Imperial College Healthcare NHS
NHS Trust

Quality Accounts
2013-2014

If you need the document in a different format

This document is available in large print, audio, Braille and other languages on request. Please contact the communications team on 020 8383 3860 or email: quality.accounts@imperial.nhs.uk**.**

A glossary of terms can be found on page 97.

هذه الوثيقة متاحة أيضا بلغات أخرى والأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে এবং অডিও টেপ আকারেও অনুরোধে পাওয়া যায়।

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Sipas kërkesës, ky dokument gjithashtu gjendet edhe në gjuhë të tjera, me shkrim të madhe dhe në formë dëgjimore.

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Part one: Statement on quality from the chief executive

Providing safe, high quality and patient centred care and treatment for all of our patients is our priority at Imperial College Healthcare NHS Trust and this responsibility sits with every staff member no matter where they are in the organisation.

Our focus and commitment to quality is enshrined in our Quality Strategy 2013-15 where we outline ambitious quality goals which the Trust aims to achieve by 2015. The Trust wide strategy ensures quality is at the forefront of everything we do.

We have reviewed how our organisation is structured and how we report on all of the six domains of quality – safety, effectiveness, patient centredness, equity, timeliness and efficiency.

Our commitment to quality was recognised by a number of significant achievements in 2013-14 including:

- being named in the top four hospital trusts in England for Summary Hospital-Level Mortality Indicator (SHMI) ratios and categorised as 'lower than expected' when compared with other trusts
- meeting all essential standards of quality and safety as assessed by the Care Quality Commission during unannounced inspections and a themed dementia inspection on three of our five sites
- achieving an 'above average' engagement score, compared to other acute trusts around the country, of 3.74 for our people in the annual NHS staff survey.

It is important that our Quality Accounts are accurate and accessible. I can confirm that to the best of my knowledge the information included in this document has been subjected to all the appropriate scrutiny and validation checks to ensure the data is accurate.

I hope that this document is user-friendly and informative and I would like to thank everyone who contributed in its development, including members of the public, our people, Healthwatch, shadow foundation trust members, local authorities and commissioner colleagues.

We have many challenges ahead including ensuring that every one of our patients has a first-rate experience whenever they use our services. I am sure that together with our partners we can meet these challenges and build Imperial College Healthcare NHS Trust into a truly integrated health provider worthy of foundation trust status.

If you would like to be involved in developing our Quality Accounts for 2014-15 please get in touch with the Trust by emailing: quality@imperial.nhs.uk

Trust board endorsement

I confirm that this Quality Account has been discussed at, and endorsed by the Trust Board.

Chief executive's signature

I declare that to the best of my knowledge the information contained in the Quality Account is accurate.

Yours sincerely

Dr Tracey Batten
Chief Executive
Imperial College Healthcare NHS Trust

A guide to the report's structure

The following report outlines targets the Trust board[1] have agreed for the coming year, 2014-15. It also summarises the Trust's performance and improvements against the quality priorities and objectives we set ourselves for 2013-14. The document is structured using the Department of Health Quality Accounts toolkit:
https://www.gov.uk/government/publications/quality-accounts-toolkit-2010-11

We have reported against the priorities, including explanations of where we have not met our targets and how we are addressing those issues.

We have worked with stakeholders and staff to establish our priorities for the year ahead and have detailed our new priorities under the headings: patient safety; clinical effectiveness; and patient experience. We have explained how we decided upon our priorities and how we will achieve and measure performance against them. We have included additional measures relevant to our Quality Improvement Goals as outlined in the Quality Strategy.

Finally, we have provided other information to review that is relevant to the overall quality performance of the Trust. We have published statements from Healthwatch, overview and scrutiny committees, Health and Wellbeing Boards, commissioners and external auditors, which were submitted in response to these Quality Accounts.

[1] The Trust board agreed targets for 2014-15 at its public meeting on 27 March 2014.

About the Trust

Imperial College Healthcare NHS Trust was formed in 2007 and is one of the largest trusts in the country. The Trust is comprised of Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and the Western Eye hospitals and seven renal satellite units offering haemodialysis throughout North-West London.

The Trust delivers world-leading clinical, acute hospital and integrated care services, treating patients at every stage of their lives – with over 55 specialist services for both children and adults.

As one of the largest Trusts in the country, in 2013-14 we had:

- 1,223,380 million patient contacts
- 192,168 inpatient cases
- 1,031,212 outpatient contacts
- an average of 85,934 outpatient appointments a month.

Our vision for the future and how we will achieve it

The Trust's vision statement places improving patient experience as the ultimate goal.

'To improve the health and wellbeing of all the communities we serve and, working with our partners, accelerate the implementation into clinical practice of innovations in research, teaching and clinical services in order to transform the experience of patients.' **Quality Strategy 2013-15**

In delivering this vision we will always put our patients first – making high quality, safe and compassionate care our top priority.

Four strategic objectives are helping us to achieve our vision. These are:

1. to develop and provide the highest quality, patient focused and efficiently delivered services to all our patients
2. to develop recognised programmes where the specialist services the Trust provides are among the best, nationally and internationally and leverage this expertise for the benefit of our patients and commissioners
3. with our partners, ensure high quality learning environment and training experience for health sciences trainees in all disciplines and develop a satisfied workforce that is representative of the communities that the Trust serves
4. with our partners in the Academic Health Science Centre and leveraging the wider catchment population afforded by the Academic Health Science Network, innovate in healthcare delivery by generating new knowledge through research, translating this through the AHSC for the benefit of our patients and the wider population.

Academic Health Science Centre

Together with Imperial College London, the Trust formed the UK's first academic health science centre (AHSC) in 2009. Imperial College London has a campus on each of our main sites and is closely integrated with all of our clinical specialties.

Imperial College Healthcare is one of eleven National Institute for Health Research (NIHR) Biomedical Research Centres. This designation is given to the most outstanding NHS and university research partnerships in the country; leaders in scientific translation and early adopters of new insight technologies, techniques and treatments for improving health.

The AHSC's work in delivering excellence in healthcare, research and education has been recognised through the confirmation of its AHSC status for a further five years from 1 April 2014.

The clinical sciences centre of the Medical Research Council (MRC) is based at Hammersmith Hospital, providing a strong foundation for clinical and scientific research.

Our hospitals

There are five hospitals in the Trust. These are:

Charing Cross Hospital, Hammersmith

- Charing Cross is a general hospital, providing a range of adult clinical services. It hosts one of eight hyper acute stroke units in London and is a key site for teaching medical students from Imperial College London.

Hammersmith Hospital, Acton

- Hammersmith is a general hospital and home to the heart attack centre for North West London. It is well known for its research achievements, hosting a large community of Imperial College London postgraduate medical students and researchers.

Queen Charlotte's & Chelsea Hospital, Acton

- Queen Charlotte's & Chelsea Hospital provide maternity and women's and children's services. The hospital has extensive high-risk services and cares for women with complicated pregnancies. It also has a midwife-led birth centre for women with routine pregnancies who would like a natural childbirth experience.

St Mary's Hospital, Paddington

- St Mary's is a general acute hospital that diagnoses and treats a range of adult and paediatric conditions. The hospital also provides maternity services and hosts one of four major trauma centres in London.

Western Eye Hospital, Marylebone

- Western Eye is dedicated to ophthalmology. It offers the only 24-hour emergency eye care service in west London.

In addition to the main hospital sites, we have seven renal satellite units offering haemodialysis throughout North-West London. These are located at:

- Ealing
- Watford
- Brent
- Northwick Park
- West Middlesex
- Hayes
- St Charles & Hammersmith

The way we provide services

During 2013-14, our clinical services were initially organised into six clinical programme groups (CPGs), with each containing a range of specialist services. In August 2013, we restructured our organisation into four divisions – medicine; surgery, cancer and cardiovascular; women's and children's and investigative sciences and clinical support (appendix two). Each division has its own management board responsible for the service, led by a medical and nursing director. More information about our divisions is available on our website: www.imperial.nhs.uk/aboutus

In 2013-14 the majority of our services were commissioned on behalf of our local population by Ealing Clinical Commissioning Group (CCG), Hammersmith and Fulham CCG, Kensington and Chelsea CCG, and Westminster CCG. We also provide highly specialist care that is not available in all acute hospitals, and these services are commissioned to provide patient care in other parts of London and in some cases nationally.

Progress towards Foundation Trust status

Significant progress has been made in our application to become a foundation trust. A successful authorisation would highlight the Trust as a well-run, financially stable NHS organisation and it would better enable us to engage with the people and communities we serve. http://www.imperial.nhs.uk/foundation-trust

Shaping a healthier future

During 2013-14, the Trust has continued to work closely with commissioners on the strategic health service development programme for north west London - *Shaping a healthier future.* http://www.healthiernorthwestlondon.nhs.uk/

The *Shaping a healthier future* programme is led by the eight clinical commissioning groups responsible for the commissioning of NHS care for the population of north-west London. Following a process of community consultation, review and referral to an Independent Reconfiguration Panel, Health Secretary Jeremy Hunt announced the changes to healthcare services in October 2013. The Trust's own transformation programme is very much informed by this wider strategic work. http://www.imperial.nhs.uk/patients/Shaping-a-healthier-future/index.htm

Quality Strategy

In November 2013, the Trust launched a three-year Quality Strategy, which outlines the quality goals the Trust aims to achieve by 2015. It explains the approach to driving improvements including governance processes and how these are set by the vision of safe, high-quality, patient-centred services for patients. You can view a copy of the Quality Strategy on our website:
http://source/prdcont/groups/intranet/@corporate/@communications/documents/websiteasset/id_042162.pdf

> 'Delivering our Quality Strategy is a shared responsibility in which every member of the Imperial team has a vital role to play.' **Quality Strategy 2013-15**

The six principles and goals

The Trust's approach to improving quality is based on Professor Donald Berwick's six principles for improvement. Professor Berwick was commissioned to review the changes needed in the NHS following the Mid-Staffordshire Inquiry.

