our processes and to provide advice on improvements. Working with our commissioners and NHS Improvement, we established a waiting list improvement programme in response and are making good progress with:

- a data quality clean up - a systematic and detailed audit of all of our waiting lists to ensure we have identified all patients who should be on an open RTT pathway.
- improved waiting list management - better processes, training and on-going audit to make sure all lists are now managed correctly and consistently.
- systematic clinical review (see below for more information) – detailed reviews by doctors to ensure patients are not coming to clinical harm as a result of their wait. We have also rolled out a new clinical outcome form which is aiming to improve the recording of clinical outcomes in outpatient clinics as a driver to improving patient safety and RTT performance;
- additional clinical activity - including running more outpatient clinics and theatre sessions, both within the Trust and with the support of independent sector providers.

- improved theatres– our Riverside Theatres at Charing Cross Hospital were completely refurbished enabling us to expand the range of procedures undertaken there. A temporary mobile operating theatre was used to ensure that we were able to maintain our theatre capacity during the refurbishment period.

More work remains to be done and the programme will remain in place into 2017/18.

We have seen a significant increase in patients waiting over 52 weeks for treatment on an RTT pathway: As part of the Trust's waiting list improvement programme, a number of clinical review processes have been established to monitor the impact waiting for treatment is having on our patients and to ensure that avoidable harm has not/is not occurring as a result of delays in treatment.

A clinical harm review steering group was set up in August 2016 with external expertise invited to join in October. This external expert has shared lessons learnt from another large hospital trust's experience which has been used to review our clinical harm review processes.

The clinical harm reviews include all patients who have been added to the RTT waiting list following validation as part of the improvement programme as well as those who were already on an RTT list. The outcomes of the reviews so far are outlined below:

- **Retrospective review:** undertaken by the deputy medical director, this review looked at all patients who waited over 18 weeks for treatment on an RTT pathway between April 2015 and June 2016. This review is now complete; out of over 8,000 patients, none have been found to have come to severe harm as a result of waiting longer than the RTT target. Given the numbers of patients involved, it was not possible to review psychological pain or discomfort through this process as this would have involved an individual patient by patient review process.
- **Review of patients waiting over 52 weeks:** A senior nurse coordinates and oversees this process and ensures that the records of all patients waiting over 52 weeks for treatment are reviewed by a consultant. These reviews and the patients' treatment plans are used as part of the weekly specialty 'long waiters' meeting to track and expedite dates where needed. If any cases of potential harm are found, they are entered onto the Trust's incident reporting system and investigated. Three cases of moderate harm (see glossary on page 77 for definition of moderate harm) identified through this process have been confirmed, with two cases still undergoing investigation. We have recently expanded the process to include 'on admission' reviews for patients in high risk specialties who have waited over 52 weeks. A dedicated email address has also been set up for GP colleagues to alert us to any patients that they are concerned about having increased risk of harm which will help us escalate patients for earlier care where appropriate.
- **On-going review:** we know that best practice would be for clinical reviews to occur for any patient waiting over 18 weeks to ensure at risk patients are prioritised. However, given the large number of patients waiting in this category we have adopted a targeted approach prioritising patients in specified high risk specialties for prospective review. Of the completed reviews in the specialties deemed 'high risk', no cases of clinical harm have been found.

We will continue the on-going reviews of patients throughout 2018/19.

We have not consistently met all eight cancer standards: We failed to meet the following cancer standards across all quarters this year:

Two week wait from urgent referral to first being seen
We have notmet this standard consistently throughout the year, however we have been working to reduce delays and improve booking times. We have an on-going programme in place to deliver the CCG aim of reducing the median wait from referral to first appointment by one day across tumour groups. This will support continued improvement against this target.

Two week wait from referral for breast cancer to first being seen
In quarter one, our performance against this target was largely affected by patient choice. Of 59 breaches, only four related to hospital initiated delays. We have since seen an improvement against this standard, partly due to the work to improve booking times outlined above. We have met this target in all quarters since.

62 day wait for first treatment from urgent GP referral and from screening
We have struggled to meet these standards throughout the year, mainly due to specific issues including late receipt of tertiary referrals from other organisations, and internal delays to the scheduling of diagnostics and treatment planning particularly in endoscopy, imaging and urology. With the support of our commissioners and NHS England, we agreed a cancer waiting times recovery plan and improvement trajectory to enable us to meet this target by the end of 2017/18.

Actions being taken include:

- working with the NHS Intensive Support Team to improve the transition of patients between surgical specialties and endoscopy;
- improved support for the urology rapid access clinic model to reduce delays experienced by patients during the diagnostic phase of the urology pathways;
- recruitment of a new administrative team to support the growing numbers of cancer referrals to the Trust who have been in post since September;
- integrating the Macmillan Navigator service into this work, to better support patient communication out of hours and facilitate the escalation of patient concerns to the Clinical Nurse Specialist (CNS) teams to avoid patient-initiated delays earlier in the treatment pathways;
- introducing the ‘straight to test’ pathway for all new suspected colorectal cancer referrals, which was rolled out across the Trust in November;
- Working with our commissioners to support a reduction in late referrals from other hospitals in North West London.

We are seeing improvements and are currently meeting the performance trajectory agreed with our commissioners.

We have not consistently met the national standard for non-clinical on-the-day cancellations of surgery: We experienced increased demand for emergency care in 2016/17 which did contribute to the cancellation of a number of planned operations, although we worked hard to minimise them being cancelled on the day of surgery. We also increased our theatre capacity in key surgical specialties and through the new Riverside Theatres at Charing Cross. Where operations are cancelled, this is usually because of bed availability, earlier cases overrunning or elective operations being cancelled for emergency cases.

As a major centre for emergency care and trauma in London, we do have to work to make sure that planned surgery is not impacted by the nature of our emergency work, and an elective care project is being developed for 17/18 to ensure that planned surgery and care gets the priority it needs.

Since April 2002, all NHS patients who have elective operations cancelled for non-clinical reasons on the day of surgery (or day of admission) should be offered another binding date within 28 days. We have not met this standard this year, with the number of patients not

subsequently treated within the 28 day guarantee period remaining high. A full review of this is underway and any improvement actions will be reported in quarter one.

We have not improved our PLACE (patient led assessment of the care environment) scores in all categories: 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 & Wellbeing
- Food & Hydration
- Condition, Appearance & Maintenance
- Dementia (introduced in 2015)
- Disability (introduced in 2016)

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

Patient representatives are always fully engaged with the assessment process, with an increased number of new patient assessors taking part this year. We have been commended by the Department of Health for our approach to the assessments and have been used as an exemplar for the correct application of the process.

We have improved our performance in three areas compared to last year's scores:

- Cleanliness – which scores above national average.
- Food and hydration – although our results remain below average, they have improved slightly since last year.
- Condition, appearance and maintenance – results remain below average, but have improved across all of our sites.

In the two other areas reported in 2015 (dementia and privacy, dignity and wellbeing) our results have deteriorated, with the Trust being in the bottom 20 per cent for these categories. We are also in the bottom 20 per cent for the disability category, which was introduced in 2016. A detailed action plan is being led by the PLACE steering group in response to the results, with themes of flooring repairs, access such as seating and hand rails, and improved signage which will be taken forward as part of the wayfinding strategy (see page 19 for more information). Dementia and disability requirements are at the heart of the designs for our new outpatients departments and A&E departments. Through our Clinical and Estates strategies, we continue to work to improve the condition of our hospitals to provide a more patient centred environment.

Well-led

The following section describes the progress we have made with the targets we set ourselves this year under the well-led domain.

The table below sets out our performance in 2016/17. Where applicable, it presents national targets and averages, and information about our performance in 2015/16. Site level data is described where available and appropriate.

Goal/Target	National Target / National Average	Performance in 15/16	Target for 16/17	Outcome in 16/17	Target achieved?
To increase the percentage of staff who would recommend this trust to friends and family as a place to work	N/A	60 per cent (internal staff survey) 57% (national staff survey)	62% (internal staff survey)	65% (internal staff survey published Sept 2016) 62% (national staff survey published March 2017)	Yes
To increase the percentage of staff who would recommend this trust to friends and family as a place for treatment	70%	77% (internal staff survey) 68% (national staff survey)	81% (internal staff survey)	83% (internal staff survey published Sept 2016) 70% (national staff survey published March 2017)	Yes
We will achieve a voluntary turnover rate of 10%	N/A	10.58%	10%	10.22%	No
We will reduce our sickness absence rate to 3.10%	N/A	3.21%	3.10%	3.00%	Yes
We will achieve a performance development review rate of 95%	N/A	91.69%	95%	86.24%	No
We will achieve a non-training grade doctor appraisal rate of 95%	86.6%	83.3% (March 2016)	95%	91.13%	No
We will achieve compliance of 90% with statutory and mandatory training	95%	86.79%	90%	85.60%	No
We will re-run our ward accreditation programme with evidence of documented rapid improvements where issues arise	N/A	Programme launched	Programme re-run	Programme re-run	Yes
We will reduce the number of programmes with red flags in the GMC's national trainee survey by 5%	N/A	50 red flags (36% increase on previous year)	5% reduction	25 red flags (50% reduction on previous year)	Yes
We will increase the overall number of green flags in the GMC's national trainee survey	N/A	20	More than 20	54	Yes
We will obtain a minimum score of 0.5 for placement satisfaction for all student placements as measured by SOLE	N/A	73% (academic year 2015/16)	100% of placements with 0.5 or more	76% (academic year 2016/17)	No
We will have trained departmental safety coordinators in 90% of specialties	N/A	90.99%	90% departments with trained coordinators	91.87%	Yes

Evidence shows that staff who are engaged and happy in their jobs, respected and given opportunities to learn, provide better care for their patients. We have implemented a number of improvements to increase staff engagement throughout the organisation and to help us to deliver our annual targets, many of which are described throughout this section.

