Quality Account

2023/24

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NHS

Imperial College Healthcare

NHS Trust

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Chief Executive's Overview

Professor Tim Orchard, chief executive

Thanks to our teams' hard work and dedication, we continue to provide some of the best outcomes in the country for our patients during challenging times for the NHS. Our mortality rates are consistently amongst the lowest in the NHS and harm levels remain well below the national average. It's a really positive indication of our safety focused culture to see that our incident reporting rates have increased too. This means staff are comfortable raising concerns, and areas for improvement are spotted earlier.

While our staff work tirelessly day-to-day to deliver the best possible individual care for their patients, we also focus on continuously learning when things do go wrong, as well as when things go right, and improving patient safety, experience and outcomes as a result. One way we do this is through our quality and safety improvement programme which is described in detail in this report. I am very proud of the progress we made during 2023/24, which includes:

- the launch of 'Call for Concern' in response to Martha's Rule
- introduction of a new mental health strategy and team with actions focused on improving care for some of our most vulnerable patients
- improvements to the quality and frequency of assessments for patients at risk of falling which have resulted in an in-year decrease in falls with harm
- delivery of an action plan to improve fetal monitoring during labour with an increase in 'fresh eyes' two person checks and the introduction of a new risk assessment tool
- development of a framework for local safer surgery champions who will support improvements in safety culture and embed the new national safety standards for invasive procedures
- our successful antimicrobial stewardship programme being recognised as the first UK Centre for Excellence by the Global Antimicrobial Stewardship Accreditation Scheme in 2023. This, alongside our new hand hygiene improvement programme, will support a reduction in healthcare associated infections
- work to improve standards and celebrate excellence in nursing care through our ward accreditation programme and the Pathway to Excellence scheme.

It will take time to fully realise the benefits of these improvements and we will continue to focus on some of these priorities into 2024/25.

Through review of our quality data and insights, we have also identified some new areas of clinical risk, as well as opportunities to improve how we engage with and involve patients and families in

our plans, and identify health inequalities to which we can respond proactively.

Central to our goal of 'patient-centred safety' will be ensuring we successfully embed the Patient Safety Incident Response framework (PSIRF), which is the new way in which the NHS investigates and learns from patient safety incidents. We implemented PSIRF in April 2024, following a year of developing and testing our processes with colleagues across the North West London Acute Provider Collaborative and the Integrated Care Board, as well as our staff and our six patient safety partners (lay partners who are actively involved in the development of safer healthcare). This approach builds on the compassionate care our staff provide daily and allows deeper engagement with those involved in patient safety incidents: patients, their families and staff.

Our work is increasingly driven by the experience and views of our patients and communities. Our user insights programme has helped to improve outpatient services, cancer pathways and our end-of-life care strategy. During 2024/25 we plan to build on this further and deliver our local strategy for 'Involving Patients in Patient Safety', which has been designed with our patient safety partners.

As the quality account demonstrates, we still have much we want and need to achieve, and many challenges ahead, but I'm so encouraged by how we've worked together to build a learning culture of continual improvement.

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

Professor Tim Orchard
Chief executive

PART 1:

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

1.1 Priorities for improvement

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

Our improvement methodology

We have a dedicated improvement team whose aim is to build learning, improvement and innovation into everything we do across the Trust. The team continues to ensure the rigorous application of the Institute for Healthcare Improvement's methodology by coaching individuals and teams in their area of work, and through large-scale improvements to drive change. An extensive education programme – available to all staff – supports this work.

In 2023/24 we trained an additional 759 members of staff, meaning we now have a total of 2,049 current members of staff trained in improvement (thirteen per cent compared with nine per cent in 2022/23).

In 2024/25 we will launch our 'Improvement for All' programme which has been designed with our staff to ensure we fully embed a culture of continuous improvement into every aspect of how we run our organisation. This will be underpinned by the Imperial Management and Improvement System (IMIS) which is the Trust's operational mechanism to help the organisation, our divisions, directorates, specialties, frontline and corporate teams deliver on their objectives.

2024/25 improvement priorities

This report focuses on the quality and safety improvement programme. The other strategic priorities are included in the full body of our annual report, which is published on our website. The annual report provides an overview of the Trust's structure, purpose and achievements. It also includes an analysis of the Trust's 2023/24 performance, activities, and challenges, details on governance structure, staff remuneration, and a summary of financial performance.

Our priority improvement areas for quality and safety for 2024/25 are set out below. These have been developed following review of quality insight data, including:

- incidents
- complaints
- patient feedback
- claims and inquests
- audit
- mortality data including structured judgement reviews
- outcomes from our ward accreditation programme
- risks and emerging issues
- national and acute provider collaborative priorities.

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

Focus area	Fully implement and embed the Patient Safety Incident Response Framework (PSIRF) with a focus on experience of and compassionate engagement with those involved
Rationale for selection	Throughout 2023/24 we have been focused on implementing the Patient Safety Incident Response Framework (PSIRF) which replaces the current serious incident framework as the way the NHS investigates and learns from patient safety incidents. The framework has four aims: • compassionate engagement and involvement of those affected by patient safety incidents (patients, families and staff) • application of a range of system-based approaches to learning from patient safety incidents • considered and proportionate responses to patient safety incidents • supportive oversight focused on strengthening response system functioning and improvement. As we fully transition to the new framework in April 2024, our focus will be on the experience of the people involved. We will work to ensure we are compassionately engaging and involving patients, family and staff in our learning responses and improvement plans.
Key metrics	• percentage of staff who have completed PSIRF and patient safety syllabus training • numbers of learning responses commissioned, and timeframes for completion • percentage of patients/families satisfied with the learning response process and outcome (quantitative and qualitative data) • number of incidents linked to ongoing improvement plans
Focus area	**Develop our approach to patient centred safety with our patient safety partners**
Rationale for selection	To achieve our patient-centred safety goals we must ensure patients are designing safer healthcare from the outset, that they know how to stay safe when they visit hospital and that we compassionately engage with them when something goes wrong. Delivery of our local strategy for involving patients in patient safety will be our focus for 2024/25. This is centred on five key areas: • Rolling out the 'Simple steps to keep you safe during your hospital stay'[1] • Engaging and training staff • Raising the profile of our patient safety partners, both internally and externally • Considering equality, diversity and inclusion • Engaging the local community.
Key metrics	To be confirmed
Focus area	**Develop and embed our approach to the use of user insights to drive improvement**
Rationale for selection	We are committed to becoming more 'user-focused' – to better understand and incorporate the needs, views and preferences of our diverse patients, staff, local communities and partners to influence everything we do. We already gather a huge amount of information from – and about – our patients and other 'users'. We created a small, central insight and experience team in 2023 to support the whole organisation in using this information more effectively, including connecting insights to inform and shape our strategy and improvement priorities. The central team also commissions user research to meet specific gaps in understanding, leads on patient and public involvement, and is working to build insight and co-design skills across the organisation. This remains a priority for 2024/25 as we continue to build on the progress made in 2023/24.
Key metrics	• Improvements in patient feedback and survey responses • Improved response rate to complaints within agreed timescales • Improved satisfaction with complaint responses

1 https://www.england.nhs.uk/publication/simple-steps-to-keep-you-safe-during-your-hospital-stay-leaflet/

Focus area	Reduce harm to patients through our safety improvement programme
Rationale for selection	We have had a safety improvement programme in place since 2018. The programme is supported by the safety improvement team, with steering groups in place for individual workstreams and overall reporting to our executive management board for quality. Following review of our quality insights and data, and progress with our previous priorities, we have agreed eight priority areas for the safety improvement programme in 2024/25. These priorities and plans form a key part of how we will move to full compliance with PSIRF with a focus on proportionate incident investigation, engagement, and improvement. Incidents and actions will be linked with existing improvement plans to reduce multiple separate plans and duplication of effort, meaning we can focus on implementing change in practice. Some of these were priorities in 2023/24 and have been extended so that we can continue to make improvements and build on the progress made. This includes: • Reduce infection transmission by improving basic standards of infection prevention and control practice, especially hand hygiene • Improve the treatment of patients with sepsis and signs of deterioration • Reduce harm from inpatient falls • Reduce medication related harm with a focus on anticoagulants and insulin • Reduce the harm caused when undertaking invasive procedures by implementing national safety standards for invasive procedures (NatSSIPS) • Improve nutrition and hydration, in particular the identification and management of adult patients with dysphagia. Two new areas of risk have been identified and are included in our work plan for 2024/25: **Improve positive patient identification (PPID)** Patients should be correctly identified before any care or treatment to ensure that the right person receives their intended care. Through our blood transfusion workstream we found that issues with positive patient identification were a contributory factor in most of the recent blood sampling and blood administration incidents, including a never event where blood products were transfused to the wrong patient. Fortunately these incidents did not cause significant harm to the patients involved, however this represents an ongoing risk to patient safety. In 2024/25 we will focus on learning about, and improving, the system issues that are making the PPID process challenging for our staff. This impacts all aspects of care, and inpatient, emergency and outpatient services. Our first action is to review our positive patient identification policy to make sure the steps are clear for staff. **Improve safe transfers of care** Ongoing reviews of incidents have highlighted a risk for patients who are being transferred between wards, other hospitals within our Trust and externally. There have been several cases where transfers have occurred unnecessarily or when the patient was not well enough. We are currently reviewing our Trust policy and developing a new tool to help staff assess whether patients are well enough to be transferred and that a senior decision maker is involved in the process. We have also started work to streamline pathways where a particular risk has been identified.
Key metrics	Each of our safety improvement priorities has its own set of defined metrics for improvement. The main metric is a reduction in the percentage of incidents causing harm to patients for each area of risk.