The six principles are:

1. safety: our patients will be as safe in our hospitals as they are in their own homes
2. effectiveness: our people will minimise the use of ineffective care and maximise the use of evidence based care
3. patient centredness: our people will respect the individual patient and their choices, culture and specific needs
4. timeliness: we will strive to continually reduce waiting times and delays for patients and our people
5. efficiency: we will strive to continually reduce waste and thereby cost of care; (this included supplies, equipment, space, capital, ideas and human spirit)
6. equity: we will seek to ensure that everyone we care for has the same high quality outcome, regardless of status.

Going forward, these Quality Accounts will be used to report against progress of the Quality Strategy, in addition to reporting against the Quality Accounts priorities. The goals and the priorities may differ slightly as the strategy is a three year plan and the Quality Accounts are reviewed each year through a process of engagement with our stakeholders and staff.

What are Quality Accounts and why are they important?

Quality Accounts are annual reports to the public from NHS healthcare providers about the quality of services they deliver. Their primary purpose is to encourage boards and leaders of healthcare organisations to assess quality across all of the services they provide. The Trust is committed to continuously improve the quality of the services we provide to patients and the Quality Accounts are a report of:

- our priorities for 2014-15
- how well we performed against the targets we were set by the Department of Health
- how well we performed against the targets we were set by our local clinical commissioning groups (CCG's) and those we set ourselves
- how well we performed against similar healthcare providers (where possible)
- where we need to focus to improve the quality of the services we provide.

How we monitor and report on quality

The Quality Accounts delivery group aims to meet quarterly throughout the year to monitor progress on the indicators. A scorecard is produced so our divisions can monitor their performance and establish which indicators require further work. In 2013-14 the scorecard was reviewed by the quality committee and reported to the Trust board.

Assurance and compliance

The Trust board is accountable for the systems of assurance, internal control and risk management and regularly monitors and reviews these at both Trust board level and via its committees. The chief executive is ultimately responsible for ensuring the Trust delivers a high quality service for all patients and for the delivery of and compliance with assurance, quality and performance targets.

This responsibility is delegated to the medical director, director of nursing and director of governance and assurance for quality and governance, to the chief operating officer for operational performance and performance targets, and to the chief financial officer for financial targets.

Board engagement

The Trust board is actively engaged in reviewing the quality of our services. The chief executive and chairman take part in regular ward visits to meet staff and talk with patients. In addition, monthly leadership walk rounds assess the quality of our services and provide internal assurance that we are compliant with the essential standards of care. Throughout the year, teams consisting of executive directors, senior nurses, infection prevention and control, estates and facilities, maintenance, corporate services and operational managers visit all our sites to assess the environment and speak with staff and patients. Local and site action plans are developed and monitored as needed.

Key themes and risks were reported through the quality and safety committee to the Trust board. In 2014, the key themes will now be reported through the quality committee each quarter.

Our 'back to the floor Friday' initiative provides senior nurses, including the director of nursing, with protected time to work clinically and lead local audits. This has been an invaluable tool in driving the quality of care through senior nurse role modelling. The director of nursing has introduced 'back to the night' walk rounds. These are led by senior nurses including the director of nursing, to focus on 'out of hours' care ensuring that we provide a safe, high quality service at all times.

Trust board reports

The Trust board gains assurance on quality through a number of reports including:

- the monthly key performance indicators (dashboard) report
- quarterly quality and safety reports such as the quality account indicators and regulatory assurance including compliance with external regulators
- patient experience/patient feedback
- board visits to wards
- patient complaints.

Quality actions for 2014-15

- A safety and quality improvement network will be set up across the Trust and its learning priorities set to drive the quality goals.
- The use of global comparator networks will be introduced in all appropriate areas.
- Updated incident and effectiveness systems will be fully rolled out across the Trust.
- Targets for improvement in QG15 (Quality Goals 2015) will be set to directorate level and variation tracked from ward to board.
- The meeting structures for quality will be embedded and their effectiveness reviewed on an annual basis.

Part two: Our priorities for quality improvement in 2014-15

We want to demonstrate our commitment to quality and to show where we intend to focus our efforts next year. We have agreed with our stakeholders to 'roll-over' some of last year's priorities as many of our priorities are significant areas of work that are continuous and require time to implement successfully.

We have agreed areas under the three quality themes as defined in the Quality Accounts framework. These are:

1. patient safety: having the right systems and staff in place to minimise the risk of harm to our patients and, if things go wrong, to be open and learn from our mistakes
2. clinical effectiveness: providing the highest quality care, with world class outcomes, whilst being efficient and cost effective
3. patient experience: meeting our patients' emotional as well as physical needs.

In addition to the areas we have chosen this year, there are those that our stakeholders have told us are important. Where appropriate, we have aligned our priorities with our 2014-15 Commissioning for Quality and Innovation (CQUIN) targets – a range of local and national quality priorities chosen by our commissioners and the Department of Health.

How we decide on our priorities

Our priorities are developed in consultation with members of the public, our patients, shadow foundation trust members, HealthWatch, local authority overview and scrutiny committees, commissioners and clinical and management staff across each of the Trust's service delivery areas.

Based on feedback received during this engagement process, the Trust board have considered the proposals and agreed the priorities for 2014-15, which are set out in the section below.

We have made every attempt to write our Quality Accounts in a way that is accessible to patients, the public and our staff. If you are interested in being involved in the development of our Quality Accounts in the future please contact the Quality Team by email: quality@imperial.nhs.uk

In addition to these priorities, we will report our performance against the Quality Strategy goals.

Summary of Priorities for 2014-15

The tables below summarise our priorities and objectives for 2014-15, reflecting our Quality Strategy goals. Please refer to the glossary for an explanation of all clinical terms.

Priorities for 2014-15

Patient safety

Quality Strategy goal: safety

Safety in clinical practice is our most significant goal; all patients will be as safe in our hospitals as they are in their own homes and outcomes will be as good as anywhere in the world. Our patient safety measures below reflect two of the key outcomes for this goal, as identified below.

Our quality priority	What will success look like
To achieve year on year reductions in infection prevention and control. We have chosen this priority to support our Quality Strategy goal. **C.difficile* is a mandated indicator in the DH reporting arrangements for the Quality Accounts.	We will achieve the *Clostridium difficile* (*C.difficile*) Department of Health (DH) target of less than **65** cases in the Trust during 2014-15. We will aim to achieve the MRSA blood stream infections (BSI's) national directive to have a **zero** tolerance for all healthcare associated MRSA Blood Stream infections (BSI's) across the NHS. We will be **90 %** compliant with the Trust anti-infective prescribing as measured by: • a reason for starting the antibiotic clearly documented within the patient's medical notes/drug chart • a stop/review date on the drug chart to optimise duration of therapy • antibiotics are prescribed in line with the Trust antibiotic policy or approved by specialists from within our infection teams.
To increase incident reporting rates and reduce their reported harm to meet NRLS peer target. We have chosen this priority to support our Quality Strategy goal. *Patient Safety incident reporting is a mandated indicator in the DH reporting arrangement for the Quality Accounts.	We will **meet** the NRLS (National Reporting and Learning System) **peer median reporting rate** for patient safety reporting rates per 100 admissions. To be **below our peers** for incidents graded as extreme (death) and severe (major). To have a **zero** tolerance for 'never events'.

To continuously improve Hospital Standardised Mortality Rates (HSMR) and Standardised Hospital-level Mortality Indicators (SHMI) ratios (a new national way of measuring mortality) and reduce variation across the week days. We have chosen this priority to support our Quality Strategy goal. *SHMI are a mandated indicator in the DH reporting arrangements for the Quality Accounts.	We will be **better than the national average** for mortality rates as measured by SHMI and HSMR.
To ensure high performance against the NHS Safety Thermometer. We will deliver 95 % harm free care to our patients by reducing the number of falls, pressure ulcers and catheter related infections, as evidenced by the NHS Safety Thermometer. This allows frontline teams to measure how safe their services are and to deliver improvements locally.	Falls to **remain below the national average** for falls with harm. To reduce the total number of all grades pressure ulcers. The current **CQUIN target is awaiting confirmation.** Venous thromboembolism: to **reduce avoidable harm** of patients acquiring a VTE through risk assessment and appropriate treatment. We are awaiting confirmation of this target. Urinary catheter related infections to continue to submit the Safety Thermometer data and to monitor our performance against peer trusts.
We want to increase the awareness of dementia and ensure that relevant patients who are admitted as an emergency are screened for dementia and have access to specialist assessments as needed.	We will achieve our CQUIN target of **90 %** compliance with the three key measures: Element A: **F**ind; identify patients aged 75 and over and ask case-finding question Element B: **A**ssess and **I**nvestigate; Element C: **R**efer; ask GP to refer on for specialist memory service assessment.

Clinical effectiveness

Quality Strategy goal: effectiveness

Our objective is that systems must match care to science, avoiding overuse of ineffective care and underuse of effective care. The Quality Accounts has two mandated indicators that measure clinical effectiveness indicators that we have included in this section.

Our quality priority	What will success look like
To reduce the number of emergency readmissions to hospital within 28 days of discharge. *This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.	To reduce the number of readmissions to hospital within 28 days of discharge for patients under the age of 14 years. To reduce the number of readmissions to hospital within 28 days of discharge for patients 15 years and over. **To be below the national average** for this indicator for both categories.
Patient Reported Outcome Measures (PROMs) measure quality from the patient perspective and provide valuable information on the outcome of the surgery for our patients. To ensure the data is reflective of our patient groups, we need to increase our participation rates. *This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.	To **increase our participation rates to above 80 %** for all PROMs (groin hernia surgery, varicose vein surgery, hip replacement surgery and knee replacement surgery).

Patient experience

Quality Strategy goal: patient centredness

Our goal is that our people will respect the individual patient and their choices, culture and specific needs. For the Trust, a key component of this goal is to improve the reported experience of our patients when compared nationally.