Areas where we are proud of the improvements we have made or sustained in our Well-led domain are outlined below under 'quality highlights', areas where we have not performed as well as we would wish are summarised under 'quality challenges'.

Well-led quality highlights

We have achieved our goal and increased the percentage of staff who would recommend our Trust as a place to work and as a place for treatment: We monitor staff engagement through the national staff survey and through our annual internal survey 'Our Voice, Our Trust' which was run between July and September 2016. 3,244 of our people responded, which represents 38 per cent of our total workforce.

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

In addition to these, the top 5 performing questions across our survey were:

- I understand how my work makes a difference to other people (96 per cent)
- I am clear about the values and behaviours expected of me at work (95 per cent)
- I am clear about my own objectives and responsibilities (94 per cent)
- I am trusted to prioritise my workload myself (92 per cent)
- Staff here are generally friendly and welcoming (89 per cent)

Other items we scored well on include "the people in my team work together to provide a great service" (88 per cent) and "I am encouraged by my colleagues to report any patient safety concerns I may have" (83 per cent).

Our staff were less positive about the following questions:

- Senior leaders are genuinely interested in staff opinions and ideas (52 per cent)
- I generally have enough time to complete all my work (51 per cent)
- Senior leaders communicate well with the rest of the organisation (50 per cent)
- Senior leaders are visible and approachable (49 per cent)
- Poor behavior and performance is addressed effectively in this organisation (43 per cent)

Overall, the results identified opportunities to act and improve at an organisational level based on staff feedback.

We also focused on the way we developed and communicated our response to this survey so that staff see action and change resulting directly from completing it. We created a tool to support managers in using these results to drive improvement in their local areas, supporting the development of action plans and running 'In our shoes' focus groups, which are an opportunity for staff to share with each other what makes a good day and what makes a bad day at work, and identify what the Trust can do to improve staff experience. Over 700 employees across the organisation have participated.

The national staff survey results were published in March 2017, and we have also seen an improvement. Our overall engagement score rose to 3.8 out of 5, moving us up two categories to 'average' for all trusts of a similar type. This is the highest we have seen since 2013.

We achieved some very positive scores, above the national average, including in three particular areas:

- percentage of staff appraised in the past 12 months (92 per cent against an average of 87 per cent)
- staff satisfaction with the quality of work and care they are able to deliver (4.04 out of 5, against an average of 3.96)
- quality of non-mandatory training, learning or development (4.10 out of 5, against an average of 4.05)

While we are beginning to see the impact of a range of improvements at all levels, the survey results also make it clear we still have much more to do. Some of our lowest scores relate to staff experiencing and reporting violence at work. We have established a task group to oversee an action plan to tackle the unacceptable level of violent incidents. We also reported below average scores in relation to the workforce race equality standard:

- 31 per cent of staff surveyed reported that they had experienced harassment, bullying or abuse from staff in the last 12 months against an average of 25 per cent.
- 80 per cent of staff surveyed believed the Trust provides equal opportunities for career progression or promotion against an average of 87 per cent.

We are currently looking into the reasons why our scores are higher than average for these questions and developing a Trustwide response and action plan. To ensure we improve, we will be training more managers in addressing bullying and harassment, as well as further promoting general awareness of dignity and respect at work. We will also review the recruitment and training selection content to raise awareness of unconscious bias and ensure that each interview panel has at least one member who has been trained.

We have slightly decreased our voluntary turnover rate: Although we have not met our target, we are pleased that we have seen a slight decrease in staff voluntarily leaving the Trust this year. A key aspect of reducing the voluntary turnover rate is to ensure staff have the opportunity for career progression, feel their job is worthwhile and fulfilling, and they are supported to develop. Some of the ways we are working to ensure this include:

- Revising our leadership development programme – building on our existing award winning schemes, we are further developing training programmes which focus on specific needs identified by our staff, including management skills, financial management, digital learning, data and analytics. More than 1,000 staff participated in our staff development programmes in 2016/17.
- Running an active coaching and mentoring register and training programme, and an innovative ‘paired-learning’ programme which enables junior doctors and junior managers to learn together.
- Refreshing and further developing our talent management programme and succession plan which identifies the highest performers and the developmental support required to enhance their contribution.
- Increasing the people recruited from our existing workforce through our retention strategy, this includes a new quality improvement project called ‘great place to work’ which is looking at how we can improve the experience of staff when first joining the Trust.
- Introducing our quarterly magazine, Pulse, focusing on our staff, patients and volunteers, boosting pride and confidence in our organisation.
- Running our second admin and clerical network in December 2016, building on the success of the first and focusing particularly on career development.
- Developing a new integrated apprenticeship scheme which aims to create a talent pipeline of young people able to fill band 2 or 3 posts in key areas.

- Introducing a comprehensive package of benefits for staff.
- Appointing two 'Freedom to Speak Up Guardians', who are overseen by one of our non-executive directors, who encourage staff to raise concerns openly as part of normal day-to-day practice so that action can be taken to ensure high quality, compassionate care.
- Continuing to run monthly Schwartz Rounds (see page 19 for more information). Since 2015, when Schwartz rounds were launched, we have hosted 23 rounds across our three main hospitals, attended by over 1,000 staff.

Our sickness absence rate remains low: Low sickness absence is an indicator of effective leadership and good people management. This year, we have focused on embedding our sickness absence policy, which was launched last year.

The other focus of our work has been on supporting the health and wellbeing of our staff. Our Occupational Health service provides a range of activities and services, including staff counselling, stress management services, yoga and meditation classes, weight management programmes, smoking cessation clinics and rapid access physiotherapy. In September 2016, we ran our second Healthy Living Week; a campaign of events designed to get staff fit, active and having fun.

In addition, we are striving to improve health and safety for staff and patients alike across the Trust, which is supported by our departmental safety co-ordinators (DSCs – see glossary on page 77 for definition), who in addition to their day jobs, ensure that their department is fully compliant with health and safety regulations.

We have increased the percentage of our doctors who have had an appraisal and are now above national average: It is a national requirement that non-training grade doctors have an annual medical appraisal as part of the General Medical Council's Revalidation process (see glossary on page 77 for definitions), during which doctors have a formal structured opportunity to reflect on their work and to consider how their effectiveness might be improved, with the focus on enhancing quality and improvements in patient care. Although we are still slightly behind our target of 95 per cent, we are pleased that our appraisal rates for doctors have improved significantly since last year. This increase is due to improved guidance and increased numbers of drop-in sessions for doctors with queries relating to appraisal and revalidation, and the implementation our revalidation and appraisal policy.

We have significantly improved our results in the General Medical Council's National Training Survey of junior doctors and have maintained our performance for placement satisfaction as measured by SOLE (student online assessment): As one of London's largest teaching hospitals, we want to provide the best training for our doctors. Two important elements we use to monitor the satisfaction of our trainee doctors and medical students are:

- **Student Online Evaluation (SOLE)**: The feedback we receive from our medical students through the local SOLE system has previously been mixed. Our aim is to focus on improving their experience in a consistent manner, with the target of obtaining a minimum score of 0.5 (which corresponds to a 'mostly agree' score) for satisfaction for all student placements. In 2015/16, we achieved this target for 73 per cent of our programmes, which was an improvement of almost 50 per cent on the previous year. We are pleased that we have succeeded in slightly improving still further, with 76 per cent of students agreeing that 'overall (they are) satisfied with their placement' in 2016/17.
- **General Medical Council's national training survey (GMC NTS):** This annual survey can highlight not only problems with teaching in organisations, but also patient safety issues and problems with bullying and undermining. The results of the GMC NTS were published in July 2016. Our results have improved significantly with a reduction in red flags (where we are a significant national outlier) by 50 per cent. We have more than

doubled the number of green flags from 20 to 54, with three times as many programmes having green flags than the previous year. As a result, we have gone from worst performing to best performing Trust compared to our peers in the Shelford Group within one year. Several specialties, including ophthalmology and GUM/HIV which were particularly challenged last year, underwent a complete transformation from multiple red flags to multiple green flags. We were also delighted that there were no bullying and undermining concerns raised by trainees in the survey this year, and a significant reduction in patient safety concerns.