Focus area	Improve the treatment of patients with deterioration in their mental health
Rationale for selection	The demand for mental health support for patients within the acute hospital healthcare setting continues to rise and is projected to increase by up to a further 20 per cent over the coming years. Managing mental health presentations remains challenging, partly because we do not always have the right environment or enough trained staff to provide the required level of care. We have invested in the development of a new mental health nursing team, which is now near full recruitment levels, to support patients on wards and in our emergency departments, but concerns raised through serious incidents highlight the need to do more. In 2023/24 we developed a strategy for improving mental health care in the Trust, and made good progress (see following section for details). This remains a priority in 2024/25 as we continue to implement our plans.
Key metrics	• reduction in agency and bank use for mental health nursing staff • improvements in compliance with mental capacity assessments • reduction in serious incidents relating to mental health • improved staff training levels and reported knowledge and awareness
Focus area	**Improve end of life care with our new Trust strategy**
Rationale for selection	We are committed to delivering a high standard of care at the end of life that respects individual choice and provides a positive experience for patients and their loved ones. Over the last two years we have put in place additional support and training for staff, including an online training module designed to help them deal confidently with cardiopulmonary resuscitation (CPR) treatment and escalation decisions, which over 90 per cent of eligible staff have now completed. We have also established an end of life transformation team who are now in post. We are seeing improvements in outcomes in mortality reviews, including resuscitation status being discussed with patients and families at an earlier stage and quick referral to the palliative care team once the need has been recognised. We know from feedback from staff, patients and their families that we still have work to do. Using learning from incidents, mortality reviews and work with people who have experience of a loved one dying in our hospitals undertaken through our user insights programme, we have developed an end of life strategy with actions to take between now and 2025. We will monitor progress through our end of life steering group. The strategy aims to: • deliver trust-wide service improvements, reducing variation in care delivery and making best use of quality frameworks; • work collaboratively across organisational boundaries to provide the best possible care at the time it is needed, in the place it is required.
Key metrics	• Staff training compliance rates • Feedback from the bereaved, including bereavement survey results • Performance with the National Audit of Care At the End of Life (NACEL) standards • Outcomes of mortality reviews
Focus area	**Develop a robust plan to collect/review data to identify inequalities in all quality metrics**
Rationale for selection	We have a key role to play in tackling health inequalities in partnership with other healthcare providers and community services. Our aim is to improve health, wellbeing and equity for our patients and within our local communities, in line with our vision of 'better health for life'. To achieve this, we must focus on improving disparities in health outcomes, especially between people from different ethnic and socioeconomic groups. We recognise that some groups and communities experience variations in patient safety outcomes and can be disproportionately impacted by patient safety events. Through PSIRF implementation, we will seek to collate and use data, including our learning responses, to identify health inequalities and make improvements where we can.
Key metrics	Data related to protected characteristics for all quality metrics

Focus area	Ensure young people who move from children's to adults' service have a co-ordinated transition plan
Rationale for selection	Transition is defined as a planned process of supporting young people to move from children's to adults' services. It is not a single act so much as a process starting from around age 12 that seeks to involve children and young people in discussions and decisions on all elements of their care management. Transition can be a difficult and anxious time for young people and their families. Without proper support there is a risk of disruptions to care provision during the already vulnerable adolescent period. We know from feedback from our children and young people, their families, their carers and our staff that we have much work to do to ensure developmentally appropriate transition pathways are in place in every specialty and that they meet the needs of the diverse range of patients that we care for. Having a transition plan that is coordinated across all services will make it clear when a young person will move from children's to adults' services and how they will be supported. Children's and adults' services will work together and with the young person and their family or carers to develop a coordinated transition plan that meets their individual needs, is practical to implement, and avoids creating gaps in services due to variation in the age for transition between different services. This will provide greater clarity on what to expect and reduce uncertainty and stress. This programme will also sit within a broader plan foryoung people covered by health and social care or education legislation. West London Children's Healthcare (WLCH) has identified 'transitioning well to adult services' as a key quality priority and a working group is in place to oversee delivery of a five-year plan. The initial focus is on ensuring adequate systems and processes for the recording and reporting of activity, training and education and the development of clear policy and guidelines.
Key metrics	We will focus on establishing simple data metrics to enable common and consistent reporting across WLCH.

In addition to our local priorities, we are also working with the other three acute trusts in the North West London Acute Provider Collaborative (Chelsea and Westminster NHS Foundation Trust, London North West NHS Trust, and The Hillingdon Hospitals NHS Foundation Trust) on a number of priority areas. Many of our local priorities are aligned with these collaborative workstreams, which are focused on areas where we can work together to make the most difference for our patients and communities, for example, infection prevention and control, implementation of the new national safety standards for invasive procedures (NatSSIPs2) and improving mental health in the acute setting. Progress is monitored through a fortnightly Acute Provider Collaborative Quality Meeting, attended by the medical and nurse directors from each Trust, and reported quarterly to the Acute Provider Collaborative Quality Committee.

Progress against our 2023/24 improvement priorities

This section describes the progress we made with the quality and safety improvement priorities we agreed for 2023/24. These were chosen following a review of our quality insights, the NHS patient safety strategy, and in consultation with staff and our partners.

Implement the NHS patient safety strategy with a focus on the Patient Safety Incident Response Framework (PSIRF) and Learn from Patient Safety Events (LFPSE)	
Focus area	**What we achieved**
Implement the Patient Safety Incident Response Framework	During 2023/24, we focused on implementing the new Patient Safety Incident Response Framework (PSIRF) with work progressing well through our task and finish group. We fully transitioned on 1 April 2024 in line with revised national timeframes, following approval from the North West London Integrated Care Board. Working collaboratively with the other trusts in the North West London Acute Provider Collaborative (APC), we have: • successfully piloted our approaches to the different learning responses, which have informed our guidance and investigation forms • developed our Patient Safety Incident Response Plan (PSIRP) in line with guidance and our local safety profile, which sets out what types of incidents we will investigate and how • commissioned and delivered PSIRF training with the other APC trusts for key roles to enable us to transition – 140 of our staff members have now been trained • achieved over 90 per cent compliance with the patient safety syllabus level one training for all staff, and launched level two (currently 26 per cent with plans to improve) • developed our approach to ensuring meaningful compassionate engagement for patients and families involved in incidents with our patient safety partners • implemented a new governance structure to support PSIRF delivery, including a new Safety Improvement Group which will oversee our improvement plans.
Implement Learn From Patient Safety Events (LFPSE)	Incident reporting is one of the most important sources of patient safety information, helping us to identify risks to patients and staff. Consistent reporting across the organisation enables us to identify actual or potential harm with more accuracy; analysing this data alongside other sources of intelligence helps us to learn and continuously improve. High rates of incident reporting are a good indication of a culture where staff feel supported to speak up. Over the course of the year we have seen a promising improvement in our incident reporting rate, particularly as our harm levels remain low (our rolling twelve-month percentage of incidents causing harm categorised as moderate or above is 0.87 per cent, below the national average of 2.61 per cent). Our patient safety incident reporting rate per 1,000 bed days is consistently above national average and has steadily increased over the last four years. In 2023/24 it was 63.8, compared to 57.1 in 2022/23. This year we have been working to transition to the new national way of reporting incidents called Learn from Patient Safety Events (LFPSE). This was completed in April 2024 following upgrades to our incident reporting system and a communication and engagement programme to help support our staff with the planned changes. Our focus for the coming year is on completing the procurement process for a new incident reporting system with the other North West London Acute Provider Collaborative trusts. The new system is expected to be in place by January 2025. As well as making it easier to report, and identify themes and learning from incidents, we will use the promotion of the new tool to highlight the importance of reporting incidents.

Involving patients in safety	In 2022 we recruited six patient safety partners (PSP) to support all elements of governance, monitoring and improvement related to patient safety. During 2023/24 our PSPs have been involved in: • our plans for PSIRF implementation, including the development of our compassionate engagement approach • our safety improvement priorities, with most priorities now having a PSP engaged in their steering group and actively supporting the work • our ward accreditation programme • delivering a collaborative event with the Institute of Global Health Innovation for world patient safety day 2023. Our PSPs have also been instrumental in developing our local strategy for involving patients in safety, which we will launch in 2024/25.

Reduce harm to patients through our safety improvement programme	
Focus area	**What did we achieve?**
Reduce infection transmission through improving basic standards of infection prevention and control (IPC) practice with a focus on hand hygiene	Hand hygiene is a key factor in the control of infection. This was one of our safety improvement priorities throughout the Covid-19 pandemic, which increased the risks associated with hand hygiene further. This was also a priority in 2022/23 and 2023/24 because incident and audit data showed there was more work needed to improve. In 2023/24 we: • designed behavioural nudge stickers following a successful pilot on three wards (11 per cent improvement in hand hygiene) which we will roll-out in early 2024/25 • launched a new monthly hand hygiene audit tool in October 2023, with the data used to shape local and Trust-wide improvement plans, including a specific programme for medical staff, who have the lowest compliance. We hope to see a steady improvement in the audit results, which are currently lower than we would like at 56 per cent (March 2024) • introduced 'glow box' and '5 moment' training with Ecolab, our supplier of clinical hand soap and gel, which is being deployed to areas which have had increases in infection rates • implemented bespoke training packages for Allied Healthcare Professionals, aimed at re-education on the core IPC principles, and the role they play in improving and sustaining high IPC standards • made changes to the infection related categories on our incident reporting sytem, to identify themes and issues and saw a positive increase in incident reporting • developed a policy and process to support staff to effectively challenge colleagues who are not complying with the requirements to be 'bare below the elbow', which will launch in 2024 • introduced a 'clinical cleaning' toolkit to support ward staff with what and how to clean patient-facing clinical equipment and improved the attendance of clinical staff on cleaning monitoring audits to over 80 per cent • continued our successful antimicrobial stewardship programme, and were recognised as the first UK Centre for Excellence by the Global Antimicrobial Stewardship Accreditation Scheme (GAMSAS) in 2023. Despite a huge amount of work, we have exceeded our yearly thresholds for four of the five mandatory reportable hospital acquired infections, in particular MRSA blood stream infections (with nine cases reported compared to five in 2023/24), E. coli blood stream infections and Clostridium difficile cases. There has been an increase in cases across the UK. There are also ongoing issues with the age and condition of our hospital estates, including lack of isolation rooms, dated ventilation systems, and water hygiene issues. Significant work programmes are in place to mitigate these where possible. Our education and support programme to improve basic standards of infection prevention and control practice will continue to be a safety improvement priority in 2024/25, with additional work focusing on encouraging good hand hygiene practice amongst our patients and visitors, supported by our PSPs. We will also continue work with our partners across North West London to support improvements across the whole of the patient pathway to minimise the risk of infection, including championing the newly developed catheter passport to help prevent catheter associated urinary tract infections.