Our quality priority	What will success look like
We aim to provide the highest quality of healthcare. We will ask patients in adult inpatient and A&E departments the Friends and Family Test (FFT): 'How likely are you to recommend our ward/A&E department to friends/family if they needed similar treatment or care?' We have chosen this priority to support one of our Quality Strategy goals.	We will meet our CQUIN targets of: **Inpatient** Quarter 1= 25 % response rate Quarter 4 = 30 % response rate with month 12 (March 2015) having a 40 % response rate **A&E** Quarter 1= 15 % response rate Quarter 4 = 20 % response rate.

*This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.	In addition to monitoring our response rates, we will include feedback on our scores over the year.
We aim to provide the highest quality of healthcare. We will ask patients in our outpatients departments (OPD): 'How likely are you to recommend our OPD to friends/family if they needed similar treatment or care?' We have chosen this priority to support one of our Quality Strategy goals.	We will **complete** the implementation of the FFT question for all outpatient areas by **October 2014**.
To improve the reported experiences of our patients including responsiveness to the personal needs of our patients. We have chosen this priority to support one of our Quality Strategy goals. *This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.	To **improve on our 2013 scores** in the National Patient Survey and National Cancer Survey. To **improve on last year's score** in relation to responsiveness to patient needs.
We recognise that by listening to our people (staff) and by improving our staff experience, we will make a positive difference to our patients' experience. We have chosen this priority to support one of our Quality Strategy goals. *This indicator is a mandated indicator in the DH reporting arrangements for the Quality Accounts.	We will **remain above average of 60 %** of staff who would recommend the Trust to friends/family needing care as measured through the annual National Staff survey and we will implement the staff FFT test in line with national guidance by June 2014.
We will nurse our patients in single sex accommodation as defined by the DH and our Trust policy.	We will have a **zero tolerance** of breaches of mixed sex accommodation as defined by the Trust policy.

Progress against these priorities will be monitored through the Quality Accounts delivery group. In line with the recent organisational changes the Trust is currently reviewing the reporting arrangements of this group.

2.1 Statement of assurance from the board

This section contains statutory statements concerning the quality of services provided by Imperial College Healthcare NHS Trust. These are common to all trust Quality Accounts and can be used to compare us with other organisations.

2.2 A review of our services

During the reporting period 2013-14 Imperial College Healthcare NHS Trust provided and/or sub-contracted 75 NHS services.

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

The income generated from the Trust's provision of NHS services in 2013-14 represents 76% of the total income generated by the Trust for 2013-14.

2.3 Participation in clinical audits and National Confidential Enquiries

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

National Confidential Enquiries investigate an area of healthcare and recommend ways to improve it.

During 2013/14, the NHS services that the Trust provides were covered by 40 national clinical audits and four national confidential enquiries.

During that period the Trust participated in 100% of national clinical audits and 100% of national confidential enquiries in which we were eligible to participate.

The following table covers:

- The **active** national clinical audits and national confidential enquiries that Imperial College Healthcare NHS Trust was eligible for and participated in during 2013/14.

National Clinical Audit / National Confidential Enquiry	Eligible (Y/N)	Participated (Y/N)	% of cases submitted / expected submissions
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	100 / 742
Adult Cardiac Surgery	Yes	Yes	100 / 749
Adult Critical Care (ICNARC CMP)	Yes	Yes	100 / 565
Adult Diabetes National Audit	Yes	Yes	100 / 6815
Blood Transfusion Management of Patients in Neuro Critical Care Units (NHSBT)	Yes	Yes	100 / 8
Blood Transfusion Patient Information and Consent	Yes	Yes	37.5 / 24
Blood Transfusion Use of Anti-D (NHSBT)	Yes	Yes	100 / 51
Bowel Cancer (NBOCAP)	Yes	Yes	Data collection ongoing, closes 1st October 2014

National Clinical Audit / National Confidential Enquiry	Eligible (Y/N)	Participated (Y/N)	% of cases submitted / expected submissions
Cardiac Arrest (NCAA)	Yes	Yes	100 / 373 (2012/13 last data-complete year available)
Cardiac Arrhythmia (Heart Rhythm Management)	Yes	Yes	100 / 1277
COPD	Yes	Yes	Data collection ongoing, closes 31st May 2014
Congenital Heart Disease (Paediatric Cardiac Surgery) (CHD)	Yes	Yes	100 / 54 (2012/13 data, which has a submission deadline of 12th April 2014)
Coronary Angioplasty (aka Cardiac Interventions)	Yes	Yes	98.8 / 1361 (January 2013 to December 2013)
Diabetes Inpatient Audit (NADIA)	Yes	Yes	100 / 193
Elective Surgery (PROMS)	Yes	Yes	100 / 675 (January 2013 to December 2013)
Emergency Use of Oxygen	Yes	Yes	100 / 173
Epilepsy 12	Yes	Yes	Data collection ongoing, closes 23rd May 2014
Falls and Fragility Fractures (FFFAP – incorporating National Hip Fracture Database)	Yes	Yes	100 / 310
Head and Neck Oncology (DAHNO)	Yes	Yes	100 / 180
Heart Failure (HF)	Yes	Yes	83.6 / 584
Inflammatory Bowel Disease (IBD)	Yes	Yes	100 / 54
Lung Cancer (NLCA)	Yes	Yes	100 / 240 (January 2013 to December 2013)
Moderate or Severe Asthma in Children	Yes	Yes	SMH – 100 / 50 CXH – N/A
National Audit of Seizure Management (NASH)	Yes	Yes	100 / 30
National Emergency Laparotomy (NELA)	Yes	Yes	100 / 29
National Joint Registry (NJR)	Yes	Yes	100 / 552 (January 2013 to December 2013)
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100 / 94
National Pulmonary Hypertension Audit	Yes	Yes	100 / 1006
National Vascular Registry (NVR)	Yes	Yes	100 / 231
Neonatal Intensive and Special	Yes	Yes	SMH – 100 / 299

National Clinical Audit / National Confidential Enquiry	Eligible (Y/N)	Participated (Y/N)	% of cases submitted / expected submissions
Care (NNAP)			QCCH – 100 / 467 (January 2013 to December 2013)
Oesophago-gastric Cancer (NAOGC)	Yes	Yes	100 / 126
Paediatric Asthma	Yes	Yes	100 / 22
Paediatric Bronchiectasis	Yes	Yes	NO ELIGIBLE CASES
Paediatric Intensive Care (PICANet)	Yes	Yes	100 / 339 (January 2013 to December 2013)
Paracetemol Overdose in Emergency Departments	Yes	Yes	SMH – 100 / 50 CXH – 100 / 50
Renal Replacement Therapy (Renal Registry)	Yes	Yes	Prevalent: 100 / 3219 Incident: 100 / 343
Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	Data collection ongoing,
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	100 / 1818
Severe sepsis and septic shock	Yes	Yes	SMH – 100 / 50 CXH – 100 / 50
Trauma Audit & Research Network (TARN)	Yes	Yes	100 / 1027
CONFIDENTIAL ENQUIRY – Child Health (CHR-UK)	Yes	Yes	NO ELIGIBLE CASES
CONFIDENTIAL ENQUIRY – Maternal, Infant and Newborn Programme (MBRRACE-UK)	Yes	Yes	100 / 102 (January 2013 to December 2013)
CONFIDENTIAL ENQUIRY – NCEPOD Lower Limb Amputation	Yes	Yes	93 / 14 for Clinical care 93 / 14 for case notes 100 / 3 for Organisational forms
CONFIDENTIAL ENQUIRY – NCEPOD Tracheostomy	Yes	Yes	75 / 56 for Insertion 93 / 56 for Critical Care 79 / 56 for Ward Care 100 / 6 for case notes 100 / 3 for Organisational forms

The reports of **39** national clinical audits were recorded as being reviewed by the provider in 2013/14. The Trust continues to follow up the reports from all relevant national audits to identify how we make improvements. The reports were as follows:

National clinical audit
National Paediatrics Diabetes Audit (NPDA)
Adult Asthma BTS

National clinical audit
NCEPOD Alcohol Related Liver Disease
NCEPOD Sub-Arachnoid Haemorrhage
Adult Community Acquired Pneumonia BTS
Paediatric Asthma BTS
Paediatric Pneumonia BTS
Child Health Reviews UK (Child Health Programme)
National Lung Cancer Audit
Potential Donor Audit (NHS Blood and Transplant)
Chronic Pain (National Pain Audit)
Pulmonary Hypertension Audit
Blood Transfusion (Blood Sampling & Labelling) NHSBT
Head and Neck Oncology (DAHNO)
Hip Fracture Database
National Joint Registry (NJR)
UK IBD Audit - 4th Round
National Diabetes Audit Adult Patients (NHS Information Centre)
Sentinel Stroke National Audit Programme (SSNAP)
Renal Colic
Fracture Neck of Femur
Emergency Use of Oxygen
National Diabetes Inpatient Audit
Fever in Children
Non-invasive Ventilation in Adults
Chronic Heart Failure Audit
Cardiac Arrhythmia - Heart Rhythm Management (HR-UK)
Acute MI & other ACS - Cardiac Ambulance Services (MINAP)
PICANet
National Neonatal Audit Programme - NNAP
Coronary Angioplasty Adult Cardiac Interventions Audit
NVD for AAA procedures
Carotid Interventions Audit - Endarterectomy (UKCEA)
Renal Transplantation - NHSBT UK Transplant Registry
Renal Replacement Therapy - Renal Registry
National Audit of Dementia
Bowel Cancer (NBOCAP)
National Audit of Seizure Management (NASH)
Heavy Menstrual Bleeding

Many of these audits demonstrated effective care, with no actions being required. The Trust intends to take the actions listed to improve the quality of healthcare provided.