These improvements are the result of our comprehensive education transformation programme launched in 2015, which included standardising local faculty group meetings (see glossary on page 77 for definition), providing improved access to educational resources and renovating our education centres and teaching rooms, delivering a 'day one ready' induction to ensure trainees are fully equipped to start their roles on the first day in their departments, and delivering a faculty development programme for unit training leads and educational supervisors.

Since the results of the survey, we have been focusing on sustaining the improvements made and driving further change by:

- Sharing good practice from the specialties with green flags;
- Conducting focused specialty reviews, chaired by the medical director, with specialties that are still challenged;
- Embedding time for education in job plans and making it sustainable;
- Supporting the development of the multi-professional workforce through the implementation of the integrated education strategy;
- Working to ensure the new junior doctor contract is implemented with educational expectations and standards maintained. We have appointed a guardian of safe working to ensure safe working of junior doctors in the Trust. The guardian runs quarterly junior doctor forums and reports to the board highlighting rota exceptions (where hours have been exceeded) and fines imposed as a result, and gaps in the junior doctor rota. 100 'exception reports' have been received in the Trust so far this year, with no confirmed breaches requiring fines to be paid.

We re-ran our ward accreditation programme and saw improvements in 25 wards: Following our CQC inspection in September 2014, we launched our own internal programme of ward inspection to carry out regular checks and instigate immediate improvement where necessary. Our ward accreditation programme (WAP) is designed to support ward, unit and department managers to understand how they deliver care, identify what works well and where further improvements are needed. Areas are assessed against a number of criteria, and given a rating, from gold (achieving highest standards with evidence in data) to white (not achieving minimum standards and no evidence of active improvement work).

We ran our first WAP in 2015; our second was run between July and December 2016. Overall, out of 75 areas reviewed, 25 had improved since last year. The QI team is supporting improvement projects on individual wards to help address their key issues. Overall Trust results are summarised below:

- Leadership: there has been a significant improvement in this domain, with 6 areas rated white for this element in 2016, compared to 13 in 2015.
- Record keeping: only one area was rated white in 2016, compared to 7 in 2015.
- Meals (nutrition and hydration): we continue to have good results in this category. Examples observed include efficient services with staff assisting patients where needed, facilities for families and carers, and hot drinks machines being available.
- Communication: this was rated gold in 19 areas this year. Examples of good practice include: intensive support rounds with the general manager, senior nurse and discharge

team; good multi-disciplinary team working; excellent handover practice; and effective huddles and safety briefings.

- Environment: we continue to struggle in this area with issues often a result of our old estate. However there were also problems such as poorly organised storage and overstocking, and some dirty equipment. Actions are in place through the estates and facilities quality committee. Monthly environment walkrounds are taking place and the divisions are managing specific issues in their clinical areas to drive improvements.
- Medicines administration and storage: there were some examples of failure to comply with medication safety checks and storage standards. Medicines safety is one of our key safety priority areas and work is being taken forward by the Medicines Safety Group. We also ran task and finish groups with some of the wards who had issues in this area. With the QI team, they developed improvements including standardised locks for medicine pods, improved signage for medicines and controlled drug cupboards and a standard for medicines administration.

Well-led quality challenges:

We have not increased the percentage of staff who have had a performance development review (PDR): Our appraisal scheme 'Performance Development and Review (PDR)' for staff, excluding doctors, is aimed at driving a new performance culture across the Trust. Although we are below target and below last year's result, our PDR rate remains high with over 7,200 staff completing their PDR with their manager within the designated timeframe of April–September 2016. This year, we revised the PDR process with a new emphasis on our values and behaviours, improved quality of objectives and on-going regular performance conversations between annual reviews to improve the link between individual and organisational objectives. We have continued to run training sessions to ensure that managers have the tools and skills to have high quality performance conversations with all their staff. Despite the reduction in numbers, 92 per cent of staff responded that they had had an appraisal in the last two months in the national staff survey. We also believe that the 94 per cent of our staff who stated that they were clear about their objectives and responsibilities in our internal engagement survey shows that the PDR process is having a positive impact. We will continue to embed and improve the process in 2017/18.

We have not achieved our target of 90 per cent of staff being compliant with core skills training: Our core skills training programme ensures the safety and well-being of all our staff and patients; this includes modules which have a direct impact on patient safety. The percentage of staff who have completed all the core skills modules has slightly decreased this year; we continue to target areas where compliance is particularly low. We have also embedded compliance in the PDR process so that managers review compliance as part of normal performance management. We are reviewing all mandatory training modules to streamline them and make them more effective which will reduce the total number which staff are required to undertake.

The Acute Quality Schedule 2016/17

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

Maternity performance indicators

The quality schedule includes 10 key targets to drive improvement in maternity care. We achieved the following six targets in all four quarters this year:

- 90 per cent breastfeeding initiation rate within 48 hours of the baby's birth
- 95 per cent of maternity booking assessments in 12 weeks and 6 days
- 95 per cent of women receiving one-to-one midwife care in established labour
- Less than 5 per cent of women smoking at the time of delivery
- Less than 13 per cent of women having an elective caesarean section
- Less than 6 per cent of women experiencing 3rd or 4th degree tears

We met the target for 100% of pregnant women with a named midwife/named team since July 2016.

Home births:
The number of women giving birth at home remains below the threshold of 1 per cent. Maternal choice is the main factor driving this. This is being driven by the popularity of our co-located 'home from home' midwifery led birth centres in which 17 per cent of our women choose to give birth. We continue to strive to increase home birth choices where clinically appropriate.

Percentage of women having a non-elective caesarean section
Performance against this target continues to fluctuate. We continue to work on improving the induction of labour patient pathway and share learning from case reviews of all non-elective caesarean sections to support improved performance.

Postpartum haemorrhage
Our performance against this target continues to fluctuate, with an average of 3.0 per cent against a target of 2.8 per cent. We have an action plan in place, and are seeing improvements; we met the target in three out of four of the last months.

In addition to the work outlined above to improve our maternity care, we are also taking forward recommendations from two national reviews:

- 'Better births', which considers how maternity services needed to change to meet the needs of the population, and to ensure that learning from the Morecambe Bay Investigation is embedded throughout the NHS, and;
- 'Saving babies' lives' which aims to reduce stillbirths across the UK. This includes four key elements: reducing smoking in pregnancy; risk assessment and surveillance for fetal growth restriction; raising awareness of reduced fetal movement; and effective fetal monitoring during labour.

Safeguarding training

We are committed to the protection and safeguarding (see glossary on page 77 for definition) of all patients, including children and young people. As part of this, we provide staff with different levels of safeguarding training, depending on their role. Throughout 2016/17, compliance with training has remained below our target of 90 per cent, this is an important but challenging priority for us.

Level 1 & 2 training for both adult and child training is delivered via e-learning modules. We have communication plans in place to improve compliance, including regular reminders to staff and reviews of monthly compliance reports with managers. In addition, all staff are now required to confirm that they are up to date with their core mandatory training as part of their annual personal development review; a failure to do so can prevent them progressing to the next pay increment. We have incorporated Prevent awareness training into the level 1 and 2 adult safeguarding training and have seen significant improvements in the uptake as a result, meaning we met our target of over 60 per cent compliance with Prevent training in December 2016, with 72% of appropriate staff trained by March 2017. In addition, we have increased the number of WRAP (Workshop to raise awareness of Prevent) facilitators and training sessions which has supported more staff to undertake this training.

Level 3 child safeguarding is delivered as a four hour face-to-face session. To improve compliance, we run three training sessions each month and have introduced bespoke sessions to support areas that can't release staff at the set times.

Further work we are undertaking to improve our safeguarding practices includes:

- Launching a joint adult and child action group in December which will be visiting areas across the trust throughout the coming year. It involves representatives from the adult and child safeguarding team visiting areas to answer questions about a range of safeguarding issues, aiming to be educational and supportive.
- Continuing to develop close links with Standing Together and Red Thread to support victims of domestic violence and gang related violence. Members of these organisations are embedded in the A&E department at St Mary's and in the maternity service.
- Working in partnership with local authority safeguarding forums.
- Working with Central North West London NHS Foundation Trust to support training at ward level in requirements of the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards.

We have not reported any SIs related to safeguarding in 2016/17.