Reduce the harm caused when undertaking invasive procedures by implementing the revised national safety standards for invasive procedures (NatSSIPs2)	This priority was chosen to improve patient and staff safety, processes and outcomes associated with invasive procedures. It was originally chosen in response to a series of never events in 2019/20 related to invasive procedures and has continued as a key area for improvement since. During 2023/24 we have worked on developing our plans to implement the new national safety standards for invasive procedures (NatSIPPs 2). The aim is to standardise, and educate across organisations and procedural teams to enable safe, reliable and efficient care for every patient having an invasive procedure. In 2023/24 we: • completed a gap analysis against the new standards to inform our improvement plan • updated our invasive procedure policy to reflect the new standards • undertook a training needs analysis and identified updates required to our existing training programmes • started a project with the Imperial Change Lab to improve digital consent across specialties using behavioural change techniques • began work on digitalisation of the WHO surgical safety checklist on Cerner in line with other North West London Acute Provider Collaborative trusts • updated and reviewed existing local safety standards for invasive procedures (LocSSIPs) • developed a framework for local safer surgery champions who will support improvements in safety culture through peer review and multidisciplinary observational audits. We will pilot this framework in early 2024/25. We are still seeing incidents where failure to follow key safety checks is a factor, including one never event declared in February 2024. We have also seen an increase in the percentage of moderate and above harm incidents in the category of operations and procedures in 2023/24, following a reduction in 2022/23 (1.96 per cent compared to 0.84 per cent). We still have much work to do to embed the new standards so this will continue as a priority in 2024/25.
Reduce harm from inpatient falls by improving the completion of a high-quality multi-factorial risk assessment (MFRA) at the point of admission and post fall assessments for people who have fallen	This has been an improvement priority for three years. Trust-wide improvement work is led by our falls prevention and safe mobility steering group. After analysing our incidents, in 2023/24 we focused on improving the completion of pre and post falls risk assessments and ensuring that positive safety actions are taken because of these assessments. We are pleased that following focused work with the divisions and changes to the electronic patient record to prompt staff action, we have achieved sustained improvement in some of these areas, particularly completion of falls risk assessments within six hours of admission (73.9 per cent in March 2024, compared to 65.9 per cent in March 2023). In 2023/24 we: • co-designed and piloted a system-based learning response to falls to support the transition to PSIRF • introduced a dedicated safe mobility and falls prevention team (funded for 12 months) who have begun engagement and support with training and education priorities • tendered for a shared falls prevention e-learning package with the other acute provider collaborative trusts • introduced a quarterly improvement collaborative to improve oversight and support of ward-based improvement work and provide a forum for recognition. Staff are provided with an evidence-based improvement tool kit, support to access and interpret data, and coaching from safety improvement leads. Outputs have included improved compliance with MFRA and techniques to minimise interruptions to enhanced observations. We are pleased that our falls rate remains below historically reported national average and that there were fewer falls resulting in moderate harm and above this year (28 reported in 2023/24 compared to 38 in 2022/23). However, there has been no statistically significant reduction in patient falls with harm since 2021 and this remains one of our most often reported incident types. This will continue to be a priority in 2024/25, with plans to develop a long-term improvement strategy.

Improve the checking of blood components prior to transfusion	Patients can be seriously harmed if given the wrong type of blood during a transfusion. This priority was chosen in 2022/23 to improve the checking of blood components at the bedside before transfusion following two never events during 2021/22. Work included the launch of a bedside checklist for blood administration and a core skills e-learning module (compliance is currently 96.8 per cent against a target of 90 per cent, excluding doctors in training). During 2023/24, following an increase in incidents of the wrong patient details on blood samples (Wrong Blood In Tube – WBIT incidents), we focused on improving in maternity areas, specifically at Queen Charlotte's and Chelsea Hospital (QCCH) which had the most incidents, with the aim to reduce these by 50 per cent by April 2024. We standardised sample collection bottles, increased printer numbers, mapped processes and co-designed solutions to improve safe practice. As a result, following a cluster of eight WBIT incidents in early 2023, we have not had one at QCCH since May 2023. Blood transfusion management will now transition to business as usual with monitoring through the Trust transfusion committee.
Improve the identification and management of adult patients with dysphagia	Patient nutrition and hydration is a cornerstone of meeting patients' basic health and care needs. In 2019 a patient died in another Trust from an incident of dysphagia (the medical term for swallowing problems) resulting from the ingestion of the wrong consistency diet. This incident led to publication of the National Confidential Enquiry into Patient Outcome and Death, "Hard to Swallow?". Following review of an increase in incidents, we identified some gaps in our assurance around the recommendations of this inquiry and this was confirmed as a safety improvement priority. Initial work focused on increasing incident reporting to support identification of key issues to understand the risks. This was successful, with an average of 22 incidents per month in 2023/24, compared to 10 per month in 2022/23. Themes we identified as a result have been used to inform our improvement plan, with progress so far including: • introduction of policies with associated implementation plans, outlining multi-disciplinary roles and responsibilities for safe eating and drinking clearly for the first time • a draft swallow screening tool developed with our acute provider collaborative partners, which is being tested within critical care • a review of education and training • improvements to the ordering process for texture-modified foods • improvements to the electronic patient record, including a prompt to consider swallowing when switching to oral medications from intra-venous and improvements to the discharge documentation. We still have work to do to deliver our improvement plans, and will carry this forward as a priority for 2024/25.

Improving fetal monitoring during labour	Cardiotocography (CTG) is the most widely used technique for assessing fetal wellbeing in labour. CTG should be systematically reviewed by two qualified professionals – this is called 'fresh eyes'. This was identified as an improvement priority in mid-2022 following concerns raised from recent incidents, and the compliance with hourly fresh eyes reviews of CTGs on our labour wards. Since this project was launched, we have seen a steady improvement on both sites with fresh eyes compliance, which is now at 91 per cent; an increase from 64 per cent in November 2022 at the start of the project. We have also developed and tested a holistic risk assessment tool for use during labour to help identify, communicate and escalate increasing risk by making patterns visible over time. A paper version is now being used for all women in labour to help assess and monitor key risks. We are working to build an interactive version of the tool in Cerner, which will reduce the need for duplication and optimise usability, accessibility and record keeping. The aim is for this to be live by the end of 2024. To help staff improve the accuracy of their CTG interpretation, as well as improve confidence, guidance is now displayed on the CTG machines and lanyard cards have been designed with CTG guidance and escalation tools to assist staff. We also redesigned our fetal monitoring training and compliance was 95 per cent by April 2024. Improvement work is progressing well and the risk assessment tool will now be implemented alongside other work underway within our maternity and neonatal services to fully implement the Saving Babies' Lives Care Bundle version 3 (2023). This will therefore be stepped down as a priority, with ongoing monitoring as part of regular maternity governance.
Reducing harm in maternity through implementing a new process for the management of test results, including urine specimens	The aim of this priority is to reduce variability and provide assurance that abnormal results in maternity across all teams are acted upon quickly. This became a safety improvement priority in July 2022 because missed follow-up of results was a contributory factor in some maternity incidents. In 2023, we adopted a new method for reviewing and endorsing results in Cerner across the Trust. We have been working to adapt this process to fully replace the current paper systems and meet the unique needs of our maternity services. A potential model is currently being tested, with the aim to go live in July 2024. As this project moves from collaborative design into implementation, it will be stepped down as a priority and monitored as part of regular maternity governance.

Reduce medication related harm – anticoagulants and insulin	Issues related to medications are one of our most frequently reported types of patient safety incidents, however the percentage of these causing moderate or above harm to patients remains low at 0.63 per cent (12/1901). Through regular review of our incident data we identified two specific areas where we have an opportunity to improve patient safety: anticoagulant therapy and insulin. **Anti-coagulation** In 2023/24 we: • agreed funding for a clinic to support patients discharged on all anticoagulation treatment. Recruitment is in the final stages and we have started mapping new treatment pathways • reviewed and updated all pre-procedure guidelines for anticoagulation in line with national guidance • focused improvement work with specialties who are not meeting the target to complete Venous thromboembolism (VTE) risk assessment for at least 95 per cent of all patients within 24 hours of admission (we consistently exceed this at Trust level and in most areas) • updated our patient information leaflets and put in place processes to help make sure all patients at risk of VTE are given these at admission and discharge. Further work is needed including Cerner workflow updates and implementation of the anticoagulation clinic. This will continue as a priority for 2024/25. **Insulin** In 2023/24 we: • piloted a dispensing change for insulin pens that will reduce the risk of incorrect device selection and decrease pen wastage • identified changes to ensure segregation of storage • reviewed the available national training with plans to develop a Safe Use of Insulin electronic training module, incorporating Diabetes UK and Diabetes Getting it Right First Time (GIRFT) Ten Point Training • Improved the availability of insulin syringes through regular drug stock security audits and review through the ward accreditation programme. We recently declared a never event involving an overdose of insulin for a patient whilst in theatre. Previous work has focused primarily on ward-based care by nursing staff. Once the investigation has been completed we will identify further actions to include in our workplan. In light of this, and our ongoing actions, we plan to continue this as a priority for 2024/25.

Improving the treatment of patients with sepsis and signs of deterioration – with a focus on appropriate treatment escalation.	Following review of key themes from incidents and mortality reviews, we expanded the scope of this priority for 2023/24 to include improving the treatment of patients with sepsis and signs of deterioration with a focus on appropriate treatment escalation. The improvement plan is led by a newly established deteriorating patient and sepsis steering group, and we have appointed a clinical lead, providing essential medical leadership for the programme. In 2023/24, we have: • implemented an improvement plan for CPR and treatment escalation decisions, co-designed with the trust end-of-life care steering group • implemented 'Call for Concern' – this enables patients and families to call for immediate help and advice when they feel concerned that the health care team has not recognised deterioration in someone's clinical condition • successfully achieved the national NEWS2 CQUIN (Commissioning for Quality and Innovation) which aims to improve the care of deteriorating patients. Sixty-six per cent of unplanned critical care unit admissions from non-critical care wards had a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in the patient's notes, against a target of 30 per cent. This has been supported by the extension of our critical care outreach services, which are now available 24/7 across all sites. We have also developed plans to improve our response to sepsis. Our data shows that we do not always respond as quickly as we could when a patient is diagnosed with sepsis, with 87.5 per cent receiving antibiotics within one hour against a target of 90 per cent. All patients have been reviewed, with minimal harm identified due to the delays. Feedback from clinical teams led to a review of the electronic alert which prompts clinicians to consider sepsis as a diagnosis, with changes planned to support staff to make accurate choices during responses. In the meantime, education continues within the divisions to support improvements; this has been particularly successful within the division of surgery and cancer where we met targets for four out of six of the last months. We are also developing a new deterioration and sepsis pathway, alongside processes for screening and assessment of sepsis, in response to new national guidance. This will remain a safety improvement priority for 2024/25. In addition to our ongoing improvement plans, we will develop a plan to fully implement Martha's Rule. We have two elements in place already (24/7 critical care outreach team, and Call for Concern); the third is to implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily.
Improve the experience of patients who are waiting for care with a targeted harm review	We introduced a process for clinical prioritisation and harm review of patients waiting for surgery in 2020, after the loss of elective care activity and reduced productivity as a result of Covid-19. This was designed to ensure that treatments are prioritised for the most urgent patients (those whose surgery is classified as P1 – emergency, or P2 – urgent and needs to occur in less than one month) and to identify any potential or actual harm which may have occurred as a result of delays. At the beginning of 2023, through our clinical harm review assurance group, we developed some targeted clinical harm processes to ensure that we are reviewing patients in other cohorts which were identified as at risk of harm due to delays. We are not identifying many cases of significant harm through these processes, and they are providing some assurance that harm for patients is being reported and investigated through our incident management processes. Key areas where we have identified risks to patient safety and put actions in place in response include: • management of patients with sepsis and patients who fall or acquire an infection while awaiting discharge; improvement actions are being taken forward through the workstreams described above • patients waiting for a complex cardiac procedure. A quality review process is in place for the specialty with a focus on supporting improvement in demand/capacity management for priority patients • patients waiting for treatment or diagnostics. A programme is now in place to improve the management of some of our cancer pathways, in particular breast, lung and prostrate. The learning from these processes is being used to develop ongoing oversight and monitoring in the key risk areas, which will include divisional reviews and a regular audit schedule. This will now be stood down as a priority, with monitoring through the clinical harm assurance group.