National Clinical Audit	Description of actions
Adult Asthma BTS	Ensure CXH and SMH Emergency Departments are giving systemic steroids if appropriate within 1 hour
	Ensure post-bronchodilator PEFR is recorded in CXH and HH Emergency Departments

National Clinical Audit	Description of actions
	Ensure smoking status is documented (HH)
	Ensure documentation of arrangement of follow up in Respiratory OPC at SMH
NCEPOD Alcohol Related Liver Disease	All relevant recommendations of the published NCEPOD report have been implemented.
NCEPOD Sub-Arachnoid Haemorrhage	All relevant recommendations of the published NCEPOD report have been implemented.
Paediatric Asthma BTS	Carry out an audit of all wheezy children presenting to A&E, including those who are not admitted.
	Create a modified discharge checklist to be used for patients discharged from the ward and from A&E including mandatory device technique assessment and clear advice for follow up.
	To present current audit at general paediatrics audit meeting and use this as a forum to discuss overuse of chest x-rays and antibiotic prescribing.
	To put together a case for an asthma nurse once the A&E asthma audit is complete.
	Perform an audit 6 months after the introduction of improved discharge planning arrangements to assess whether this has led to a change in practice.
	Review A&E symphony notes of patients with non-documented observations and clarify the situation - arrange to meet with A&E consultants to discuss if appropriate.
Pulmonary Hypertension Audit	Local audit of first line treatment of pulmonary hypertension with sildenafil.
Blood Transfusion (Blood Sampling & Labelling) NHSBT	Collector must label by the patient side taking patient information from the wristband.
	Competency assessment of correct sample collection procedure for all staff members who collect samples.
Hip Fracture Database	Circulation of robust weekly performance data to all key stakeholders in the pathway.
	Quarterly presentation at Clinical Governance Meetings to raise awareness of position to department.
	Escalation process to theatre teams if they require additional emergency capacity.
	To hold meeting at SMH site with attendance of key stakeholders to review and agree any remedial actions.
NVD for AAA procedures	Coding issues need to be closely examined and a structure is now in place to ensure correct procedure
Renal Replacement Therapy - Renal Registry	Explore funding/business case options for a dedicated Renal Unit Data Manager.
National Audit of Dementia	Trust Policy for Dementia.
	Care pathway for dementia to include acute admission and end of life care - currently in progress.

National Clinical Audit	Description of actions
	Protocol for the management of behavioural and psychological symptoms of dementia.
	Development of a comprehensive dementia awareness training programme for all health and allied health professionals employed by the Trust.

The reports of **72** completed local clinical audits were reviewed by the provider in 2013/14 (out of **284** local clinical audits registered in 2013/14 or carried over from 2012/13) and the Trust records all recommendations which it intends to implement to improve the quality of healthcare provided. By the end of 2013/14, **40** of the **72** completed local clinical audits had recommendations which had been recorded as being implemented, with a total of **68** implemented recommendations. It should be noted that much of the planned implementation of recommendations for local clinical audits completed in 2013/14 will be on-going into 2014/15.

Local Clinical Audit	Implemented actions
Reviewing the accuracy of assembling discharge medications and patient information given on discharge at ward level 2012/13	Education and training for nursing staff specifically related to labelling requirements, and the importance of communicating changes to medicines on discharge.
Cone biopsies showing CIN1 or less after High Grade cervical punch biopsy 2012/13	Should discuss these patients at MDT if in reproductive age group.
Review of the pre-assessment patient pathway within the Imperial Surgical Innovation Centre 2012/13	Patient pathway to be reviewed to make the process clearer for both staff and patients supported by a patient information leaflet.
	Patients to be discussed at the MDT prior to being added to the waiting list for surgery.
Written discharge communication from Acute Stroke Inpatient Service	Ensure consistent agreement with and implementation of Stroke Discharge Summary Template, to be used in conjunction with EDC software.
	Re-audit following implementation of discharge summary template across ICHT Stroke service.
	Feedback of findings of full audit cycle and recommendations to senior clinicians.
	Training of staff involved in discharge summary writing and reviewing.
	Review of recording of key items in medical notes (e.g. NIHSS on discharge, cognitive and psychological assessments).
Trust Consent Form Audit 2012/13 - Re-audit	Encouragement of thorough completion of Form 4.

Local Clinical Audit	Implemented actions
	The importance of thorough documentation of the consent process, using the appropriate consent form, needs reinforcing through education.
	Raise awareness of the findings of the Consent Audit.
Vitamin D supplementation in babies and mothers in Prolonged Neonatal Jaundice Clinic	Compulsory follow up of vitamin D supplementation in deficient babies by current doctors/nurses.
	Specify medications and their dose on the discharge letter to parents and GP.
Acute oncology service activity	Development of a spinal MDT to track AOS patients.
Management of pleural effusions	A Pi bundle should be created to guide investigations needed for pleural fluid.
	A chest drain bundle should be created and placed on the source, to ensure guidelines are followed – including identifying who, where, when and how chest drains should be put in.
Safety and monitoring around blood transfusion	Improved documentation of end time of transfusion.
EDC to GP Audit	Disseminate results to CQUIN GP information in real time group, and relevant groups who can work on improving the system.
	Review systems and processes for distributing EDCs – ongoing.
	Raise GP awareness of how they can access EDCs – ongoing.
	Share results with ICP.
Recurrence following piecemeal resection of large polyps (re-audit)	Satisfactory results, recommend continue current practice.
Withdrawal time for negative colonoscopies for colonsocopists	Colonoscopists should aim for withdrawal time of 10 minutes.
Colonoscopy completion, photographic evidence, adenoma/cancer detection, polyp retrieval	Cover for vacant lists to be offered to Colonoscopist C in first instance. Colonoscopist C's list to be filled with patients prior to filling list of other screening colonoscopist.
Management of jaundice on Neonatal Unit & Postnatal Ward (2013/14)	Education of staff re updated local guideline.
Data accuracy on BCSS (re-audit)	Improve communication practice between screening practitioners and consultants.
HASU to SU transfer of patients	Develop transfer proforma for movement of stroke patients from HASU to SU (Grafton Ward).

Local Clinical Audit	Implemented actions
	Distribute proforma to local HASUs.
Dementia assessment in patients admitted under Acute Medicine at CXH (re-audit)	Teaching for junior doctors rotating through Acute Medicine (3-4 monthly basis) – ongoing.
Nurse led Nipple Areola micropigmentation service - Audit	Service to be expanded over the next 6 months to allow for 3-4 patients per clinic as opposed to 2 patients.
Swab counting techniques in the operating theatre (Reaudit)	To ask the senior surgeons to remind their colleagues (especially new junior colleagues) about pause for the gauze.
Colonoscopy Complications	SSP's to ensure that adverse events on BCSS have a corresponding entry on AVI log.
Bowel Preparation Recorded for Each Colonoscopy Procedure	Satisfactory results - continue current practice.
Prescription of Long Term Anti TNF Medication in Gastroenterology and Dermatology	Satisfactory results - continue current practice.
Repatriation Documentation from HASU to SMH SU	Agreed criteria for stability of transfer of patient with MEWS incorporated and documented prior to transfer.
	Feedback to HASUs on advanced planning of patient transfer to SU to ensure in-hours transfer.
Prescribing in Hammersmith EU	Prescribing doctors to be taught about the Trust prescription guidelines and importance of accurate written communication.
Anti-dsDNA antibodies in patients with SLE 2013/14	To stop measuring anti-dsDNA antibodies by Luminex (Retrospective Study).
Trust Documentation Audit 2013/14 - Re-audit	Findings to be shared within the relevant Divisions via the Divisional Governance Leads, who will present to their Divisions and develop and deliver their own local actions.
Trust Consent Form Audit 2013/14 - Re-audit	Share report with Tissue Guardian, Patient Information Leads and Medical Education Leads.
	Raise report at Guidelines & Clinical Effectiveness Monitoring Group.
Clinical indications for CTPA requests	Improved training for EU doctors. New request system.
Longitudinal audit of turnaround times for core Chemical Pathology / Haematology tests from A&E	Satisfactory results - continue current practice.
Urea & Electrolytes That Require a Change in Preparation	Satisfactory results - continue current practice.

Local Clinical Audit	Implemented actions
8 Day Re-admission (April 2012 - March 2013)	Satisfactory results - continue current practice.
30 Day Mortality	Satisfactory results - continue current practice.
Gastric Ulcer Endoscopy Follow-up	Follow up OGDs must be recorded accurately on Scorpio.
	Endoscopists to be reminded of the endoscopic criteria for gastric ulcers and their responsibility for ensuring OGD follow up within 12 weeks where appropriate.
	OGD to be offered to patients identified as having no follow up performed.
Random Colonic Biopsies in Patients with Persistent Diarrhoea Attending for Colonoscopy	Endoscopists to ensure they taken random biopsies from patients with unexplained persistent diarrhoea and that they accurately detail the clinical indications in the endoscopy report and indications box.
	Endoscopists to ensure they record when they take biopsies in the colonoscopy report so it can be audited.
OGD Completion Rates	Disseminate audit results to all endoscopy users.
Assessment of Out of Hospital Falls in the Elderly During Medical Admissions	Teaching to acute medical team of use of falls bundle and referral to falls clinic.
	Discussion with ED clinical leads and orthogeriatrics to extend scope of bundle to other clinical areas.
	Design of new falls bundle.
	Falls screening questions added to acute medical clerking proforma.
	Teaching new acute medical team for ongoing use of falls bundle.
Comfort Score (re-audit)	Satisfactory results - continue current practice.
Referral to orthoptic services from SMH stroke unit	Document where patients are not appropriate for referral.
	Refer patients who have diplopia, hemianopia or other visual issues as long as they can sit in a chair,communicate and follow commands.
	Perform full visual assessment including visual fields, eye movement and acuity for all new patients on admission and 2 weeks later.
Colonoscopy completion rate	Colonoscopist's lists to be filled with patients prior to filling lists of other operators.
	Cover for vacant lists to be allocated to colonoscopist who did not perform the required number of procedures.
	Lead colonoscopist to discuss low ADR with operator to determine reasons for fall in ADR. This will be monitored in next audit in 6 months' time.
Withdrawal Time for Colonoscopies	Colonoscopists to aim for withdrawal time of 10 minutes as may increase ADR.