The NHS Outcomes framework indicators 2016/17

The NHS Outcomes Framework 2016/17 sets out high level national outcomes which the NHS should be aiming to improve. The framework provides indicators which have been chosen to measure these outcomes. An overview of the indicators and our performance is outlined in the table below. Some of this data is repeated because we chose to include these indicators as our quality strategy targets for 2016/17. It is important to note that whilst these indicators must be included in the quality accounts, the most recent national data available for the reporting period is not always data for the most recent financial year. Where this is the case, the time period used is noted underneath. This data is included in line with reporting arrangements issued by NHS England. Further information about what we are doing to improve our performance can be found in the individual target pages.

Indicator	ICHT 2016/17	National Average (Median Reporting Rates)	Where Applicable - Best performer	Where Applicable - Worst Performer	Trust Statement	2015/16	2014/15	2013/14
SHMI value and banding (Oct 2015 – Sept 2016)	78.05 Band 3 (band 3 = lower than expected)	100	69	116	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from nationally reported data • We were one of only 8 NHS trusts nationally that have consistently recorded a lower than expected SHMI rate for the last two years. • We have reported a lower than expected SHMI rate for the last three years. • ICHT has the fourth lowest SHMI of all acute non-specialist providers in England. We intend to take the following actions to improve this rate, and so the quality of our services, by: • Continuing to work to eliminate avoidable harm and improve outcomes. • Reviewing every death which occurs in our Trust and implementing learning as a result.	73.8 Band 3	73.17 Band 3	Band 3
% of admitted deaths with palliative care coded (Oct 2015 – Sept 2016)	54.9%	29.7%	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. • it shows we have the highest rate of palliative care coding as measured by this indicator of all acute non-specialist providers. • We are confident that we have a robust process in place to ensure that we are coding patients correctly. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Continuing to work to improve the accuracy of our clinical coding.	53.5%	24.6%	32.70%
Patient reported outcome	* (Low sample size)	EQ-5D: 0.089	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 independently administered NHS Digital PROMS	* (low	* (low sample	0.327

scores (PROMs) for groin hernia surgery (April - September 2016)		EQ-VAS: -0.1			database. • We had no cases assessed for health gain for three of the four PROMs procedures as the data was supressed to protect patient confidentiality. Therefore, ICHT has no reportable PROMs outcome scores for groin hernia for the period April-September 2016. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • implementing our action plan and working with our external agency to improve submission rates to allow health gain to be calculated and improvements directed appropriately. See pages 39-40 for further information.	sample size)	size)	
PROMs for varicose vein surgery (April - September 2016)	EQ-5d: 0.083 EQ-VAS: 0.3 Aberdeen: -0.1	EQ-5D: 0.099 EQ-VAS: 1.4 Aberdeen: -8.5	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 independently administered NHS Digital PROMS database. • It shows that we had below average reported health gain for varicose vein procedures in this time period for two out of the three indexes measured. We intend to take the following actions to improve this percentage, and so the quality of our services, by: •See pages 39-40 for information on our improvement plans.	EQ-5D: 0.046 EQ VAS: 1.110 Aberdeen varicose vein score: -2.050	0.054	0.474
PROMs for hip replacement surgery (April - September 2016)	* (Low sample size)	EQ-5D: 0.449 EQ-VAS: 13.7 Oxford: 22	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 independently administered NHS Digital PROMS database. • We had no cases assessed for health gain for three of the four PROMs procedures as the data was supressed to protect patient confidentiality. Therefore, ICHT has no reportable PROMs outcome scores for hip replacement for the period April-September 2016. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • implementing our action plan and working with our external agency to improve submission rates to allow health gain to be calculated and improvements directed appropriately. See pages 39-40 for further information.	EQ-5D: 0.451 EQ VAS: 12.607 Oxford Hip Score: 22.695	* (Low sample size)	0.324

PROMs for knee replacement surgery (April - September 2016)	* (Low sample size)	EQ-5D: 0.337 EQ-VAS: 8.1 Oxford:16.9	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 independently administered NHS Digital PROMS database. • We had no cases assessed for health gain for three of the four PROMs procedures as the data was supressed to protect patient confidentiality. Therefore, ICHT has no reportable PROMs outcome scores for knee replacement for the period April-September 2016. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • implementing our action plan and working with our external agency to improve submission rates to allow health gain to be calculated and improvements directed appropriately. See pages 39-40 for further information.	EQ-5D: 0.323 EQ VAS: 10.729 Oxford Knee Score: 15.187	* (Low sample size)	0.77
28 day readmission rate for patients aged 0-15 (Dr Foster data – Oct 15-Sept 2016)	5.15%	8.97%	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 • we have maintained our low unplanned readmission rate for both paediatric patients and adult patients with both rates remaining below national average throughout the year. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Through our clinical strategy, continuing to ensure we treat and discharge patients appropriately so that they do not require unplanned readmission. • Working to tackle long-standing pressures around demand, capacity and patient flow.	4.81% (Jan-Dec 2015)	6.31%	5.95%
28 day readmission rate for patients aged 16 or over (Dr Foster data – Oct 15-Sept 2016)	6.64 %	7.98%	N/A	N/A	See above.	7.39% (Jan-Dec 2015)	8.84%	7.90%

% of staff who would recommend the provider to friends or family needing care	70%	70%	Not available	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 from the National Staff Survey which was published in March 2017. • The results show an improvement in our national staff FFT score compared to last year, which is now average for acute trusts. Results from our local engagement survey also show an improvement, with 83% of staff recommending the Trust. We intend to take the following actions to improve this percentage, and so the quality of our services, by: •See pages 54-55 for information on our improvement plans.	68%	71%	69%
% of admitted patients risk-assessed for VTE	95.33% (full year of data)	95.64% (Q3 16/17)	100% (Q3 16/17)	76.48% (Q3 16/17)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from the nationally reported data published quarterly by NHS England. • Last year, an internal audit identified some issues with our data for this indicator which is being rectified as described on page 35. • we have monitored VTE risk assessments on a monthly basis throughout the year. We have been above the target of 95% throughout the year until December 2016 when we fell below 95%. We intend to take the following actions to improve this percentage, and so the quality of our services, by: •See page 36 for information on our improvement plans.	95.9%	96.56%	96%
Rate of C-Diff per 100,000 bed days	18.03 (Total cases: 63)	14.9 (2015/16 data)	0.0 (2015/16 data)	66 (2015/16 data)	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • it is drawn from nationally reported data • we monitor performance regularly through our Trust Infection Control Committee and weekly taskforce meeting. We intend to take the following actions to improve this percentage, and so the quality of our services, by: •See page 36 for information on our improvement plans.	21.7 (73)	24.1 (79)	19.4 (58)
Responsiveness to inpatients personal needs: National Inpatient survey score	79 [national inpatient survey overall score – published July 2016] 6.74 [responsiveness score –	Not available	90	75	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 Inpatient Survey which was published in July 2016. We intend to take the following actions to improve this percentage, and so the quality of our services, by: •See pages 43-44 for information on our improvement plans.	75.8 [national inpatient survey overall score – published May 2015] 6.82	74.4 [overall score] 6.78 [responsiveness score]	76.2 [overall score] 6.64 [responsiveness score]