Improve the treatment of patients with deterioration in their mental health

What did we achieve

During 2023/24 we have developed and begun delivery of a mental health strategy and action plan. This is monitored through a monthly mental health care improvement steering group attended by key internal and external stakeholders. In the last year we have:

- developed a collaborative staff training plan to promote positive behaviours and manage acute behavioural disturbance working alongside health and safety, security and clinical colleagues
- implemented a mental health awareness training programme for multi-disciplinary teams following an external training needs analysis
- developed a suite of mental health related policies to address improvements in practice and meet legislative requirements
- built a mental health platform on the electronic patient record
- carried out environmental risk assessments and successfully bid for funds to improve safety
- piloted a new protocol to support long-stay mental health patients in our emergency departments with regular liaison psychiatry reviews, access to psychiatric medication and regular nursing interventions
- created new posts to address mental health care and support needs to reduce reliance upon temporary staffing.

This will continue as a quality priority for 2024/25.

User insights and focus

What did we achieve

In 2023 our new central insight and experience team started work on a new approach to how we collect, interpret, and apply 'user-insights' to inform and shape our work and deliver improvements. Some examples include:

- End-of-life care: we used research studying people with lived experience of a family member or friend dying in hospital to inform improvements to information for people visiting someone who is in their last days or hours of life and to the end-of-life. We are also making changes to the feedback survey, due to be in place by June 2024. This work has also influenced our end of life care strategy.
- Outpatient services: feedback from user groups is now being used to inform the design of our outpatient improvement programme.
- Interpreting services: last year a review of our interpreting services showed that poor services are contributing to inequitable care. We appointed a dedicated patient interpreting improvement lead to deliver and coordinate a range of immediate improvements and co-design our longer-term interpreting strategy.

We have also worked to improve our responsiveness to complaints and concerns and integrate our approach with PSIRF processes.

This will remain a priority for 2024/25, focusing on the outpatient improvement programme, cancer care pathways, and our interpreting services.

Embed our ward accreditation programme as an enabler for Pathway To Excellence®

What did we achieve

The Pathway to Excellence programme (PtE®) is a global accreditation initiative aimed at promoting collective leadership, research, and innovation in healthcare organisations. It is run by the American Nurse Credentialing Centre (ANCC). We are one of only fourteen trusts selected by the Chief Nursing Officer for England for this prestigious programme. Charing Cross Hospital was chosen as the pilot site with the goal of achieving PtE® accreditation by mid-2024. If successful, Charing Cross would be the first London teaching trust to achieve the standard.

Our Ward Accreditation Programme + (WAP+) aims to support PtE®, as well as deliver continuous improvement in nursing care. It accredits wards in a variety of metrics across the six PtE® standards (leadership, shared decision-making, safety, quality, professional development and wellbeing).

During 2023/24 we have:

- accredited 72 clinical areas using the revised WAP+ methodology. We co-created bespoke metrics for specialist clinical areas and included our patient safety partners in programme delivery and design. We have seen evidence of strong clinical leadership, positive staff behaviours, and good patient experience data. Areas for improvement are shared with clinical areas and responded to as part local action plans or trustwide programmes e.g. hand hygiene.
- celebrated achievements through the DAISY scheme – an international nurse recognition programme. Three hundred nurses have been nominated by relatives and carers and twenty individuals have received honours awards for their work.
- ran 28 decision councils where nurses present their improvement projects ranging from improving patient pathways and care, staff wellbeing and improving efficiency. Many of these were presented to the chief nurse and chief executive at our leadership councils, attended by over 400 staff.
- submitted our pathway standards evidence document to the ANCC for review.

Given our ward accreditation programme is showing positive results, this programme will transition to business as usual. We will maintain the Pathway to Excellence core standards through our ward accreditation and improvement programmes, and if we achieve accreditation at Charing Cross, will consider introducing the process on our other sites.

1.2 Statements of assurance from the board

This section includes mandatory statements about the quality of services that we provide, relating to financial year 2023/24. This information is common to all quality accounts and can be used to compare our performance with other organisations. The statements are designed to provide assurance that the board has reviewed and engaged in cross-cutting initiatives which link strongly to quality improvement.

Review of services

In 2023/24, we provided and/or sub-contracted 110 NHS services. We have reviewed all the data available to us on the quality of care in these NHS services through our performance management framework and assurance processes.

The income generated by the NHS services reviewed in 2023/24 represents 95 per cent of the total income generated from the provision of Trust services in 2023/24. The income generated by patient care associated with these services in 2023/24 represents 86 per cent of the total income generated from the provision of services by the Trust for 2023/24.

Participation in clinical audits and national confidential enquiries

We use clinical audits to benchmark our care against local and national guidelines so we can make changes to areas requiring improvement as part of our commitment to ensure the best treatment and care for our patients.

During 2023/24, 65 national clinical audits covered relevant health services that we provide. During this period, we participated in 97 per cent of national clinical audits and 100 per cent of national confidential enquiries.

The national clinical audits and national confidential enquiries that we were eligible to participate in are included in a table in Annex 3. The number of cases submitted are presented as a percentage where available. Please note that these will be accurate up to March 2024 when host organisations were contacted, but some data collection was still ongoing.

National clinical audit

We reviewed the reports of 49 national clinical audits and confidential enquires in 2023/24. These clinical audits, linked to our focused improvement work, have identified several areas of excellent practice as well as opportunities for development and improvement. Some examples of these national audit reports are given below to indicate the range of work and performance across the Trust.

National Audit of Inpatient Falls (NAIF)

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

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) 2021 Perinatal Mortality Report

The perinatal mortality surveillance covered perinatal deaths from 22 weeks gestational age (including late fetal losses, stillbirths, and neonatal deaths) of babies born between 1 January and 31 December 2021. The audit showed that our stabilised and adjusted mortality rates were similar to, or lower than, those seen across comparable trusts and health boards in the comparator group with a Level 3 neonatal intensive care unit. There has been a year-on-year reduction in stillbirths.

All cases are investigated using the Perinatal Mortality Review Tool, with insights feeding into our improvement plans.

Our maternity and neonatal services focus on a number of national and local schemes to improve patient safety, quality and experience, including the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (year 5) which we reported full compliance with in February 2024, the national three year delivery plan, and implementation of the Saving Babies' Lives care bundle (version 3).

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

NACEL evaluates the quality and outcomes of care experienced by dying people and those important to them in hospitals in England and Wales.

Overall, results were positive and the report was graded as 'acceptable risk/reasonable assurance'. The possibility of dying was recognised in 96 per cent of expected deaths. In 68 per cent, dying was recognised over 48 hours before death occurred giving time for individualised end-of-life care plans to be agreed (three quarters of patients recognised to be dying had one of these in place). The majority of patients were involved in CPR and treatment escalation discussions with senior doctors, and if they couldn't be this was communicated and documented. This year's audit demonstrated high compliance with documentation of the more general assessments (e.g. bowel, bladder, skin, pain, shortness of breath) but scored much less well for the more end of life focused assessments of nausea, secretions, agitation and mouth care. The results have fed into the end of life strategy.

Local clinical audit

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

Audit title	Audit findings
Consultant ward round audit	This audit was focused on transfers from the Emergency Department to inpatient wards (patients referred to specialties for admission). The audits assessed whether there was documented evidence of a ward round taking place daily, whether a consultant was present at each of these ward rounds and whether any emergency inpatient admission was seen by a consultant within 14 hours. The audit showed substantial assurance that ward rounds are occurring daily, however consultants were not always present. Improvements are being taken forward as part of the work to deliver the seven day services standards described later in this section.
Bed rails audit	The audit reviewed whether bed rails were being used appropriately, and whether risk assessments were completed, and patients, relatives or carers were educated about the potential risks. The results showed improvement needed for all elements, which our safe mobility and falls prevention steering group are working on.
Air flowmeter audit	A national patient safety alert was issued in 2021 asking all providers to discontinue the use of air flowmeters because there was a significant risk that patients may be inadvertently connected to medical air instead of oxygen. This audit was to provide assurance that air flowmeters were no longer in use and all air flowmeters have been removed and sent to Clinical Engineering for disposal. Ten air flowmeters were found on five wards during the audit, and none of these were in use. These were all sent to the equipment library for immediate disposal.
Consent audit	This looked at the use of consent form 4 (for adults who are unable to consent for treatment) on our online consent platform. Overall compliance was 97 per cent. We identified improvements around documentation of mental capacity assessments which are being taken forward by the mental capacity steering group.

In addition to the Trust-wide audit work described above, specialties within directorates conduct local audit activities which provide information on how their services are performing. Throughout 2023/24 there were 286 local audits registered. These reports, including any action plans, are reviewed through local audit and risk governance meetings and logged centrally.

Our participation in clinical research

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

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

The NIHR Imperial BRC, the largest in the country, has been operating for over a year. The BRC focuses on experimental medicine – early phase discovery science trialled in the clinic for the first time – and is structured around four main strategic areas:

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

BRC highlights from the past year include a practice-changing trial in coronary intervention for particular heart conditions, new insights into mortality rates from cancer which vary due to population inequalities, a potential new approach to enable doctors to distinguish between bacterial and viral infections in febrile children, and further understanding of how the Covid-19 virus behaves in the upper respiratory tract.

We continue to invest in the analysis of large, interlinked datasets, and to develop new artificial intelligence (AI) tools to assist in clinical decision-making, including a combining medical imaging with AI to provide "virtual biopsies" of patients with lung cancer.

We also have a strong focus on those sectors of our population who are underrepresented or underserved in terms of their involvement and inclusion in clinical research, with a view to addressing the wide variations in health across our local and national populations. We aim to widen access and increase opportunities for participation in clinical research to better reflect our patient demographics. This is essential to developing and rolling out health technologies which are effective for all.

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

The total number of patients receiving NHS services provided or sub-contracted by the Trust in 2023/24 that were recruited to participate in research approved by a research ethics committee was 23,248. 19,171 patients were recruited into 406 NIHR portfolio studies in 2023/34 – this includes 522 patients recruited into 103 studies sponsored by commercial clinical research and development organisations.

Our CQUIN performance

Commissioning for quality and innovation (CQUIN) is a quality framework that allows commissioners to agree annual payments to hospitals based on the number of schemes implemented. The total value of the schemes we signed up to in 2023/24 is 1.25 per cent of the contract value for NHS specialised healthcare services as agreed with NHS England, and 1.25 per cent of the contract value for schemes agreed with the Integrated Care Board .