2.4 Participation in clinical research

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

The Trust has continued to make significant scientific advances in 2013-14 and to attract further new investment to support clinical research and development (R&D). The Trust's research strategy is integrated with that of Imperial College London – together we constitute the Imperial academic health science centre (AHSC), a designation we successfully renewed in 2013 for a further five years (one of only six AHSCs in the country).

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

During 2013-14, a total of 306 new studies were approved within the Trust, of which 76 were sponsored by commercial organisations. The number of patients receiving NHS services provided or sub-contracted by the Trust in 2013-14 that were recruited during that period to participate in research approved by a research ethics committee was 19,179 – representing more than 600 active research projects.

The National Institute for Health Research (NIHR)

Within the specific context of the NIHR Portfolio, more than 12,000 patients were recruited into 329 portfolio studies in 2013-14, an increase of over 12 % from 2012-13. This included 500 patients within 62 studies sponsored by commercial clinical R&D organisations (a 50 % increase from 2012-13).

The Trust hosts the largest of the 11 NIHR Biomedical Research Centres (BRCs) in the country. BRCs are awarded to the most outstanding NHS and university research partnerships – leaders in scientific translation and in the early adoption of new insights in technologies, techniques and treatments for improving health. In 2013-14, the NIHR Imperial BRC continued to develop a wide range of novel devices, diagnostics, and new therapeutic advances across 15 research themes. Its portfolio of projects was underpinned by state-of-the-art facilities for gene sequencing, imaging, metabolic analysis, and biobanking. In the last year our BRC-supported clinical academics published over 450 peer-reviewed articles.

The Trust is playing an active role with other major NIHR BRCs in establishing the NIHR BioResource – a national database of consented and genotyped healthy volunteers. It will provide the basis for testing the next generation of personalised medicines.

The Imperial BRC is also involved in a collaborative initiative to explore the possibility of integrating and sharing electronic patient data, together with genotypic and phenotypic information derived from clinical studies, in order to demonstrate benefits for particular patient

populations. The NIHR Health Informatics Collaborative (NHIC) joins Imperial with the BRCs at Cambridge, Oxford, UCLH and Guys & St Thomas' hospitals to link the collection of routine clinical data for research in the five fields of cardiology, transplantation, cancer, liver disease and critical care.

The NIHR complimented the Imperial BRC on the patient and public involvement and engagement activities which took place within its research themes in 2012-13. Together with other research organisations, it intends to build on this success by developing an integrated approach to patient and public involvement across NIHR programmes in NWL.

In September 2013, the Trust was selected to host the NIHR Clinical Research Network for NWL (NWL CRN) – one of only 15 in the country. The Trust will receive around £80 million to run the NWL CRN for five years. With other NHS providers in the region, the network will increase opportunities for patients to participate in clinical research, ensure studies are carried out efficiently, and support the Government's Strategy for UK Life Sciences by improving the environment for commercial contract clinical research in the NHS.

The Trust continued to attract further R&D investment from the NIHR in the form of a Diagnostic Evidence Collaborative (DEC) – one of only four in the country – which aims to catalyse the generation of evidence of clinical utility and cost-effectiveness of diagnostic medical devices. The Imperial DEC will focus on evaluating new point-of-care diagnostics which will bring diagnosis out of the laboratory and to the bedside.

The Imperial AHSC was also awarded four new NIHR Health Protection Research Units (HPRUs) – centres of excellence for studying particular priority areas in public health. The Imperial HPRUs will focus on respiratory infections, antimicrobial resistance, modelling outbreaks of infectious disease, and the health impact of environmental hazards (with King's College London). This is a considerable achievement, given that only 13 HPRUs were awarded nationally, and reflects the strong research base in infectious diseases across the Imperial AHSC.

2.5 Our CQUIN performance

CQUIN framework & data quality (goals agreed with commissioners)

Commissioners hold the NHS budget for their area and decide how to spend it on hospital and other health services. A proportion of the Trust's income in 2013-14 was conditional on achieving quality improvement and innovation goals agreed between Imperial College Healthcare NHS Trust and any person or body they entered into a contract or agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework (CQUIN).

In 2013-14, 2.5 % of our clinical income depended on achieving these goals. This equated to £17m of our income.

Further details of the agreed goals for 2013-14 can be found at https://www.gov.uk/government/publications/leave-for-will-pls-nhs-standard-contracts-for-

2012-13 and details of last year's CQUINs can be found in the Trust board performance reports as part of the Trust board papers on our website.

2.6 Care Quality Commission (CQC) registration status

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

The Care Quality Commission has not taken enforcement action against Imperial College Healthcare NHS Trust during 2013-14.

We are subject to periodic reviews by the Care Quality Commission and three sites have been inspected between April 2013 and March 2014. These were:

- St Mary's Hospital
- Western Eye Hospital
- Charing Cross Hospital.

The Trust was found to be fully compliant with the Essential Standards of Quality & Safety that were assessed. The reports of these inspections are available on the CQC website at www.cqc.org.uk/directory/ryj

2.7 Our data quality

The Trust continues to improve its data quality and has a robust governance structure for monitoring and improvement. Data quality indicators are reported to the Trust Board and Management Board and are also included within the Trust's monthly divisional performance scorecards to ensure data quality governance is aligned with the Trust's performance management framework.

An operational data quality group, which has representation from all service areas, looks in detail at a number of data quality indicators and monitors improvement. There are 44 priority data quality indicators in use across the Trust, which are available via a data quality dashboard tool.

Access to the dashboard is via the Trust's intranet site and is promoted regularly to staff through internal communications and training sessions.

NHS number and general medical practice code validity

The Trust submitted records during 2013-14 to the Secondary Users Service for inclusion in the Hospital Episode Statistics. The percentage of records in the published data to month eleven of 2013-14 (latest available) which included the patient's valid NHS number was:

- 97.3% for admitted patient care
- 98.7% for outpatient care
- 87.3% for accident and emergency care.

The percentage of records in the published data to month 11 which included the patient's valid general medical practice code was:

- 100% for admitted patient care

- 100% for outpatient care
- 99.9% for accident and emergency care.

The Trust will be taking the following actions to improve data quality:

- Continue to implement the Trust's NHS number strategy, including implementation of a new patient administration system with a real-time connection to the national patient demographic service, which can be used to search for patients' details.
- Assess the benefit of patient self check-in kiosks in outpatient areas, where patients have the opportunity to validate their demographic information.
- Continue to include data quality indicators in the Trust and divisional performance scorecards for review and performance management.

2.8 Review of data on quality of care

The Trust's performance against national priorities for 2013-14 is shown in appendix three. We have met our threshold targets for this year to date. In 2013-14, the Trust has consistently delivered on the 18 week referral to treatment (RTT) standards and the six week diagnostic standard. This meant that over 90% of patients having inpatient treatment and over 95% of patients having outpatient treatment waited less than 18 weeks, and over 92% of patients were waiting for treatment for less than 18 weeks.

The Trust has achieved this by following best practice guidance on the management of 18 week pathways. This includes treating the longest waiting patients first, whilst prioritising urgent patients, such as those with cancer.

Patient experience

The results of the national cancer patient experience survey, which were published in August 2013, were a less positive story. A programme of work was initiated that focused on strengthening leadership in cancer areas, redesigning cancer pathways and improving communication with patients. Much of this work was led at local level and a series of events have run quarterly throughout the year at which staff can feedback the improvements that have been made. For example, the development of a one-stop clinic for urology patients means that all the key things can be done at one visit; this has been very positively evaluated by patients.

In the cancer wards, an Imperial College Healthcare Charity funded project has focused on implementing care and compassion related behaviours identified in the Macmillan Values Based Standard. Again this has been very positively evaluated by patients. In addition the Trust commissioned quarterly surveys that repeat the national questions to see what improvements are being made. We undertook three of these surveys in 2013/14 and some small improvements are being seen.

An online staff training programme on the RTT standards and rules has been developed and will be rolled out over 2014-15. This will be targeted at all new starters to the Trust and for those staff who need refresher training.

Internal and external audits on the quality of RTT data concluded that there was no evidence for concern and adequate data assurance was given. RTT will continue to be part of the annual audit cycle to ensure that the quality of our reported data remains high priority.

In 2013-14 the Trust also continued to meet the six week diagnostic test standard and has delivered this standard each month since June 2012. The focus on cancer performance and patient experience remains high on our agenda and the Trust has made great improvements in 2013-14.

These include:

- establishing a cancer steering board in 2013 led by the chief operating officer and the medical director, Professor Chris Harrison. Professor Harrison was previously medical director at The Christie NHS Foundation Trust, the largest specialist cancer centre in Europe
- the cancer steering Board further strengthens the focus on the initiatives of the multi-disciplinary team (MDT). The MDT sits at the centre of improving cancer performance, delivering success through improved team work
- with the guidance of Macmillan cancer support, launching a north west London initiative to link with partner trusts improving patients' experience throughout London
- holding a workshop every 100 days, bringing all staff working on cancer care together to share best practise and update on progress.

2.9 Information governance toolkit scoring

Good information governance means keeping the information we hold about our patients and staff safe.

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

The Trust's information governance assessment report overall score for 2013-14 was 72% and was graded 'satisfactory'.

This is comparable to last year although we have seen an improvement in performance training due to the development, implementation and delivery of new in-house on-line training that achieved a compliance rate of 98% against the target of 95%.

2.10 Clinical coding quality

The Trust was subject to the Payment by Results audit by the Audit Commission during 2013-14 and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were:

Two areas were looked at in the 2013-14 clinical coding audit and 100 finished consultant episodes were audited in each area:

HRG Sub chapter SA (Haematological Procedures & Disorders), Short Stay Admissions in Gastroenterology and Cardiology.