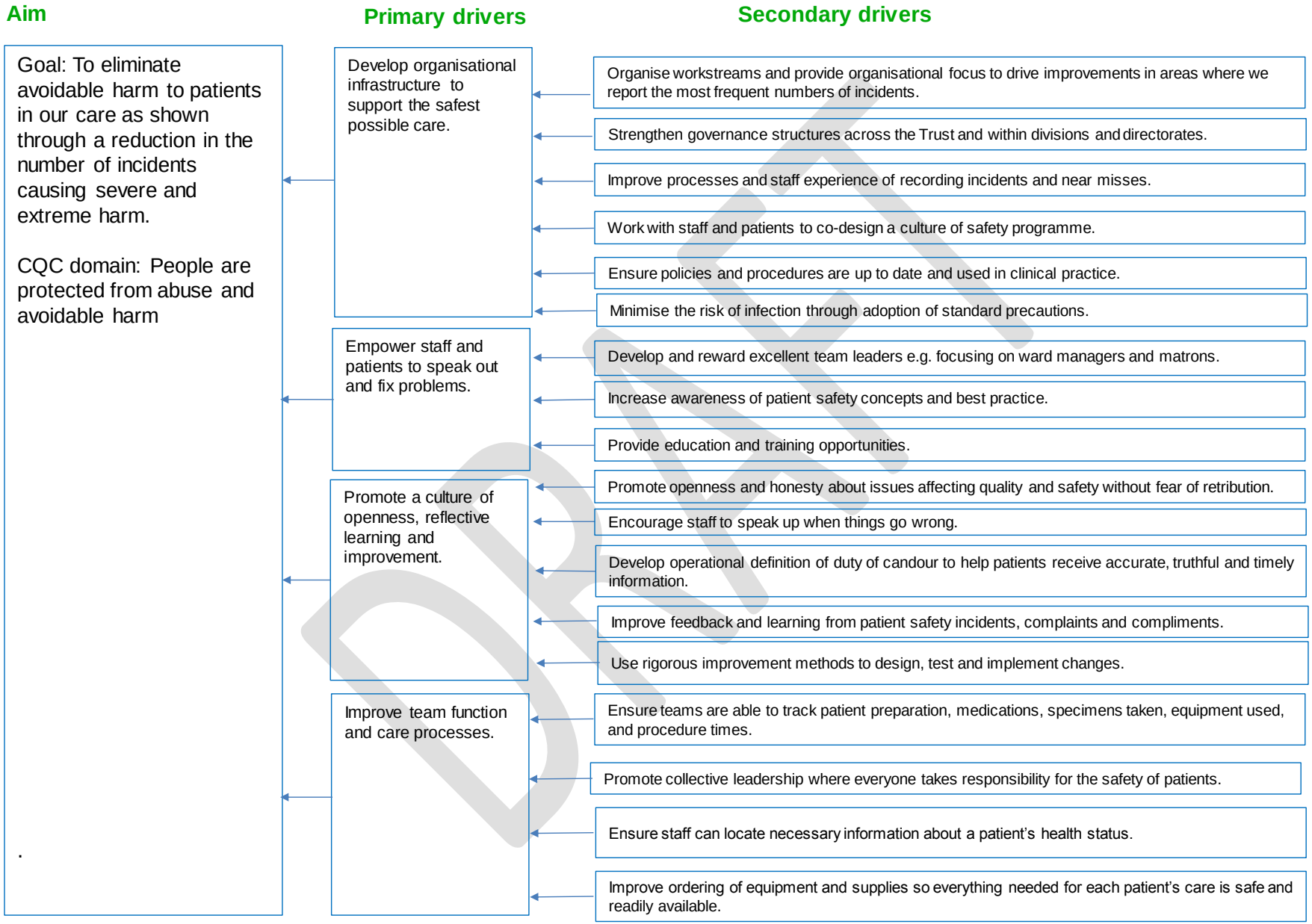
	published July 2016]					[responsiveness score – published May 2015]		
Rate of reported patient safety incidents per 1,000 bed days (NRLS data Apr 16 – Sept 16)	42.3 (7,532 incidents)	40.02	71.81	21.15	Imperial College Healthcare NHS Trust considers that this data is as described for the following reasons: • the NRLS data is nationally reported and verified. • The data shows all incidents reported by ICHT for the period April – Sept 2016: our incident reporting rate for this period was 42.3 against a median peer reporting rate of 40.02. • Our individual incident reporting data is made available by the NRLS on a monthly basis; there has been an improvement in our performance since September 2016, and except for February 2017, we have been consistently above the top quartile since then. We intend to take the following actions to improve this percentage, and so the quality of our services, by: • Improving how we report, manage and learn from incidents as part of our safety culture work. See page 33-34 for further information.	41.38 (NRLS published data April-Sept 2015)	42.98(NRLS published data April 2014 – Sept 2014)	6.5 (data reported per 100 admissions)
% of patient safety incidents reported that resulted in severe/major harm or extreme harm/death (NRLS data Apr-Sep 16)	0.1% (severe harm) 0.0% (extreme harm/death)	0.3% (severe harm) 0.1% (extreme harm/death)	0.0% (severe harm) 0.0% (extreme harm/death)	1.4% (severe harm) 0.5% (extreme harm/death)	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 NRLS published in March 2017. •We reported 0.1% severe/major harm incidents (7 incidents) compared to a national average of 0.3%, and 0.0% extreme/death incidents (2 incidents) compared to a national average of 0.1%. • We have also achieved a reduction in the number of incidents causing extreme harm/death or severe/major harm with a total of 28 in 2016/17, compared to 31 reported in 2015/16. We intend to take the following actions to improve this percentage, and so the quality of our services, by:•See pages 33 for information on our improvement plans.	0.1% - severe/major harm (8 incidents) 0.1% - extreme harm/death (5 incidents) (NRLS data April-Sept 2015)	0.1% severe/major harm incidents (13 incidents) 0.3% extreme harm/death incidents (19 incidents) (NRLS data April-Sept 2014)	0.3% (38 incidents)

Inpatient Friends & Family Test	97% (April 2016 – March 2017)	96% (April 2016 – March 2017)	100% (March 2017)	82% (March 2017)	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 throughout the year. We intend to take the following actions to improve this percentage, and so the quality of our services, by: •See pages 43-44 for information on our improvement plans.	97%	95%	95%
A&E Friends & Family Test	95% (April 2016 – March 2017)	86% (April 2016 – March 2017)	100% (March 2017)	34% (March2017)	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 throughout the year. We intend to take the following actions to improve this percentage, and so the quality of our services, by: •See page 44 for information on our improvement plans.	95%	89%	91.9%

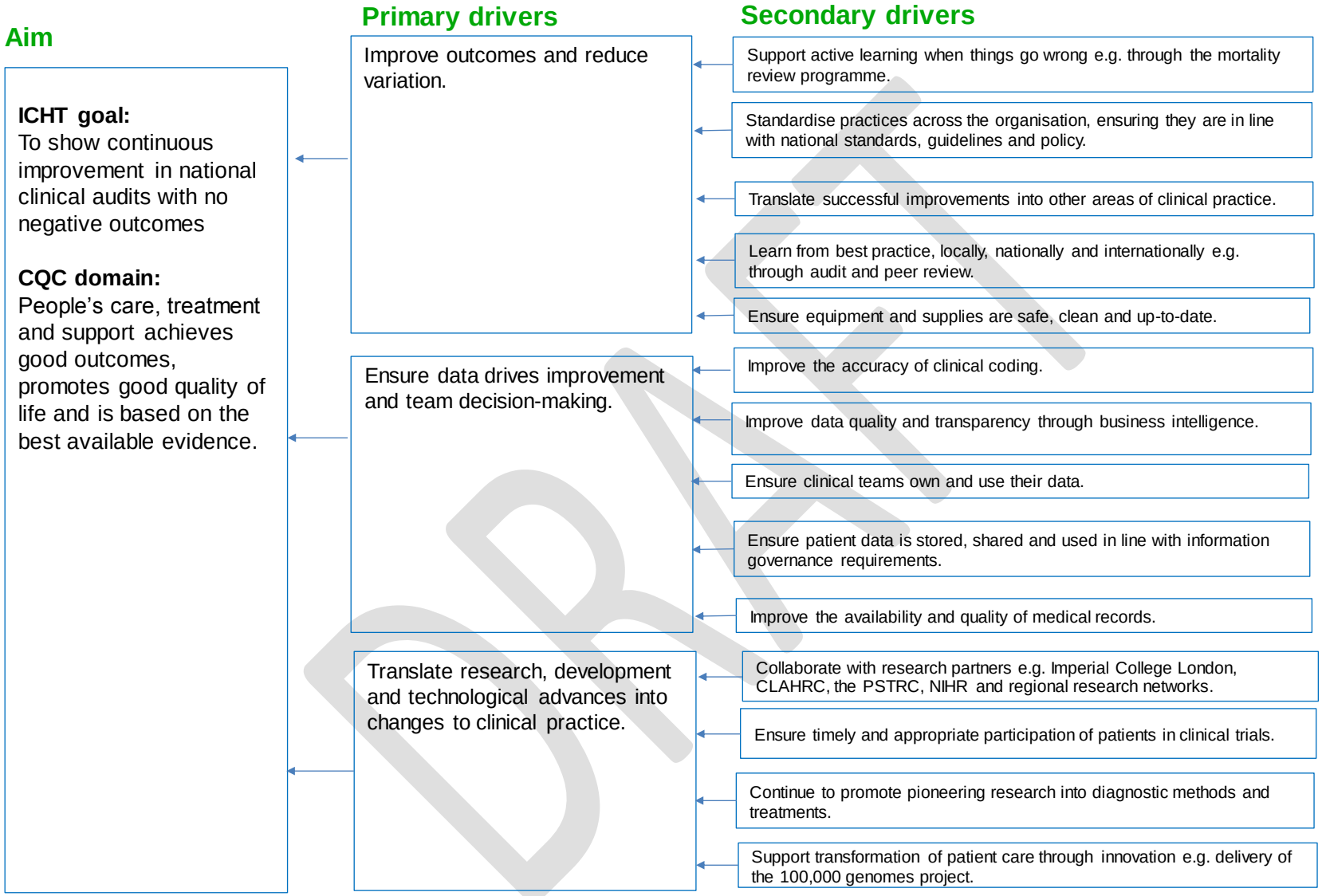
Statements from stakeholders

(to be inserted once received)