The schemes we signed up for along with progress made is shown in the table below.

CQUIN title	Progress
CQUIN03: Prompt switching of intravenous (IV) to oral antibiotic	Achieved
CQUIN05: Identification and response to frailty in emergency departments	Achieved
CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions	Achieved

CQUIN09: Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres	Ongoing technical issues with extracting the data at a national level. Other metrics are being monitored and are on track.
CQUIN12: Assessment and documentation of pressure ulcer risk	Not achieved. Compliance was 55 per cent against an 85 per cent target. Actions are in place to improve, including training, education and a ward champion programme. A new improved adult risk assessment tool will be implemented across the trust in 2024/25 and rolled out to maternity and paediatrics in 2025/26.

Following consultation, NHS England have announced that the CQUIN scheme will be paused in 2024/25. They have published a non-mandatory set of quality indicators that providers and commissioners may choose to use locally. We are working with the ICB and the other trusts in the Acute Provider Collaborative to confirm these local improvement initiatives.

Statements from the Care Quality Commission (CQC)

We are required to register with the CQC for all of our sites. We were compliant with the requirements of our CQC registration during 2023/24 and our current registration status is 'registered without conditions'. We were not subject to any enforcement action this year. Our overall CQC rating remains 'requires improvement'.

The CQC returned to routine activity (including inspections) in January 2024, and also continue to carry out urgent inspections for serious concerns. We were not subject to any inspections in 2023/24.

Following an inspection of our maternity services in March 2023, capturing both NHS and private care, the final report and our updated ratings were published in July 2023. We were delighted to retain our 'outstanding' rating, which is positive recognition of the hard work and commitment of our maternity and neonatal teams.

Our data

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

NHS number and general medical practice code validity

We submitted records during 2023/24 to the Commissioning Data Sets (CDS) Dashboard (formerly the secondary uses service) for inclusion in the hospital episode statistics. The percentage of records in the published data, which included the patient's valid NHS number was:

1. 98.3 per cent for admitted patient care
2. 99.5 per cent for outpatient care
3. 94.6 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:

1. 100 per cent for admitted patient care
2. 100 per cent for outpatient care
3. 100 per cent for accident and emergency care.

Data security and protection toolkit

The data security and protection toolkit is an online self-assessment tool that all organisations must use if they have access to NHS patient data and systems, to show they are securely handling personal information.

For the 2022/23 DSPT submission, we met all the mandatory standards of the toolkit and therefore produced a 'satisfactory' return. The outcome of the 2023/24 submission will be confirmed by 30 June 2024.

Clinical coding quality

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

We were not subject to any clinical coding audits by NHS commissioners in 2023/24.

Data quality

For 2022/23 as a whole, we achieved the benchmark for the Data Quality Maturity Index, a national measure of data quality that monitors coverage, consistency, completeness and validity across a number of datasets, and is published by NHS England.

However, we recognise that the pandemic, industrial action, our growing waiting list for planned care and some of our wider operational challenges have had an impact on our waiting list data quality and we continue to prioritise improvement in this area. Progress is managed through our waiting list data quality and reporting framework, which reports regularly to the executive management board. An important component of this is a quality assurance and sample audit process to inform training, learning and development. The performance support team carries out routine audits of referral to treatment (RTT), emergency care metrics, diagnostics (DM01) and cancer waiting time data.

Learning from deaths

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

Structured judgement review is a validated methodology in which trained clinicians critically review medical records and comment on and score phases of care through the patient journey and determine if there were any problems with the care delivered. These undergo further review and, dependent on any issues identified, may be subject to more in-depth investigation via our incident management processes to identify further areas for learning and improvement. In addition to this, a regular death review panel reviews complex cases or cases where problems with care have been identified by bringing together all associated investigations.

We have aligned our quality of care scoring system with other Trusts in the NWL Acute Provider Collaborative so that we can better share information from these reviews, with a final decision then being made on whether the death was more likely than not to have occurred due to problems in care. We have also agreed a standard set of triggers for a structured judgement review if concerns are raised.

Patient deaths: 1 April 2023 to 31 March 2024

	Q1	Q2	Q3	Q4	Total
Number of patients who died – based on date of death	443	414	445	461	1,763
Number of deaths referred for SJR – based on date of death	39	67	73	70	250

Deaths which occurred in 2023/24

Of the 1,763 deaths which occurred in 2023/24, all deaths were subject to medical examiner review, and 250 were referred for structured judgement review. Of the 259 deaths which have had these reviews completed (the number also includes some structured judgement reviews completed that were allocated in 2022/23 but completed in 2023/24), there were 11 for which some issues were identified in the overall care delivered. The key themes from these were around improving end of life care and recognising and responding to the deteriorating patient; these are included in our quality and safety improvement priorities.

Of these 11, the death review panel has reviewed three cases so far and has confirmed poor care in two. The panel concluded that in one case, the poor care more likely than not contributed to the death. There are seven cases for which further investigation is required before a final decision can be made. During 2023/24, the panel also reviewed seven deaths that occurred in 2022/23; poor care was confirmed in five of these and for one it was felt that the poor care contributed to the death.

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

There were 57 perinatal mortality reviews reported to MBRRACE-UK in 2023/24 for babies who died in the year, of which 44 reviews were completed. Four had care or service delivery issues identified that may have changed the outcome. We started the year with a backlog of 86 PMRT cases caused by pausing of the review process during pandemic surges. During the year, all cases were reviewed, 81 have been completed with reports published and four had care or service delivery problems identified which may have changed the outcome.

Learning from these cases has led to a number of changes to improve care, including improvements to our bereavement care and facilities, changes to our electronic record to make risk assessments easier to access and amend, and improved access to interpreters.

We have worked to align our maternity and neonatal death processes, including the PMRT process, with our overall mortality review governance and reporting to improve visibility of outcomes and actions. This was implemented in the second quarter of 2023/24.

The outcomes of mortality reviews are shared with the clinical teams for review and development of actions at their specialty mortality and morbidity (M&M) meetings. In 2023/24 we introduced new guidance for these meetings to improve how they are run and how the outputs are documented. Cases are also shared with the safety improvement programme workstream leads to ensure the improvement work covers the findings of the reviews.

Throughout 2023/24, we continued to expand our medical examiner service to include deaths which occur in the community within the London Borough of Hammersmith & Fulham and the City of

Westminster. This will improve how we learn from deaths across the local healthcare system. This is in advance of death certification reforms due for statutory implementation in England and Wales from September 2024.

Seven-day hospital services

From 2018, all NHS trusts have been required to report their activity and progress towards delivering high quality and consistent levels of service and care seven days a week. There are 10 defined standards for seven-day services, of which NHS England classify four as key standards. Our compliance with the four key standards is:

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

Although our policies and procedures support delivery of standards two and eight, and this is the expected standard of care here in the Trust, our audit and incident data demonstrate that we do not consistently achieve this across all areas. For example, although all areas audited demonstrated that daily ward rounds occur, they were not always led by a consultant. Our main action is to improve ward and board round routines; a programme to do this was launched in 2022. We are making good progress, with data showing that board rounds are now happening consistently in the majority of areas, with an increase from 41 per cent to 88 per cent.

Rota gaps

We have 823 doctors in training working at the Trust, with 41 gaps on the rota. 26 of these gaps have been filled by locally employed doctors. We have 15 unfilled posts, 8 of which are being recruited to. In addition to recruiting, we take action each month to make sure that the rotas are filled, including proactive engagement with Health Education England so we can accurately plan targeted campaigns for difficult to recruit specialties and the use of locums, where necessary.

1.3 Reporting against core indicators

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

Mortality

As part of our drive to deliver good outcomes for our patients we closely monitor our mortality rates, using two indicators, HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator), which enable us to compare ourselves with our peers. The two measures differ slightly in methodology. SHMI is the official measure of all deaths that occur in England, including those that occur within 30-days of discharge from hospital. HSMR measures more variables than SHMI, such as patients receiving palliative care, deprivation and whether the patient has been transferred between providers. We believe using both measures gives us the best picture of our mortality rate across our hospitals.

SHMI

National performance 23/24*				Trust performance 23/24*			
	Mean	Lowest	Highest	2023/24	2022/23	2021/22	2020/21
SHMI	100	72.6	122.93	75.59	76.25	72.73	77.02
Banding**	2	3	1	3	3	3	3
% deaths with palliative care coding	41.00%	15.00%	66.00%	64.00%	64.00%	61.00%	56.00%

*National and Trust position currently rolling 12 months from October 2022 to September 2023
**SHMI Banding 3 = mortality rate is lower than expected
Source: NHS Digital / Telstra Health

HSMR

Trust performance*				
	2023/24*	2022/23	2021/22	2020/21
HSMR	72.5	77.8	68.03	75.9
National performance	5th lowest HSMR of all acute non-specialist providers	3rd lowest HSMR of all acute non-specialist providers	6th lowest HSMR of all acute non-specialist providers	3rd lowest HSMR of all acute non-specialist providers

*National and Trust position currently rolling 12 months from December 2022 to November 2023
Source: Telstra Health

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

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

We intend to improve our mortality rates by:

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

Patient reported outcome measures (PROMs)

Patient reported outcome measures assess quality from the patient perspective and seek to calculate the health gain experienced following surgery for hip replacement and knee replacement. Patients who have these procedures are asked to complete the same short questionnaire both before and after surgery. Analysis of any differences between the first and second questionnaires is used to calculate the overall health gain.

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

	National performance*			Trust performance			
	Mean	Best	Worst	2021/22*	2020/21	2019/20	2018/19
Hip replacement surgery (EQ-5D)	0.456	0.779	-0.035	0.666	0.535	0.468	0.480
Knee replacement surgery (EQ-5D)	0.324	0.74	-0.034	0.523	0.316	0.425	0.310

Source: NHS Digital
*2021/22 data is latest full year of data available.

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

- we have a process in place to collect, collate and calculate this information monthly, which is then sent to NHS Digital
- we are performing above the mean for both hip and knee replacement surgery.

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

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

28-day readmissions

	National mean*	2023/24*	2022/23	2021/22	2020/21
28-day readmission rate (Patients aged 0-15)	10.31%	5.51%	5.30%	5.35%	4.80%
28-day readmission rate (Patients aged 16+)	8.60%	6.20%	6.01%	6.32%	6.18%

*Most recently available data covers the period of October 2022 to September 2023

We believe our performance reflects that:

- we have maintained our low unplanned readmission rate for both paediatric patients and adult patients with both rates remaining below national average throughout the year.