Diagnoses and procedures coded correctly:

Primary diagnoses = 95%
Secondary diagnoses = 82%
HRG error rate = 10.3% (spell based)

Primary procedures = 89%
Secondary procedures = 71%

Attainment level two (with three being the highest) was reached for clinical coding quality under the national information governance assessment report in 2013-14.

Diagnoses and procedures coded correctly:

Primary diagnoses = 87%
Secondary diagnoses = 91%
HRG error rate = 14.5% (spell based)

Primary procedures = 90%
Secondary procedures = 90%

Part three: Progress against priorities for 2013-14

Of the fourteen targets we set ourselves in last year's Quality Accounts, we have fully achieved seven, partially achieved three, did not achieve three and did not report against one. A summary of our performance against the quality account priorities is in the tables below. Details of our progress against each of the priorities are discussed after the table.

Data is generally produced quarterly, presented as Q1, Q2, Q3 and Q4, and this will be represented in the smaller tables under each priority. We have added a RAG (red-amber-green) rating to the data to highlight if we have met our target or not; therefore the final column will be coloured. Where possible we have included national comparative data. The data is presented using different measurements; these are identified for each individual indicator.

Summary of Progress against Quality Account indicators for 2013-14 (details follow the table)

Our quality indicator	What success looks like	How did we do?	Page
Reducing avoidable harm by ensuring patients are assessed for a risk of Venous Thromboembolism (VTE).	95% of all inpatients having been assessed for a VTE within 24 hours of admission in accordance with the CQUIN target.	**We achieved this target throughout the year.**	37
To ensure high performance against the NHS Safety Thermometer.	Falls – to reduce low and minor harm falls (per 1,000 bed days) by 10%. Pressure ulcers – to reduce the total number of grade 1 and 2 pressure ulcers (per 1,000 bed days) by a further 10%. Urinary catheter related infections – to continue to submit the Safety Thermometer data and to monitor our performance against peer trusts.	**We met all of these targets throughout this year.**	38
To reduce healthcare associated infections.	*C. difficile:* to achieve the DH target of less than 65 cases in the Trust during 2013-14. MRSA BSIs: to meet the national directive to have a zero tolerance for all healthcare associated MRSA BSI's.	**We met the target over the year for *C.difficile*, with a total of 58 cases during the year.** **We have not met this target with 13 MRSA BSI's reported this year.**	41
To increase compliance with anti-infective prescribing.	To be 90% compliant with the Trust anti-infective prescribing policy.	**We have not met this target this year with 83% compliance.**	44
To create a culture of openness and learning through patient safety incident reporting.	To be 10% above the national average for reporting patient safety incidents.	**We did not meet this target, reporting rate was under the national average.**	45

	To be 10% below the national average for reporting patient safety incidents resulting in severe harm or death.	**We partly met this target; met severe harm reporting but not death reporting.**	
To increase awareness of dementia and ensure that relevant patients who are admitted as an emergency are screened and have access to specialist assessments as needed.	To be 90% compliant with the CQUIN target.	**We met this target.**	50

Clinical effectiveness

Our quality indicator	What success looks like	How did we do?	
Standardised Hospital-level Mortality Indicators (SHMI).	To be in the top ten trusts in the country for below the national average for SHMI rates.	**We achieved this target.**	52
Readmissions to hospitals within 28 days.	To remain below the national average for emergency readmissions to hospital within 28 days of discharge.	**We did not meet this target of 6.53%.**	53
Patient Reported Outcome Measures.	To be above the 80% participation rates for all PROMs (groin hernia surgery; varicose vein surgery; hip replacement surgery and knee replacement surgery).	**We did not meet this target.**	54

Patient experience

Our quality indicator	What success looks like	How did we do?	
Waiting times in outpatients department (OPD).	To reduce the number of patients waiting over 30 minutes as measured in the annual OPD Patient Survey.	We were unable to measure this indicator as there was not an annual OPD Patient survey.	55
To improve responsiveness to inpatient needs.	To improve on last year's score and to be one of the best performing trusts.	**We have met this target.**	56
To have caring and compassionate staff.	To improve on last year's score.	**We have part met this target.**	

Friends and Family Test – staff perspective.	To remain above average for staff who would recommend the Trust to friends or family needing care.	**We met this target.**	57
Friends and Family test – patient perspective.	To achieve the DH target of 15% response rate.	**We met this target.**	59

3.1 Progress against each of the 2013-14 priorities

Priority 1: patient safety priorities

To be compliant with the venous thromboembolism (VTE) CQUIN

What is Venous thromboembolism (VTE) *– VTE or blood clots is a major cause of death in the UK. Some blood clots can be prevented by early assessment and intervention.*

Over the past year, the Trust has worked hard to continue to improve our VTE assessment so that 95% of patients are now assessed for their risk of thrombosis (clotting) and bleeding on admission. The Trust considers that this data is as described for the following reasons: we have met our target of >95% of all inpatients having been assessed for a VTE within 24 hours of admission and that patients receive the appropriate treatment as indicated by this assessment.

VTE results

Indicator CQUIN 1	**Q1**	**Q2**	**Q3**	**Q4**	**YTD**	**Target**
Inpatients assessed for VTE **2013-14**	95.1%	96.1%	96.3%	96.8%	>95%	95%
Inpatients assessed for VTE **2012-13**	91.10%	91.11%	91.13%	91.83%	>90%	90%

The number in the brackets in the table below, is the target agreed for that quarter.

Indicator CQUIN 2	**Q1**	**Q2**	**Q3**	**Q4**
Patients identified with a hospital acquired VTE (HAT) have a formal root cause analysis **2013-14**	87.50% (50%)	90.48% (60%)	88.57% (70%)	84.12% (80%)

Action

The Trust has taken the following actions action to continue to improve this percentage and so the quality of its services:

- developing a weekly report to the divisional teams of the number of VTE assessments completed ward by ward. Wards that have not been meeting the targets have been reviewed and supported to improve
- as from the second part of last year, all patients identified as having a hospital acquired VTE (HAT) are subjected to a formal root cause analysis (RCA) with the responsible clinician. This means a thorough investigation is undertaken and any learning identified and shared. The outcome of the RCA is reviewed by the VTE lead

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

- the VTE task force meeting bimonthly and continuing to raise awareness through internal advertising campaign on all sites. The new trust VTE guidelines (directly linked to the NICE guidance) were launched in June 2013.

VTE has also been collected as part of the NHS Safety Thermometer for 2013-14 and this monthly spot audit has repeatedly demonstrated high levels of harm-free care. This means that patients in our organisation are less likely to develop a VTE.

VTE risk assessment compliance will not be a CQUIN scheme in 2013-14. However, performance against the 95% threshold will continue to be monitored through the contract as it remains a high priority for the Trust to continue to deliver.

To ensure high performance against the Safety Thermometer: reducing harm from pressure ulcers, falls and catheter related urinary infections.

What is the NHS Safety Thermometer? *The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm free care. In this report, the Safety Thermometer records pressure ulcers, falls and catheters with urinary tract infections. We have measured our venous thromboembolisms (VTEs); using the CQUIN data.*

The Trust has had between 95% to 97% harm free care during April 2013 and March 2014. This compares with the national average of between 92-94% during the same period. We have performed better than the majority of our peer comparators over the same time period. This means that patients in our hospital are less likely to experience harm when compared with other trusts.

Falls

What are slips, trips and falls? *Across England and Wales, approximately 152,000 falls are reported in acute hospitals every year. A significant number of falls result in severe or moderate injury. Patients of all ages fall. Certain risk factors are more common in younger people (including trip hazards, faints, fits, acute illness, recovery from anaesthetic) but falls are most likely to occur in older patients, and they are much more likely to experience serious injury (NPSA 2007). The causes of falls are complex and older hospital patients are particularly likely to be vulnerable to falling through medical conditions including delirium, cardiac, neurological or muscular-skeletal conditions, side effects from medication, or problems with balance, strength or mobility. Problems like poor eyesight or poor memory can create a greater risk of fall when someone is out of their normal environment on a hospital ward. .*

The Trust reports falls as patient safety incidents via our datix reporting system. We consider that this data is as described for the following reasons: we have continued to remain below the national average rate of reported falls, that being 5.6 per 1,000 bed days. We have also met our target of having fewer than 33% of cases per year where falls have resulted in low/minor harm.

Falls results 2013-14

Indicator	Q1	Q2	Q3	Q4	Target
Remain below the national average of total reported falls	3.82	3.78	4.34	**3.83**	Below 5.6 per 1000 bed days
To reduce the percentage of patient falls that result in low/minor harm (%)	29.1%	34.0%	27.3%	**25.0%**	<33 %

We also collect data using the NHS Safety Thermometer National Tool. The Safety Thermometer Tool measures falls in a different way from patient safety reporting. Each month on one day, we measure how many patients had a fall in the 72 hour period before the time of audit. This type of measurement is referred to as point prevalence as it refers to how many people or patients have fallen at this time of measurement. It is therefore a snap shot of time whereas the patient safety reporting measures all falls over a period of time, in this case a year.

The Safety Thermometer results confirm that patients in our Trust are less likely to come to harm through falls than in other NHS trusts.

Action

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

- using nursing forums to promote best practice in falls treatment and management
- monitoring falls by the number, type, severity of harm and location in order to learn from them and share this information with clinical teams

- reviewing our compliance with our falls care plan through our 'back to floor Friday' audit schedule. Falls are also monitored alongside other key performance indicators at divisional performance reviews
- our falls nurse specialist conducts a falls clinic and reviews patients who fall
- our falls specialist consultant works alongside the falls nurse specialist to review those high risk patients.

Pressure ulcers

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

The Trust reports pressure ulcers as patient safety incidents via our datix reporting system. We consider that this data is as described for the following reasons: we have met our target for this year to have less than 1.23–1.89 pressure ulcers graded as 1 or 2 per 1,000 bed days.