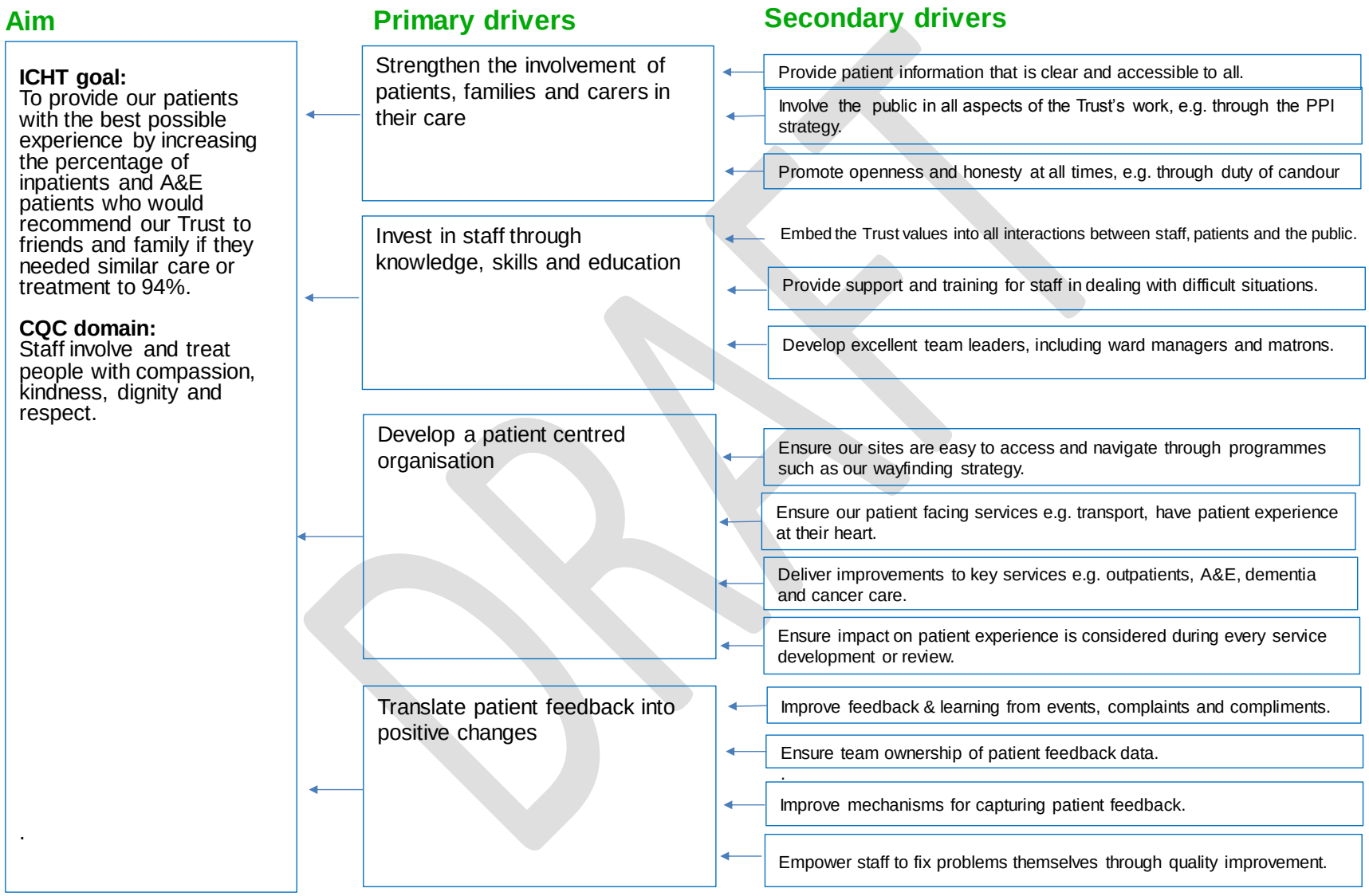
Appendix A - Safe Driver Diagram



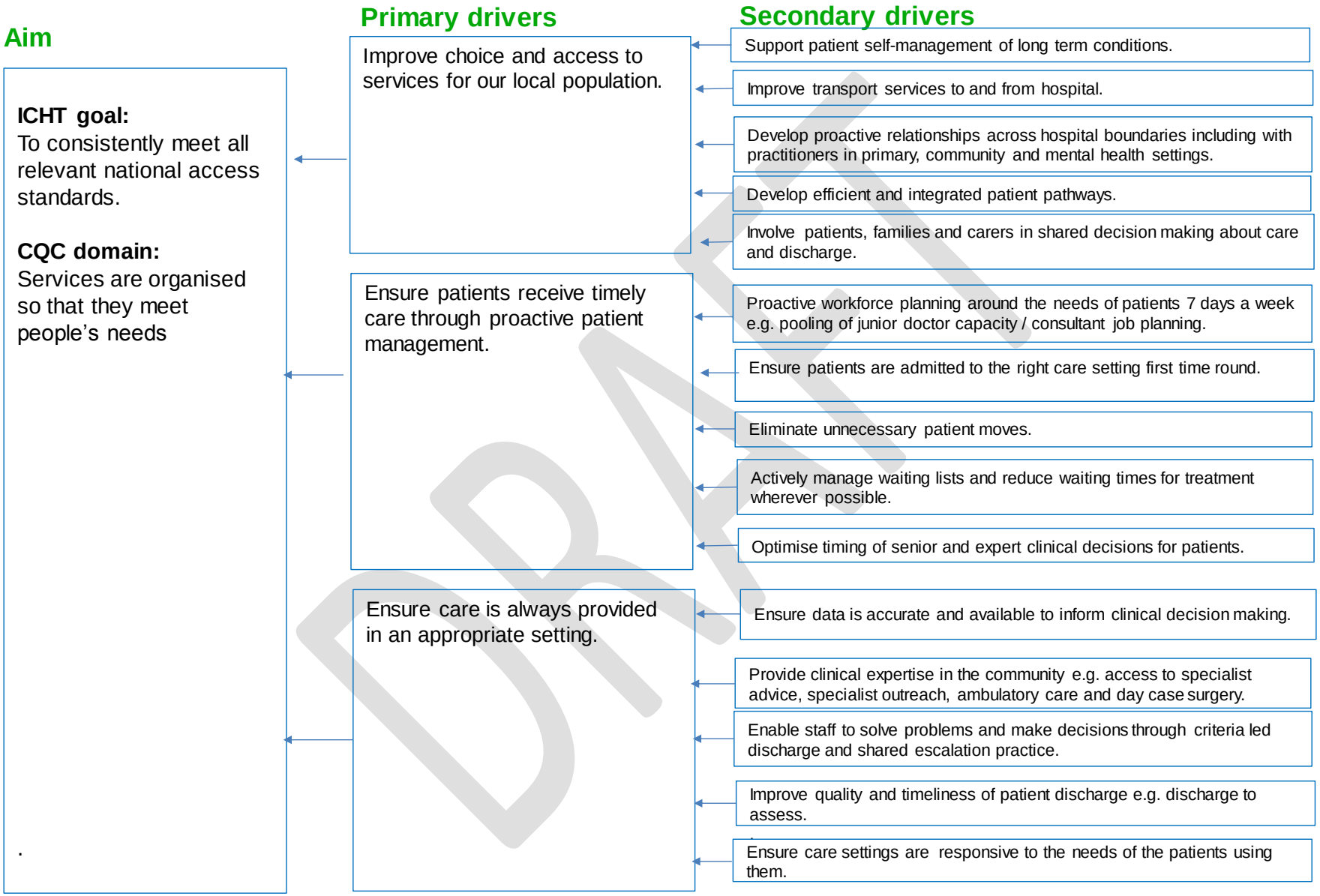
Effective driver diagram



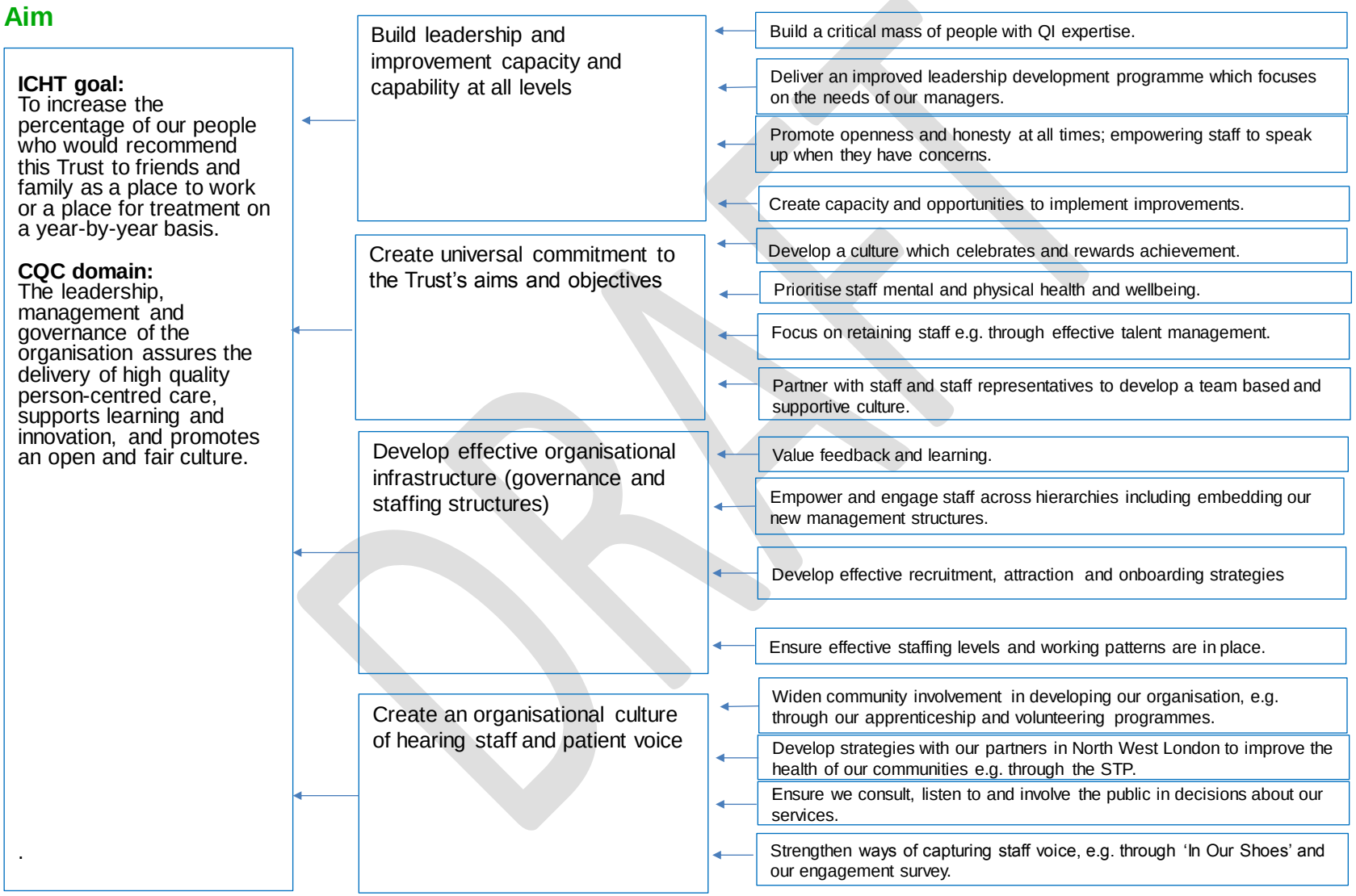
Caring driver diagram



Responsive driver diagram



Well-led driver diagram



Appendix B: National Clinical Audit

National Audits reported 2016/17	Outcomes	Improvements made, or to be made as a result
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	For cases coming direct from the community our performance was better than the average reported in the national report, performance was worse for patients transferring from another hospital, however this is outside of our control	There are no specific actions
End of Life Care Audit: Dying in Hospital	We achieved above average for all End of Life quality indicators, however were below average for the organisational indicators.	•Deliver improved training for staff, including around advanced care planning, communication and DNACPR decision making •Improve documentation of assessment and support around artificial hydration/nutrition •Review care of the dying patient policy/guidelines.
National Diabetes Audit – Adults Foot care 2014-2016	The Trust reported fewer deaths than average with healing rates in keeping with national average	•Review systems to ensure that on discharge, patients can still have access to service as “new” without referral •Review of non-medic supported Foot Clinic sessions.
Renal Replacement Therapy (Renal Registry)	The Trust performs well against the audit criteria	There are no specific actions
MBRRACE - UK Perinatal Mortality Surveillance Report	We had a neonatal mortality rate and stillbirth rate which is up to 10% higher than average (data is for 2014).	•Introduction of weekly neonatal grand rounds with increased and regular input from Microbiology and the Infectious Disease team; •Introduction of monthly neonatal M&M meeting where all neonatal deaths are discussed with learning points disseminated to all neonatal staff; •Validation of all neonatal mortality and stillbirths on monthly basis through named neonatal and maternity consultants; •Strengthening the neonatal nursing leadership; •Implementation of 24/7 Consultant Delivered Care model on level 3 NICU.
Diabetes (Paediatric) (NPDA)	We are in the top 3% for completion of care and the top 10% for outcomes of care.	There are no specific actions
National Diabetes Audit - Adults In-patient	The specialist nature of the trust means we are an outlier for end stage renal failure prevalence at HH and active foot disease prevalence at SMH	•Fully implement education strategy including an in-house inpatient diabetes course; •Incorporate insulin safety into junior doctors’ induction.
National Emergency Laparotomy Audit (NELA)	Our results have improved since the last report	•Improve consultant review before surgery and of CT scans
National Heart Failure	Our performance meets NICE guidelines	•Appointed heart failure consultant and additional heart failure nurses.
Rheumatoid and Early	We do not currently meet all the audit	•Establish a named Arthritis

Inflammatory Arthritis	standards	Pathway Coordinator to align appointments and investigations •Establish dedicated, weekly , one-stop EIA clinic including ultrasound assessment and specialist nursing
National Oesophago-gastric cancer	The Trust performs well against the audit criteria	All recommendations and actions have been implemented by the service
National Hip Fracture Database	The audit identified issues with delay in time to an orthopaedic ward, patients in receipt of pre-op AMTS and a higher than average mortality rate.	•The ANPs will as part of clerking include a mental assessment, with the orthopaedic SHO doing this out of hours. •Mortality rates to be monitored via Trust process and HDU provision considered as part of the critical care re-organisation.