We intend to take the following actions to improve this percentage:

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

Staff recommendation to friends and family

The extent to which our staff would recommend the Trust as a place to be treated is as measured by the national staff survey is another way to measure the standard of care we provide. We are above the acute trust average for this question, and also for staff who would recommend their organisation as a place to work. We also scored well for staff saying care of patients is their organisation's top priority, up from 80 per cent in 2021 to 82 per cent in 2023.

	National performance			Trust performance		
	Average (acute trusts)	Best	Worst	2023	2022	2021
Percentage of staff who would recommend the Trust to friends and family needing care	63.32%	88.82%	44.31%	74.28%	73.34%	74.24%

	National performance			Trust performance		
	Average (acute trusts)	Best	Worst	2023	2022	2021
Percentage of staff who would recommend the Trust as a place to work	60.52%	77.09%	44.05%	68.71%	66.05%	64.41%

Another key measure in the NHS Staff Survey is the overall measure of engagement and morale. Overall engagement measures motivation, involvement and advocacy. In 2023, our overall score for engagement was 7.08, increased from 7.02 last year, and is above the average for acute trusts in 2023 (6.91). The same trend is seen in the overall score for morale, where we are above the average for acute trusts and improved since 2022.

These results show that we are making progress in a number of areas, despite incredibly challenging demands on our staff. This includes increased scores for all questions at Trust level about team working, line management and compassionate leadership that show the impact of our 'improvement through people management programme'.

Other areas where we have seen improvement include: equality, diversity and inclusion; retention; wellbeing; and questions relating to values and behaviours. These map to the areas where we have implemented a range of improvement programmes.

The one theme where we remain below the national average is flexible working, which will remain a priority in 2024/25, although there have been two years of improvement from 5.89 in 2021 to 6.10 in 2023.

We use the results to identify areas for improvement at Trust, Divisional, Directorate and department level and incorporate these findings into our 2024/25 people priorities.

Patient feedback and experience

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

Since 2015, we have used the national friends and family test (FFT) question as a tool to collect patient feedback across all our clinical areas, including accident and emergency (A&E), inpatients, maternity and outpatients. Since 2020 the question has asked: 'Overall how was your experience of our services?' Those who respond can choose from the following options: very good, good, neither good or poor, poor, very poor or don't know.

We publish monthly FFT results on the Trust website (https://www.imperial.nhs.uk/experinceresults) and on the NHS England website (https://www.england.nhs.uk/fft/). You can also view our average performance scores for 2023/24 A&E and inpatient services below. The rating is based on the percentage of people who describe the service as very good or good.

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

A&E friends and family test

	National performance 2023/24			Trust performance 2023/24		
	Mean	Best	Worst	2023/24	2022/23	2021/22
Score	79%	88%	65%	84%	82%	84%

The average participation rate in 2023/24 was 6.7 per cent. This is slightly lower than 2022/23, of which was 7.3 per cent.

We believe our performance reflects that:

- at a time of extreme pressure and competing demands, extended winter pressures and strike action, we have tried to maintain a high standard of care. This is reflected in an overall improvement in our results, which are above national average.

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

- running a two-year dedicated work programme to ease the pressure on our urgent and emergency services, especially during the winter. This has included efforts to increase physical capacity by creating 50 extra beds during winter, two new resuscitation bays and a new four-bed children's assessment unit, and refurbishing and expanding Charing Cross Hospital's emergency department.
- working to improve the flow of patients through our hospitals (further detail can be found in the performance section of the annual report, which is published on our website).

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

Friends and family test

	National performance 2023/24			Trust performance 2023/24		
	Mean	Best	Worst	2023/24	2022/23	2021/22
Score	95%	98%	92%	96%	96%	95%

The average participation rate over the past year has been 34.92 per cent. This was a higher rate than 2022/23, which was 32.25 per cent.

Responsiveness to inpatients' personal needs

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

	National performance 2022/23			Trust performance		
	Mean	Best	Worst	2022/23	2021/22	2020/21
Score	72	86	62	72	73	70.8

**The most recent data is from the national survey which was published in September 2023 for data from 2022

We believe our performance reflects that:

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

We intend to take the following actions to improve these scores:

- continuing to work to be more user focused, with patient feedback central to our improvement plans (see our improvement priorities for more information).

Venous thromboembolism

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

	National performance*			Trust performance			
	Mean	Best	Worst	2023/24**	2022/23	2021/22	2020/21
Percentage of patients risk assessed for VTE	95.5%	100%	71.8%	97.1%	96.5%	96.4%	96.6%

Source: Trust Data – suspended reporting to NHS England/Improvement
*National performance data is currently suspended – figures reflect performance from 2019/20 National data.
**2023/24 based on Trust data.

Our performance reflects that:

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

We intend to improve this percentage by:

- working with the areas that are below target to support staff to complete the assessment
- improving how we manage anticoagulation therapy through our safety improvement programme priority.

Clostridium difficile

	National performance*			Trust performance			
	Mean	Best	Worst	2023/24	2022/23	2021/22	2020/21
Rate of Clostridium difficile per 100,000 bed days	29.4	0	96.2	24.1	27.7	25.3	16.5
(Number of cases)				85	90	71	59

*National performance figures are based on UK Health Security Agency (UKHSA) epidemiological data
***Change to UKHSA *C.diff* definitions

Our performance reflects that:

- we reported 85 cases of *C.difficile* attributed to the Trust. This is above the threshold allocated to us by NHSE of 65 cases, but slightly fewer cases than in 2022/23. Our rate is below the national mean. We have had no lapses in care this financial year and none in the previous financial year 2022/23, an improvement for the Trust when compared with the two lapses in care reported in 2021/22.

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

- reducing the use of anti-infectives (antibiotics) and improving our hand hygiene rates to reduce the incidence and transmission of infection.

Patient safety incidents

	National performance*			Trust performance			
	Mean	Best	Worst	2023/24	2022/23	2021/22	2020/21
Patient safety incident reporting rate per 1,000 bed days	53.9	205.5	23.7	63.8	57.1	56.6	52.1

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

We believe our performance reflects that:

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

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

- continuing to highlight the importance of reporting incidents and ensure we feedback to our staff, and patients, the improvements we have made as a result of the incidents they report
- making it even easier for our staff to report incidents through procurement of a new incident reporting system. This system will also allow us to pull incidents from our electronic patient record (Cerner) and capture more data on adverse events that can inform our improvement plans. In advance of this, we are planning a pilot of direct Cerner incident pulls, starting with falls.

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

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

(N.B. these processes changed in April 2024 following implementation of PSIRF)

	National performance*			Trust performance			
	Mean	Best	Worst	2023/24	2022/23	2021/22	2020/21
Percentage of severe/ major harm incidents	0.26%	0.02%	1.06%	0.10%	0.13%	0.10%	0.12%
(Number of incidents)				23	26	19	18
Percentage of extreme harm/death incidents	0.14%	0.00%	0.90%	0.08%	0.05%	0.03%	0.06%
(Number of incidents)				19	10	6	9

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

We believe our performance reflects that:

- our percentages of incidents causing harm remain below national average (compared to the most recently available national data). When considered with our mortality rates and the outcomes of our learning from deaths process, we believe this demonstrates that we are providing safe care for the majority of our patients. However there was an increase in the number of extreme harm incidents reported compared to the previous year. Themes and learning from these cases have been used to identify our improvement priorities.

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

- continuing to work to eliminate avoidable harm and improve outcomes. See 'Our 2024/25 Improvement Priorities' section for more detail.

PART 2:

OTHER INFORMATION AND ANNEXES

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

Our performance with NHS oversight indicators

NHS England uses several national measures to assess services and outcomes. Performance with these indicators acts as a trigger to detect potential governance issues and prompt further investigation of support needs. We report on the majority of these monthly through our performance scorecards and to the Board in common through the acute provider collaborative operational performance dashboard.

Key performance indicators

A narrative summary of our performance against our key operational targets for 2023/24 and the major developments of the past year can be found in our annual report, which is published on our website.

Note that as of October 2023, new national standards for cancer waiting times were introduced, moving from ten standards to three headline standards. This is reflected in the table below.

		Performance		Quarterly trend			
		Target	Annual	Q1	Q2	Q3	Q4
Ambulance handovers	% patients waiting less than 30 minutes between ambulance arrival and handover	95%	95.2%	94.0%	95.3%	94.6%	96.8%
Emergency care waits	% patients waiting over four hours in urgent and emergency care	95% (with nationally set target to achieve 76% in March 2024)	75.2%* (77.8% in March 2024)	76.0%	77.0%	71.9%	76.4%
Referral to treatment times	% incomplete pathways less than 18 weeks (in aggregate)	92%	57.1%	59.1%	57.4%	56.2%	55.5%
Referral to treatment times	Patients waiting over 78 weeks for elective care	0	63 at March month end (0.06% of RTT waiting list)	-	-	-	-

Referral to treatment times	Patients waiting over 65 weeks for elective care	0 by March 24 (with objective extended to September 2024)	756 at March month end (0.76% of RTT waiting list)	-	-	-	-
Diagnostics	Maximum six week wait for diagnostic procedures	1% (with objective of improving during 2023/24 to 5% or less by March 2025)	10.0%	9.0%	10.2%	7.8%	12.7%
Cancer access initial treatment	Two-week wait	93%	N/A	92.4%	93.7%	N/A	N/A
Cancer access initial treatment	Breast symptom two week wait	93%	N/A	89.9%	90.4%	N/A	N/A
Cancer access initial treatments	% cancer patients treated within 62 days of urgent GP referral	94%	N/A	65.2%	63.9%	N/A	N/A
Cancer access initial treatments	% patients treated within 62 days from screening referral	85%	N/A	56.3%	55.3%	N/A	N/A
Cancer access initial treatments	% patients treated within 62 days (upgrade standard)	90%	N/A	87.6%	81.6%	N/A	N/A
Cancer access initial treatments	% patients treated within 31 days of decision to treat	96%	N/A	91.2%	92.2%	N/A	N/A
Cancer access subsequent treatments	Surgical treatments within 31 days	94%	N/A	82.5%	84.0%	N/A	N/A
Cancer access subsequent treatments	Chemotherapy treatments within 31 days	98%	N/A	99.8%	94.6%	N/A	N/A

Cancer access subsequent treatments	Radiotherapy treatments within 31 days	94%	N/A	94.9%	99.8%	N/A	N/A
28 day general faster diagnosis standard	A diagnosis or ruling out of cancer within 28 days of referral	75%	N/A	N/A	N/A	81.7%	83.8%
31 day general treatment standard	Commence treatment within 31 days of a decision to treat	96%	N/A	N/A	N/A	94.4%	90.8%
62 day general treatment standard	Commence treatment within 62 days of being referred	85% (with objective of improving during 2023/24 to 70% or more by March 2025)	N/A	N/A	N/A	72.2%	77.6%
Infection control	C. difficile acquisitions	65	85	23	18	26	18

* Between May 2019 and May 2023, we participated in a national pilot to test new standards for urgent and emergency care. During this time, reporting of information on four-hour performance stopped. Performance figures reflect data from June 2023 onwards.