Pressure ulcer results 2013-14

Indicator	Q1	Q2	Q3	Q4	Total	Target
To reduce the number of pressure ulcers graded 1 or 2 per 1000 bed days	2	1.33	0.86	0.98	**1.29**	<1.23-1.89 per 1000 bed days

We also collect data using the NHS Safety Thermometer National Tool. The Safety Thermometer Tool measures pressure ulcers in a different way from patient safety reporting. We record pressure ulcers at a 'snap shot' of time as explained in the falls section above. The Safety Thermometer results show that we are performing better than most other NHS trusts and therefore our patients are less likely to develop a pressure ulcer whilst in our care.

Action

The Trust established a pressure ulcer prevention and reduction working group, chaired by the deputy director of nursing. This group will oversee the pressure ulcer work, underpinning Trust wide improvements with key principles and objectives, and setting targets for the on-going prevention and reduction of all pressure ulcers. The working group is:

- developing a Trust wide pressure ulcer reduction and prevention strategy
- launching a new pressure ulcer policy in 2014 to deliver the pressure ulcer reduction strategy and outline clear management strategies for the investigation, reporting and management of pressure ulcers
- developing new ways of working to improve practice including a focused approach to pressure area management in critical areas led by senior nurses
- undertaking a thorough investigation of all pressure ulcers using a pressure ulcer toolkit
- sharing learning between the divisions to support improvement in clinical practice.

In addition, the tissue viability nurses are conducting quality rounds to support staff at ward level.

Urinary catheter related infections

What is a urinary tract infection? *A urinary tract infection is an infection that can happen anywhere along the urinary tract. People are at increased risk of urinary tract infections if they are diabetic, older, have a urinary catheter (a tube inserted into the urinary tract to drain the bladder), have kidney stones, are immobile or have had surgery.*

The Trust considers that the data is as described for the following reasons: we did not set a target for this indicator other than to report the data, we have done this through the Safety Thermometer tool.

Action
The Trust will continue to submit NHS Safety Thermometer data related to urinary catheters and urinary tract infections over the next year and to compare ourselves against peer NHS organisations.

To reduce the risk of healthcare associated infections

- ***Clostridium difficile**** **(*C.difficile*)**

What is Clostridium difficile (C.difficile)? *Clostridium Difficile* is an anaerobic (an organism living in the absence of air) bacterium that can live in the gut of healthy people, where it does not cause any problems. However, some antibiotics can interfere with the balance of bacteria in the gut which may allow *C.difficile* to multiply and produce toxins that damage the gut. The bacteria can be spread on the hands of healthcare staff and others who come into contact with patients who have the infection, or with environmental surfaces contaminated with the spores.

Our performance on reducing the rate of *C.difficile* continues to improve. The Trust considers that the data is as described for the following reasons: we have continued to reduce the total number of *Clostridium difficile* cases per year as per table below.

- ***C.difficile*** **results (Trust data)**

Year	Indicator	Q1	Q2	Q3	Q4	Total	Number set by DH
2012-13	To reduce the number of *C.difficile* cases as set by the Department of Health (DH)	23	20	23	20	**86**	110 cases per year
2013-14		26	11	10	11	**58**	65 cases per year

The number of cases of *C.difficile*, as a rate of patients admitted to our hospitals per 100,000 bed days, is 15 cases per 100,000 bed days (using 2012-13 bed days data, supplied by Public Health England).

There were 12 laboratory tests that did not represent cases of *C.difficile* infection and were not reported. There were other clear reasons for a loose stool in these cases and there was no evidence of *C.difficile* infection.

C difficile infection cases reported at Imperial are in patients who have diarrhoea, evidence of *C difficile* infection and where there is not another clear cause for their loose stool (e.g. laxatives or enemas). Although staff are encouraged to think about underlying causes of diarrhoea, we do not restrict the testing for *C.difficile* across our hospitals, as a positive test in a patient with even a single loose stool indicates a patient may be a carrier of *C.difficile* and therefore poses a potential risk of transmission, warranting local infection prevention action.

All patients who have a positive PCR test for *C.difficile* have a clinical review by an IPC nurse and by an expert multidisciplinary *C.difficile* ward round team. Symptoms at the time of the test are confirmed and evidence of disease systematically and objectively reviewed against standardised criteria. Decisions about the treatment of the patient are made by the patient's clinician with input from the *C.difficile* expert team. These rests entirely on the clinical circumstances and do not rely on the toxin status.

Over the past year, the Care Quality Commission (CQC) has reviewed our infection control practices in one of their planned inspections. They found the wards they inspected to be clean and that the Trust had the right systems in place to prevent and control the risk of infection.

The CQC inspection team found many examples of good practice in the care they observed our teams providing and did not require us to carry out any additional actions.

Action
We have taken the following actions to continue to reduce this rate and so the quality of its services:

- Implemented the guidance from Public Health England that requires the isolation of patients with suspected or confirmed infectious diarrhoea within two hours of onset of diarrhoea.
- Reviewed and updated our policies and procedures to reflect the above.
- We closely monitor the time to isolation as a quality metric.
- Conduct detailed clinical reviews of each case of *C.difficile.*
- Monthly MDT review of all *C.difficile* cases is undertaken in which risk factors for each case are collated and learning shared with primary care colleagues. Our consultant pharmacist has highlighted these issues to GPs (via the GP bulletin newsletter) to help raise awareness and look to mitigate these.

- ***Methicillin resistant Staphylococcus aureus (MRSA) Blood Stream Infections (BSI)***

What is Methicillin resistant Staphylococcus aureus (MRSA)? MRSA is a bacterium that is found on the skin and in the nostrils of many healthy people without causing problems. It can cause disease, particularly if there is an opportunity for the bacteria to enter the body, for example through broken skin or a medical procedure.

The Trust considers that the data is as described for the following reasons:

- We had continued to reduce the total number of MRSA BSI cases per year. In 2011-12 there were thirteen cases of MRSA BSIs attributable to the Trust, with a further reduction noted in 2012-13 to eight.
- In 2013, a new system was introduced as to how we measure MRSA BSIs. We believe this has made a difference to our numbers and note that six of the cases reported below are actually attributable to the Trust.

MRSA BSI results

Indicator	Year	Q1	Q2	Q3	Q4	Total	Number set by DH
To reduce the number of MRSA cases as set by the Department of Health (DH)	2011-12					**13**	
	2012-13	1	1	2	3	**8**	**9**
	2013-14	5	4	2	2	**13**	**0**

Action

We have taken the following actions to continue to reduce this rate and so improve the quality of our services:

- We are working with peer hospitals, the Clinical Commissioning Group, Trust Development Authority and Public Health England to ensure all appropriate processes are in place and a robust MRSA action plan has been developed to ensure these key elements are delivered.
- We have reviewed the MRSA policy including increased MRSA screening reflecting themes identified from in depth reviews of each case of MRSA blood stream infection.
- We discuss and review all cases of MRSA BSI with the individual consultant at the weekly medical director's meeting with actions agreed and implemented.
- We have reviewed and re-launched our Trust wide vascular access committee to reflect the changes in clinical structures across the Trust. This group consists of senior clinicians and managers who are key to supporting the clinical divisions to deliver our on-going quality improvement programme.
- Since the aseptic non-touch technique (ANTT) programme commenced in 2012, 9,645 staff have now been competency assessed.

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

- We have increased our vascular access team.
- We have reviewed all our isolation facilities and have highlighted the limited availability of these on the Trust risk register.
- We commissioned an international expert to undertake a review of vascular access practice and quality improvement programmes with a view to providing recommendations on how to further improve our outcomes. The independent expert endorsed our competency assessment framework, and gave further recommendations for the planning and implementation of the reassessment process. They highlighted the need to increase multi-professional involvement in the planning and delivery of a comprehensive BSI prevention programme and also provided their expert opinion on surveillance and analysis of the overall burden of MRSA across our health economy.
- The Trust has an on-going commitment to continuously improve quality in relation to the safe management of all vascular devices. A number of quality improvement actions have been implemented by the divisions which focus on documentation and review of all vascular devices during every shift and locally reviewing compliance data. The Trust is looking to further invest in resources to sustain and monitor best practice.

To ensure compliance with the Trust policy for anti-infectives

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

The Trust considers that the data is as described for the following reasons: we looked at three parts of anti-infectives prescribing, including:

- having a reason for starting the antibiotic clearly documented within the patient's medical notes/drug chart
- a stop/review date on the drug chart to optimise the duration of therapy
- are anti-infectives prescribed in line with the Trust's antibiotic policy or approved by a Trust infection specialist.

These three parts were chosen as they are considered to be the most important aspects of using anti-infective medications. Our own target is 90% compliance in all three areas. We found that we did not meet our target for all three areas.

Results

We conducted two Trust-wide audits in 2013-14 and have reported them as audit 1 and audit 2 (see overleaf). The Trust made significant progress with 93% of our prescriptions having a documented reason for starting anti-infective medications; and 90% for prescribing in line with the Trust antibiotic policy or having prescriptions reviewed by an infection specialist. However, we need to continue to improve on the documentation of start-stop dates as we achieved 66% against this measure.

Average compliance with anti-infective policy results 2013-14

Indicator	Audit 1	Audit 2	Target
To ensure we are compliant with the anti-infective policy	**83%**	**83%**	90% compliant with policy

Action
We have has taken the following actions to improve our practices in prescribing anti-infectives:

- Increased our monitoring of compliance from twice a year to quarterly to facilitate greater feedback and engagement within the organisation. This will take effect from April 2014.
- Launched a revised adult antibiotic policy and a new adult surgical prophylaxis policy.
- Reviewed various anti-infective policies within the organisation.
- Continued to promote the Department of Health 'Start Smart Then Focus' initiative which aims to encourage regular review of patients who are taking antibiotics.
- Updated our Trust antibiotic application for smart phones to facilitate access to our policies and started work on a paediatric version.