Inflammatory Bowel Disease Programme (IBD)	Our results improved for one of the audit criteria and remained the same for two.	•Weekly Virtual Biological MDT established to discuss and review treatment for all patients on biological therapy. •Weekly IBD MDT established to discuss cases of complex IBD in a multidisciplinary setting.
National Intensive and Special Care (NNAP)	We have improved for 3/7 of the audit criteria and remained the same for the other 4.	•Ensure temperatures meet required standards •Ensure ROP screening results are entered into the electronic records •Implement QI project to improve consultation with parents.
National Joint Registry	No concerns identified by the report	There are no specific actions
Specialist Rehabilitation following major Injury	We meet all the audit criteria.	•Work with commissioners and Major Trauma Network to improve service provision
Sentinel Stroke National Audit Programme (SSNAP)	Our performance has been rated ‘good’ in the SSNAP since April 2014.	•Work with North West London Stroke Steering Group tom improve bed availability •Recruit speech and language therapist
National Vascular Registry	All surgeons are in range for infrarenal aneurysm with a rate of 0.7%. Carotid stroke rate is 3.5% with all surgeons in expected range	•Focus on reducing length of stay and wait times for CEA after symptoms.
Paediatric Intensive Care (PICANet)	The audit shows good performance in terms of mortality rates and emergency readmissions, however nursing establishment is lower than the recommendations	•Review nursing establishment
National Lung Cancer Audit –Consultant Outcomes	Our mortality rates are good when compared nationally	•Recruit additional thoracic surgeon •Agree funding for additional Macmillan Nurse
MBRRACE - UK Maternal Mortality Surveillance Report	Audit identifies variable practice	•Establish an accepted method of cardiac assessment and liaise with reproductive medicine. •Initiate referrals from cardiology and establish referral pathway •Enquire at maternity booking re family history of sudden death

National Prostate Cancer Audit	Trust outcomes are broadly in line with national average	All recommendations and actions have been implemented by the service
National Bowel Cancer Audit	To be confirmed	All recommendations and actions have been implemented by the service
NCEPOD Physical and mental health care of mental health patients in acute hospitals	Trust level outcomes not included	There are no specific recommendations
National Lung Cancer	The Trust performs well against the audit criteria	There are no specific actions
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	The Trust performs well against the audit criteria	The majority of the report's recommendations are already in place.
Myocardial Ischaemia National Audit Project (MINAP)	Trust level outcomes not included	All recommendations and actions have been implemented by the service
Cardiac Rhythm Management Devices	Trust level outcomes not included	There are no specific recommendations
National Audit of Pulmonary Hypertension	Time from diagnosis of chronic thromboembolic pulmonary hypertension at PH centres to pulmonary endarterectomy surgery at Papworth Hospital is too long - this affects all PH centres	All actions are implemented with work continuing to refer appropriate patients to Papworth Hospital within 5 days.
Procedural Sedation in Adults (care in emergency departments) – CXH & SMH	We performed above average for a number of outcomes	Actions are under review by the service
Vital Signs in Children	We performed above average for 4/5 standards	Actions are under review by the service
VTE risk in lower limb immobilisation (care in emergency departments)	Our performance is below average	Implement assessment on the electronic record on admission to ensure that adequate assessment is taking place