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

NHS North West London Integrated Care Board (ICB)

The NHS North West London Integrated Care Board (NWL ICB) has welcomed the opportunity to respond to the Imperial College Healthcare NHS Trust (ICHT) Quality Account 2023/24 which was received on 7th May 2024. The ICB acknowledge the work that has been undertaken in relation to the quality priorities you set yourselves for this year. In particular;

The transition to the Patient Safety Incident Response Framework (PSIRF) has been a focus in 2023/24 and we have enjoyed working with you on developing and transitioning to PSIRF and we are looking forward to working with you to monitor the improvements. We note you are uploading your incidents to the Learn From Patient Safety Events system.

The ICB notes the large amount of the work the Trust has undertaken in relation to hand hygiene. We are aware the Trust has exceeded four of the five mandatory reportable targets for hospital acquired infections Therefore, we support the work to improve basic standards of infection prevention and control will continue to be a priority for 2024/25.

We acknowledge the work the Trust is doing to implement the revised national safety standards for invasive procedures (NatSSIPs2) to improve the safety of those patients undergoing invasive procedure. Following the increase in incidents causing a higher level of harm, we support the Trust in continuing this work into 2024/25.

The ICB would like to congratulate you on your reduction in patient falls following the work youhave undertaken in this area, specifically, the work on falls risk assessments being completed.

The ICB recognises the work the Trust has undertaken in relation to wrong blood in tube incidents and you are able to monitor this as business as usual going forward. We support the work undertaken regarding improving the identification and management of adults with dysphagia and we support the ongoing work into 2024/25.

In terms of maternity services, in relation to CTG monitoring, the ICB acknowledge the improvements in 'fresh eyes' compliance and the levels of staff who have completed their fetal monitoring training. We support ongoing monitoring in line with the 'Saving Babies' Lives Care Bundle' Version 3 (2023). We also note the improvements in the management of test results which was a contributory factor in some maternity incidents where results are endorsed using Cerner.

The ICB note work on anti-coagulants and insulin and support the Trust in carrying these over into 2024/25 to continue the focus on improvement.

Sepsis and clinical deterioration focussed work has had an impact on your patients and we acknowledge there is work ongoing in terms of education and pathway development for patients. We support continuing this priority into 2024/25.

The ICB welcome the work you have undertaken, both internally and in collaboration with external stakeholders, in relation the development and delivery of a mental health strategy and action plan. We support this work continuing into 2024/25 to continue further pathway development.

We note that you are continuing the user insights and focus work to improve patient experience and access to services, including responding to complaints and concerns. We also support the engagement process and the priorities set for 2024/25 and look forward to working with you on these.

We congratulate the Trust on the successes associated with the Patient to Excellence programme at Charing Cross Hospital and your ambition to consider introducing this process to your other sites.

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

On behalf of NWL ICB, we can confirm that to the best of our knowledge, the information contained in the report is accurate. The ICB supports the on-going quality priorities for 2024/25 and looks forward to working closely with ICHT in exploring further quality improvement initiatives to build on the provision of safe and effective services for our patients.

I would like to take this opportunity to thank ICHT for its continued focus on quality in 2024-25.

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

The London Borough of Hounslow's Health and Adults Care Scrutiny Panel (the 'Panel') welcomes the opportunity to provide a response to the Imperial College Healthcare NHS Trust (the 'Trust') Quality Account 2023-24 report. This report provides an update on progress made and identifies future priorities. The Panel would like to thank the Trust and its staff for continuing to provide services, and for preparing the Quality Account for comment.

Improvement priorities

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

The Panel commends the Trust and its staff for its commitment to delivering a high standard of care for patients. We are pleased to see the continued work being carried out to improve the quality of care being delivered by the Trust.

Progress against 2023/24 improvement priorities:

1. **Implementing the NHS patient safety strategy with a focus on the Patient Safety Incident Response Framework (PSIRF) and Learn from Patient Safety Events (LFPSE)**
    - We note the implementation of the new 'Patient Safety Incident Response Framework' and collaboration with other local partners. Likewise, the implementation of the 'Learn From Patient Safety Events' framework is commended.
    - We would like to continue to see the Trust continue to do well at reporting of incidents and are pleased to see the low rates of incidents compared to the national average.
2. **Reduce harm to patients through our safety improvement programme.**
    - *Reduce infection transmission through improving basic standards of infection prevention and control (IPC) practice with a focus on hand hygiene.*
        - We note the continued work at improving basic standards of infection prevention and control and the focus on hand hygiene is welcome. The introduction of additional training and deployment of new policies are also welcome.
        - We are concerned with some of the low rates of hand hygiene amongst medical staff (56%) and hope that the new improvements will reduce the chance of future E. coli infections and Clostridium difficile cases.
    - *Reduce the harm caused when undertaking invasive procedures by implementing the revised national safety standards for invasive procedures (NatSSIPs2)*

- The Panel is pleased to note that safety remains a priority and that continued learning is embedded across the Trust.
- The Panel would like to see further goals and targets developed so progress can be tracked in the future.

- *Reduce harm from inpatient falls through by improving the completion of a high-quality falls multi-factorial risk assessment (MFRA) at the point of admission and post fall assessments for people who have fallen.*
  - The Panel is pleased to note that there have been further reductions in falls in the Trust and that this will continue to be an area of focus.
- *Improve the checking of blood components prior to transfusion.*
  - We commend the success relating to blood transfusion management which now means that the service is returning to business as usual, however, we are somewhat concerned about some of the incidents of 'Wrong Blood In Tube' at the Trust.
  - The Panel is very pleased that 96.8% of staff have completed the relevant training and that this is above the target of 90%.
- *Improve the identification and management of adult patients with dysphagia.*
  - We note the organisation faced challenges in addressing and identifying patients with dysphagia and stress the importance of continued work to address patient safety.
  - The Panel notes that even with improvements the Trust will continue to carry this over as a priority into the next year.
- *Improving foetal monitoring during labour*
  - We are pleased to note the continued increased compliance on the 'Fresh Eyes' directive and understand why this no longer needs to be a priority moving forward.
- *Reducing harm in maternity through implementing a new process for the management of test results including urine specimens*
  - The Panel notes that this has moved to the implementation stage and look forward to seeing more data emerge to be used as a benchmark as it is implemented.
- *Reduce medication related harm – anticoagulants and insulin.*
  - The Panel commends the work being done to reduce harm and the steps to reduce the impact of harm from anticoagulants and insulin.
  - The Panel is concerned about the 'Never Event' which took place in an operating theatre and looks forward to this being addressed in the workplan.
- *Improving the treatment of patients with sepsis and signs of deterioration – with a focus on appropriate treatment escalation*
  - The Panel notes the progress and work being carried out to ensure that the Trust meets its targets with respect to treating sepsis and deterioration.
  - The Panel would like to see that patients that need antibiotics do receive them in a timely fashion and would like to see the current rate of 87.5% of patients receiving their dosage within an hour be increased to 90% and the target be hit next year.
  - We commend the work being carried out to implement Martha's rule at the Trust.
- *Improve the experience of patients who are waiting for care with a targeted harm review.*
  - The Panel notes the progress that has been made on this item since 2020.

- We commend the several programmes which have been put in place and are pleased to note progress.

3. **Improve the treatment of patients with deterioration in their mental health.**
    - We commend the implementation of a mental health strategy and action plan across the Trust. Likewise, the deployment of additional training schemes and platforms for training are also welcomed.
4. **User insights and focus**
    - We note the deployment of a new central insight and experience team and their work on collection, interpreting and analysing data that informs work across the Trust.
    - The Panel is pleased to see that this will continue to be developed in the future.
5. **Embed our ward accreditation programme as an enabler for Pathway To Excellence®**
    - The Panel is pleased to note that the Trust is one of the only sites in the UK which is part of the PtE scheme and notes the work carried out to maintain accreditation.

Statements of assurance from the board

- We are pleased to see that the Trust continues to be involved in both national audits, as well as many local clinical audits.
- We are pleased that many of these audits are linked to areas of improvement for the Trust.
- We note that the Trust works closely with a broad range of research partners to improve the quality and variety of services it offers.
- The Panel notes the work CQUINS looks forward to seeing further progress on this topic.
- The Panel would like to see the outcome of additional measure to achieve CQUIN12 and how this may increase compliance from 61% to the target of 85%.
- We note that the Trust's CQC rating is 'Requires improvement' which is of concern and ask that this continues to be a priority. We do however note that some services, such as maternity services are 'Outstanding' and commend the Trust on this.
- We also note that there has been continuous learning from deaths in the Trust and look forward to seeing how this work is embedded across the service.
- We note the progress on seven days services and commend the Trust on improving ward and board round routines and ensuring they happen consistently.

Reporting against core indicators

- The Panel notes that the rates of mortality continue to be low across the Trust, as has been the case in several of the previous years. We note the collaboration with North West London Acute Provider Collaborative to share knowledge and data to make evidence-based improvements.
- The Panel notes the good scores that the Trust has received on patient reported outcomes measures. The Panel is also pleased to note that the Trust is seeking to maintain this standard.
- The Panel also notes the lower rates of 28-day readmissions and commend the Trust on only having 6.2% of adults and 5.51% of children being admitted especially with the pressures in the sector.
- The Panel also commends the Trust on having 74.28% of staff recommending the Trust to friends and family.

Patient feedback and experience

- The Panel commends the Trust on having very good results on the A&E friends and family test, scoring above the national average, and noting further work being carried out to improve this score.
- The Trust is performing at the expected level on inpatient measures, and this is good to see considering the pressures that the sector faces. The Panel is keen to see the further work to improve this score.
- The Panel notes the work being done on Venous thromboembolism and it is good to see the Trust doing well on this metric.
- The Panel would like to see a continued decrease in the number of clostridium difficile infections but is pleased to see this being linked to other work being carried out to improve hand hygiene and use of antibiotics.
- The Panel is very pleased to see progress on patient safety incidents with an increase of incidents being reported from 57.1 to 63.8 and appreciate that this helps to create a culture in which reporting is viewed as a good thing. The Panel is also pleased to note that there is continued learning from these issues.
- The Panel also commends the Trust on having low rates of serious incidents and harm from these incidents but would like to see a total elimination of Never Events as well.

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

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

The Health and Social Care Select Committee welcomes the opportunity to comment on the Trust's 2023/2024 Quality Report.

Members note that the following priorities have been set for 2024/2025:

1. Fully implement and embed the Patient Safety Incident Response Framework (PSIRF) with a focus on experience of and compassionate engagement with those involved;
2. Develop our approach to patient centred safety with our patient safety partners;
3. Develop and embed our approach to the use of user insights to drive improvement;
4. Reduce harm to patients through our safety improvement programme;
5. Improve the treatment of patients with deterioration in their mental health;
6. Improve end of life care with our new Trust strategy;
7. Develop a robust plan to collect / review data to identify inequalities in all quality metrics; and
8. Ensure young people who move from children's to adult's service have a co-ordinated transition plan.

Good progress appears to have been made by the Trust in relation to its 2023/2024 quality priorities. The Trust continues to work with the other three acute trusts in the North West London Acute Provider Collaborative (NWL APC) (Chelsea and Westminster NHS Foundation Trust, London North West NHS Trust and The Hillingdon Hospitals NHS Foundation Trust) on a number of priority areas. These areas include infection prevention and control, implementation of the new national safety standards for invasive procedures and improving mental health in the acute setting.

On 1 April 2024, working collaboratively with the other trusts in the NWL APC, the Trust transitioned to the new Patient Safety Incident Response Framework (PSIRF) in line with revised national timeframes. The Committee is pleased to note that PSIRF training has been delivered to APC trusts for key roles with further staff training planned and that a new governance structure has been implemented, including a new Safety Improvement Group to oversee the improvement plans. They are also impressed that performance in relation to inpatient falls has seen sustained improvement with the completion of falls risks assessment within 6 hours of admission increasing from 65.9% in 2023 to 73.9% in 2024. However, whilst Members commend the work that has been undertaken in relation to falls, there are no targets mentioned and little information is included in the report to indicate how this performance compares to comparable trusts elsewhere.

Members are pleased to note the activity undertaken over the last year in relation to improving the treatment of patients with deterioration in their mental health. The Trust's commitment to continuing this work over the next year is very much welcomed.

Looking forward, there are areas where the Trust continues to express a commitment to make improvements, and the Committee notes that there are a number of areas where further improvements are still required. Members look forward to being provided with more detail, on the progress of the implementation of priorities, but more importantly on the achievement of objectives outlined in the Quality Report and improved outcomes over the course of 2024/2025.

Healthwatch Brent, Healthwatch Kensington & Chelsea, Healthwatch Westminster

Our Healthwatch teams in Brent, Kensington & Chelsea and Westminster are pleased to see that the trust has a real commitment to engaging with patients and the wider community.

This has included supporting Healthwatch Westminster and Healthwatch Kensington & Chelsea to carry out a project looking at the experiences of patients receiving intermediate care. The trust has also engaged well with out maternity project, looking at 'Quality and Equality in North West London maternity services.' Findings from this work have been presented to the trust and to the local MVP group.

We found the Quality Account comprehensive, with clear objectives and measures for improvement. We currently receive information from the trust through a number of channels, and really value the strong communication and clear updates about any issues that may impact our local residents. We look forward to this continuing through the coming year, and support the priorities outlined in this Quality Account.

Annex 2: Statement of directors' responsibilities for the quality report

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

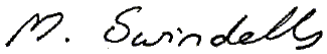
NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality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

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

- the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2019/20 and supporting guidance Detailed requirements for quality reports 2019/20*
- the content of the quality report is not inconsistent with internal and external sources of information including:
    1. board minutes and papers for the period April 2023 to May 2024
    2. papers relating to quality reported to the board over the period April 2023 to May 2024
    3. feedback from the Integrated Care Board
    4. the annual governance statement May 2024
    5. feedback from local Healthwatch and local authority overview and scrutiny committees
    6. the trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    7. the national Staff Survey 2023
    8. the Head of Internal Audit's annual opinion of the trust's control environment May 2024
    9. Mortality rates provided by external agencies (NHS Digital and Telstra Health).
- the quality report presents a balanced picture of the NHS trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report. The quality account was reviewed at our Audit, Risk and Governance Committee held in June 2024, where the authority of signing the final quality accounts document was delegated to the chief executive officer and chair.

By order of the board



Matthew Swindells, Chairman
26 June 2024

Professor Tim Orchard, Chief executive
26 June 2024

Annex 3: Participation in national clinical audits and confidential enquiries 2023/24

Name of project	Host organisation	Did we participate?	Stage / submission details
Adult Respiratory Support Audit	British Thoracic Society	Yes	Ongoing
BAUS Nephrostomy Audit	The British Association of Urological Surgeons (BAUS)	Yes	100%
Breast and Cosmetic Implant Registry	NHS Digital	Yes	CXH –15, HH – 1535
British Hernia Society Registry	British Hernia Society	Yes	New in 23/24 – Not started
Case Mix Programme	Intensive Care National Audit and Research Centre	Yes	Ongoing
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	Yes	Ongoing
Elective Surgery: National PROMs Programme	NHS Digital	Yes	Ongoing
Emergency Medicine QIPs – 253 cases in Total			
a. Care of Older People	Royal College of Emergency Medicine	Yes	CXH – 133 cases
b. Mental Health (self-harm)	Royal College of Emergency Medicine	Yes	SMH – 120 cases
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health	Yes	583 cases
Falls and Fragility Fracture Audit Programme (FFFAP)			
a. Fracture Liaison Service Database	Royal College of Physicians	Yes	666 cases
b. National Audit of Inpatient Falls	Royal College of Physicians	Yes	Ongoing
c. National Hip Fracture Database (NHFD)	Royal College of Physicians	Yes	Ongoing

Name of project	Host organisation	Did we participate?	Stage / submission details
Improving Quality in Crohn's and Colitis (IQICC) [Previously named Inflammatory Bowel Disease (IBD) Audit]	IBD Registry	Yes	Ongoing
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	NHS England and NHS Improvement	Yes	Ongoing
Maternal and Newborn Infant Clinical Outcome Review Programme	University of Oxford / MBRRACE- UK collaborative	Yes	Ongoing
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death	Yes	Ongoing
National Adult Diabetes Audit			
a. National Diabetes Foot care Audit (NDFA)	NHS Digital	No	Awaiting access to the national submission system
b. National Diabetes Inpatient Safety Audit (NDISA)	NHS Digital	Yes	Ongoing
c. National Pregnancy in Diabetes Audit (NPID)	NHS Digital	Yes	45 cases
d. National Diabetes Core Audit	NHS Digital	Yes	Ongoing
National case and Chronic Obstructive Pulmonary Disease Audit Programme			
a. Chronic Obstructive Pulmonary Disease Secondary Care	Royal College of Physicians	Yes	CXH – 90; SMH – 105
b) Pulmonary Rehabilitation	Royal College of Physicians	Yes	Ongoing
c) Adult Asthma Secondary Care	Royal College of Physicians	Yes	Ongoing
d) Children and Young People's Asthma Secondary Care	Royal College of Physicians	Yes	Ongoing
National Audit of Cardiac Rehabilitation	University of York	Yes	Ongoing
National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	Yes	Ongoing

Name of project	Host organisation	Did we participate?	Stage / submission details
National Audit of Dementia (NAD)	Royal College of Psychiatrists	Yes	Ongoing
National Audit of Pulmonary Hypertension	NHS Digital	Yes	Ongoing
National Cancer Audit Collaborating Centre	Royal College of Surgeons of	Yes	Ongoing
National Breast Cancer Audit1	England (RCS)	Yes	Ongoing
National Cardiac Arrest Audit	Intensive Care National Audit and Research Centre	Yes	Ongoing
National Cardiac Audit Programme (NCAP)			
a. National Adult Cardiac Surgery Audit	Barts Health NHS Trust	Yes	Ongoing
b. National Congenital Heart Disease	Barts Health NHS Trust	Yes	Ongoing
c. National Heart Failure Audit	Barts Health NHS Trust	Yes	Ongoing
d. National Audit of Cardiac Rhythm Management	Barts Health NHS Trust	Yes	Ongoing
e. Myocardial Ischaemia National Audit Project	Barts Health NHS Trust	Yes	Ongoing
f. National Audit of Percutaneous Coronary Interventions	Barts Health NHS Trust	Yes	Ongoing
National Child Mortality Database	University of Bristol	Yes	Ongoing
National Comparative Audit of Blood Transfusion			
a) 2023 Audit of Blood Transfusion against NICE Quality Standard 138	NHS Blood and Transplant	Yes	Ongoing
b) 2023 Bedside Transfusion Audit	NHS Blood and Transplant	Yes	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)	British Society of Rheumatology	Yes	Hammersmith Hospital – 76 cases
National Emergency Laparotomy Audit(NELA)	Royal College of Anaesthetists	Yes	Ongoing

Name of project	Host organisation	Did we participate?	Stage / submission details
National GastroIntestinal Cancer Audit Programme (GICAP)			
a) National Bowel Cancer Audit (NBOCA)	Royal College of Surgeons of England (RCS)	Yes	231 cases
b) National Oesophago-Gastric Cancer Audit (NOGCA)	Royal College of Surgeons of England (RCS)	Yes	131 cases
National Joint Registry	Healthcare Quality Improvement Partnership	Yes	100%
National Lung Cancer Audit (NLCA)	Royal College of Surgeons	Yes	Ongoing
National Maternity and Perinatal Audit (NMPA)1	Royal College of Obstetrics and Gynaecology	Yes	Ongoing
National Neonatal Audit Programme (NNPA)	Royal College of Paediatrics and Child Health	Yes	QCH – 109 cases; SMH – 82 cases
National Obesity Audit (NOA)	NHS Digital	Yes	Ongoing
National Ophthalmology Database Audit	The Royal College of Ophthalmologists	Yes	3125 cases
National Cataract Audit	The Royal College of Ophthalmologists	Yes	Ongoing
National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	Yes	Ongoing
National Prostate Cancer Audit (NPCA)	Royal College of Surgeons of England (RCS)	Yes	767 cases
National Vascular Registry (NVR)	Royal College of Surgeons (RCS)	Yes	46 cases
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)	University of Warwick	Yes	Ongoing
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds / University of Leicester	Yes	Ongoing
Perinatal Mortality Review Tool (PMRT)	University of Oxford / MBRRACEUK collaborative	Yes	Ongoing
Perioperative Quality Improvement Programme	Royal College of Anaesthetists	Yes	Ongoing
Sentinel Stroke National Audit Programme	King's College London (KCL)	Yes	>90%

Name of project	Host organisation	Did we participate?	Stage / submission details
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Serious Hazards of Transfusion	Yes	50 cases
Trauma Audit and Research Network (TARN)	Trauma Audit and Research Network	Yes	Ongoing
Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	No	Trust is using other ways to measure the service
The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	National Institute for Cardiovascular Outcomes Research (NICOR) hosted at NHS Arden and Greater East Midlands CSU	Yes	Ongoing
UK Renal Registry Chronic Kidney Disease Audit	UK Kidney Association	Yes	Ongoing
UK Renal Registry National Acute Kidney Injury Audit	UK Kidney Association	Yes	Ongoing

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