Appendix C: Local Clinical Audit

Local Audits reported 2016/17	Improvements made, or to be made, as a result
CCG Discharge Letter Audit	•Escalation process for concerns established with CCG
A&E Safety Audit	•Development of further tools to validate patient data. •Staff to update patients movement in real time •Develop options on Cerner for reasons for non-documentation of patient's information to capture data
Duty of Candour – Annual Review	•Full action plan implemented (for further details see page 35)
Elective Weekend Mortality	•Include review of admission route and type to the clinical coding validation process that already exists for mortality cases •Ensure booking processes clearly embed the need for pre-assessment
Safer invasive procedures audit	•Full action plan implemented (for further details see page 34-35)
Haematological Cancers: improving outcomes – NG47	•Re-examine workload and staffing levels
Jaundice in Newborn Babies under 28 days – CG098	•Review current practice and develop a tool that identifies babies at risk of developing jaundice.
Routine Preoperative Tests for Elective Surgery – NG045	•Preoperative assessment clinics should examine whether a Full Blood Count test is required by taking into account the patient's ASA score and the severity of the surgery.
VTE Compliance Audit	•Full action plan implemented (for further details see page 36)
A study into patient satisfaction on neurosurgical ward round and whether a divided cranial/spinal ward round improves this	•Implement split cranial/spinal ward round where possible
Declined donor offers from the West London Renal Transplant Centre	•Ensure surgeons are fully aware of responsibilities
Documentation and consent audits – PUVA therapy	•Implement new consent form in keeping with guidelines •Ensure correct training for locum staff
Radiotherapy Patient Pathway - Breast	•Review documentation system •Promote risk management locally •Review and update training and competency management
Red Blood Cell Transfusion in Critical Care	• Develop further staff training
Documenting Consent for Anaesthesia	• All anaesthetic pre-op assessment charts should include a note relating to discussion of consent • Nurses in PAAC should document when anaesthetic information leaflets given to patients
An audit of the referral letters sent to the clinical genetics team	•Template to be produced to prompt referral letters to include all relevant details
IVF Cycle cancellations due to risk of OHSS	•Ensure AFC is assessed for all patients prior to ovarian stimulation
Management of acute pain in paediatric patients	•Focus on improving the time analgesia is given in response to severity of pain
Neonatal transfusion: assessment of QCCH neonatal unit compliance with local, JPAC and BCSH guidelines	•Improve documentation around transfusion and transfusing older babies
Use of Inotropes on ITU Audit	•Improve education and training for junior doctors and nursing staff •Develop new prescribing tool

Glossary

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

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

Ambulatory Emergency Care (AEC) – a service where some conditions may be treated without the need for an overnight stay in hospital. It is a streamlined way of managing patients presenting to hospital who would traditionally be admitted. Instead, they can be treated in an ambulatory care setting and discharged the same day – offering benefits to patients, carers, and NHS trusts.

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

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

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

Care Pathway – an outline of anticipated care in an appropriate timeframe to treat a patient's condition or symptoms.

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

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

Clinical Guidelines – these are recommendations of how healthcare professionals should care for people with specific conditions. They can cover any aspect of a condition and may include recommendations about providing information and advice, prevention, diagnosis, treatment and longer-term management. They aim to help health professionals and patients make the best decisions about treatment or care for a particular condition or situation. They include national guidelines, published by organisations such as NICE (National Institute for Health and Care Excellence), as well as locally developed guidelines.

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

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

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

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

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

Departmental Safety Coordinator (DSC) – appointed by departmental managers to assist them in meeting their health, safety and wellbeing responsibilities.

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

Dr Foster Global Comparators –an international hospital network, created by Dr Foster in 2011 as a global hospital benchmarking collaborative. It brings together data from hospitals in different countries, enabling comparison of the results within the network.

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

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

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

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

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.

Integrated Care – person-centred and co-ordinated care within healthcare settings, across mental and physical health and across health and social care. For care to be integrated, organisations and care professionals need to bring together all of the different elements of care that a person needs.

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

Macmillan Navigator – a single point of contact via telephone for cancer patients, from the point of diagnosis to the end of treatment, aiming to create a more streamlined service and positive experience for the patient.

Medical Appraisal - annual medical appraisal is the cornerstone of the General Medical Council (GMC) revalidation process. All doctors must undertake and record an annual medical appraisal in order to demonstrate that they comply with Good Medical Practice as required by the GMC.

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

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.

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

Patient led assessments of the care environment (PLACE) – introduced in April 2013 this is a national system for assessing the quality of the patient environment. The assessments apply to hospitals, hospices and day treatment centres providing NHS funded care. The assessments will see local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. The assessments take place every year, and results are reported publicly to help drive improvements in the care environment.

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.

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

- Near miss – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm.
  No harm – any patient safety incident that ran to completion but no harm occurred.
- Low harm: Any patient safety incident that required extra observation or minor treatment and caused minimal harm.
- Moderate harm: Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm.
- Severe harm: Any patient safety incident that appears to have resulted in permanent harm.
- Extreme harm/death: Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.

Performance Development Review (PDR) – our annual performance review process which was introduced in 2014-5 for all staff, excluding doctors, which is aimed at driving a new performance culture across the Trust.

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

Quality Improvement (QI) – is a formal approach to the analysis of performance and systematic efforts to improve it. It is a method for developing, testing and implementing changes so that improvements can be made quickly. Our QI programme takes the form of training in QI methodology and a QI hub team who support teams undertaking QI projects.

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

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

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

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

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

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

Serious Incident (SI) – events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

Sign Up To Safety – a national campaign launched in 2014 by the Secretary of State for Health which aims to save 6,000 lives and halve avoidable harm, to deliver harm free care for patients.

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

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

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

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

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

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, during and after surgery.

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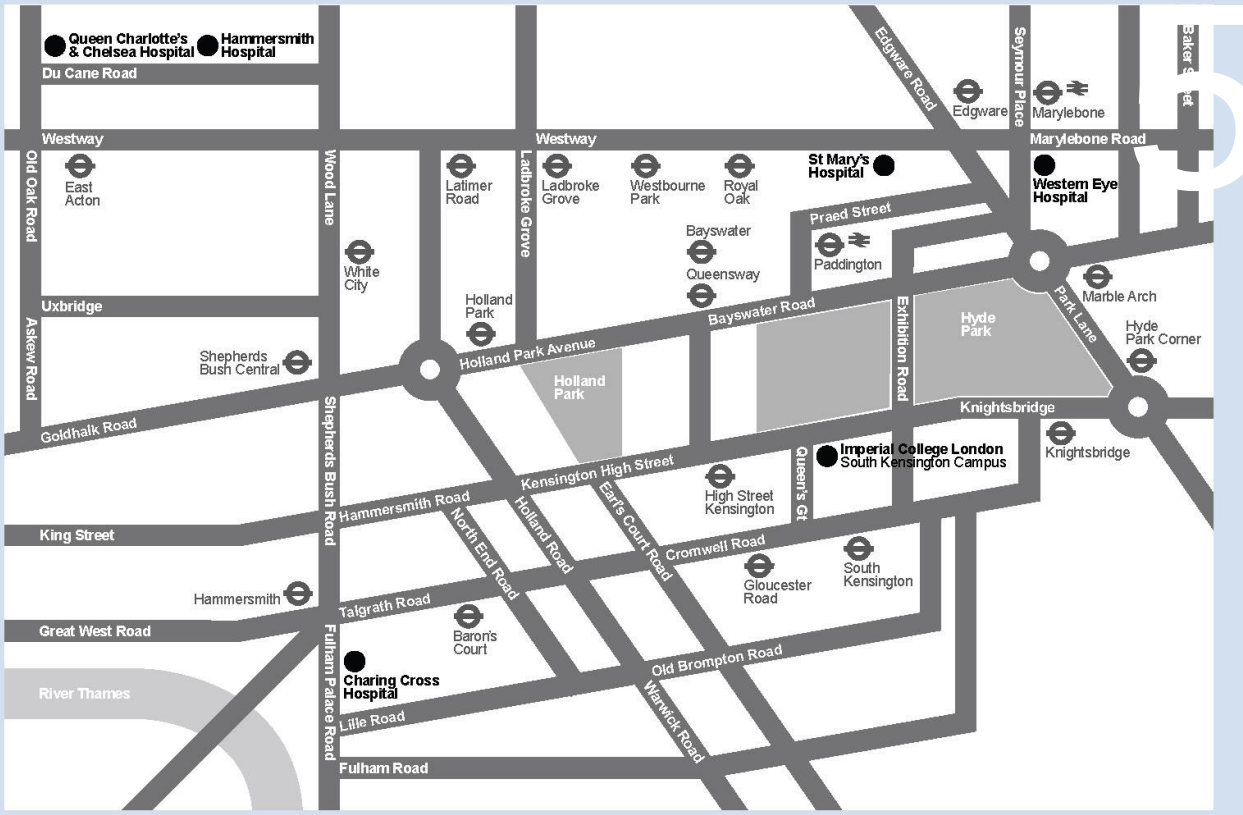

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