Our anti-infective prescribing is monitored and reviewed at regular intervals by the Trust infection prevention and control committee, antibiotic review group and pharmacy department. These groups engage with clinical and managerial teams to promote best practice.

In 2013, the Department of Health launched its five year antibiotic resistance strategy. This focuses on raising the awareness of antibiotic resistance, improving both staff and patients' knowledge of antibiotics and ensuring antibiotics are used correctly. The Trust will be working on implementing this throughout 2014.

We are committed to making improvements in this important area and will continue to monitor our indicators as part of the 2014-15 Quality Accounts in our priority to reduce healthcare acquired infections.

Reporting of patient safety incidents

What is a patient safety incident? *– A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care. (National Patient Safety Agency).*

The National Reporting and Learning Service (NRLS) was established in 2003. The system enables patient safety incident reports to be submitted to a national database on a voluntary basis and is designed to promote learning.

To avoid duplication of reporting, all incidents (including near misses) are reported to the NRLS who then report incidents resulting in moderate harm, severe harm or death to the

Care Quality Commission (CQC). There is a mandatory requirement for trusts to report incidents resulting in severe harm or death to the NRLS and CQC. The majority of NHS trusts report patient safety incidents through NRLS.

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

The Trust considers that the data is as described for the following reasons:

- We have not met our targets to be 10% above the national average for patient reporting safety incidents or to be 10% below the national average for reporting patient safety incidents resulting in death (graded extreme).
- We have met out target to be below the national average for reporting patient safety incidents graded severe.

Results

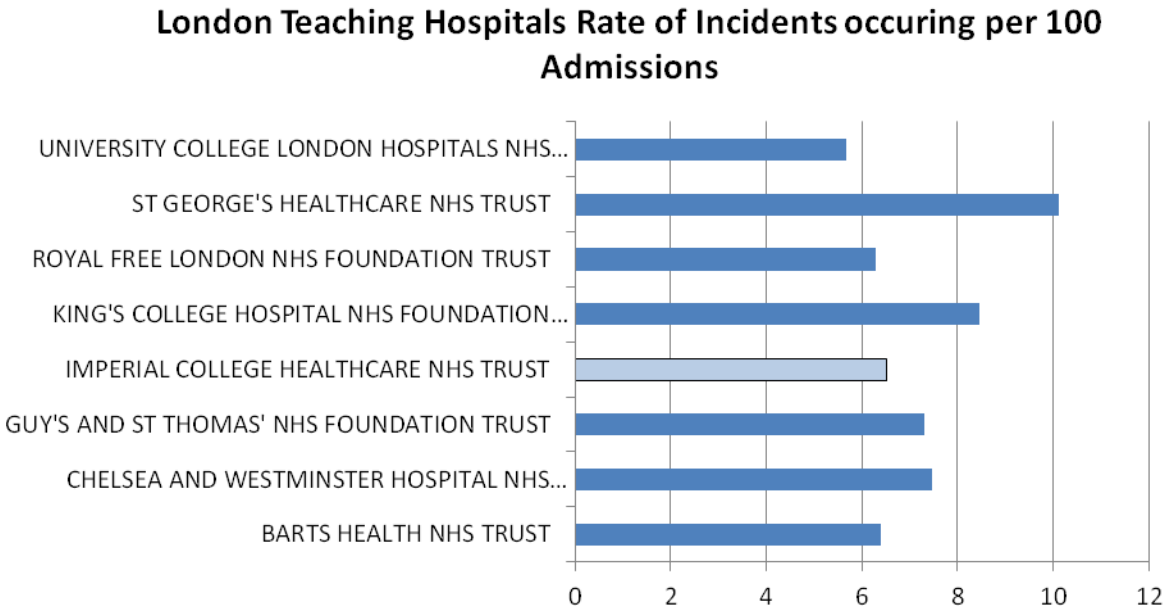
An important measure of an organisation's safety culture is its willingness to report adverse events, learn from them and deliver improved care. A high reporting rate of patient safety incidents is viewed as a positive reporting culture, as staff feel supported to report. Our reporting rates have increased over the past year when compared with 2012-13 (6.5 % last year); however nationally patient safety reporting rates have also increased. The 'major' (severe) and 'extreme' (death) incidents are reported as a percentage of the overall incidents reported.

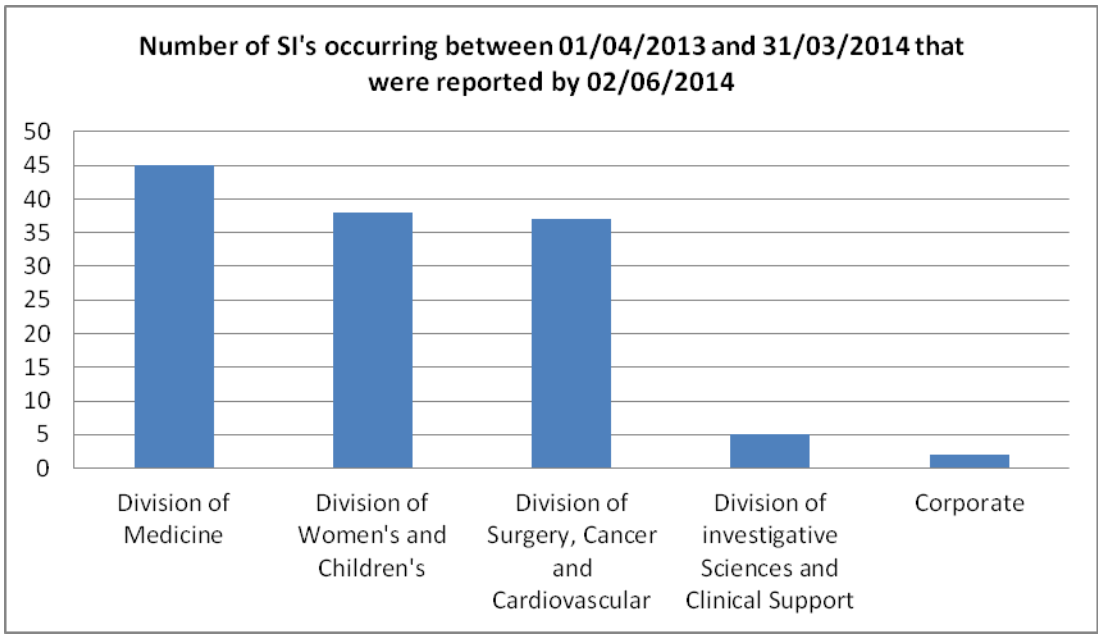
During the data period April 2013-March 2014, a total of 12,509 patient safety incidents were reported. (data extracted from online incident reporting system on 2nd June 2014. The online incident reporting system is a live database and the data is subject to change).

Indicator	Q1	Q2	Q3	Q4	Average	Target
To remain above average for patient safety reporting rates per 100 admissions in 2013-14	6.8	6.1	6.7	6.5	**6.5**	>8.78 per 100 admissions
To remain below the peer average for incidents graded as extreme (death) in 2013-14	14 (0.4%)	8 (0.3%)	4 (0.1%)	4 (0.1%)	**30 (0.2%)**	<0.1 % of average patient safety incidents reported for the Trust graded as extreme (death)
To remain below the peer average for incidents graded as major (severe)	1 (0.03%)	4 (0.1%)	2 (0.1%)	1 (0.03%)	**8 (0.1%)**	< 0.2% of average patient safety incidents reported for the Trust graded as major (severe)

Serious incident data is not available nationally so benchmarking is not possible. Using National Reporting and Learning System (NRLS) to benchmark performance of incidents reported (per 100 bed days) places the Trust as either within or better than the peer group.

Each incident which is declared a serious incident is investigated using root cause analysis (RCA) methodology, a report is written which is presented to a panel chaired by the medical director, where an action plan is agreed and implemented. The aim of the investigation is to improve care delivered to our patients and to prevent a recurrence of the incident or similar situation. The table overleaf shows the overall reporting rate of all patient safety incidents by the Trust compared to London Teaching Hospitals.





The table above shows that:

- the investigative sciences and clinical support division are the lowest reporters of serious incidents
- the medicine division are the highest reporting.

In addition to this, the Trust site with the most reported SIs over the past year was St Mary's Hospital. To put this into context, the medicine division accounts for the largest activity in the Trust and St Mary's site has the majority of the acute services with the major trauma centre being located there.

The most reported five themes from serious incidents in 2013-14 are:

- pressure ulcers (Grade 3 and above)
- maternity services
- delayed diagnosis
- unexpected death
- sub-optimal care of the deteriorating patient.

Action

During 2013-14 the Trust has taken the following actions to improve patient safety reporting and the quality of services:

- Introducing a weekly incident panel, led by the medical director where all incidents that result in moderate or above harm are reviewed with the divisional director and their senior team.
- Launching a new Quality Strategy for the financial years 2013-15, based on Berwick's six goals for improvement.
- Introducing division based quality and safety teams to provide thorough and regular review of incident themes, trends and implementation of action plans ensuring local learning.
- Upgrading the Datix Incident Reporting system to provide improved systems and processes for monitoring, reporting and learning from adverse events.
- Linking of incident trends and themes to service improvement and junior doctors' training.
- Implementing a rolling programme of training for all clinical staff. The new system is easier to use and allows feedback of actions to the person who reported the incident.
- Developing new patient safety registrar roles within the divisions.
- Establishing new divisional quality boards to ensure that learning from incidents is shared within and across the divisions.
- Sharing learning from all serious incidents with staff through the Trust intranet site.

In relation to the most reported themes arising from patient safety incidents, the Trust has taken the following actions:

- The escalation process for emergency theatre access has been modified, with escalation now direct to the consultant.
- The step-down process for the major trauma ward has been revised.
- A new process for tracking direct access referrals to diagnostic services in primary care has been implemented.

- Outreach support is available on all sites and is supported out of hours by the site team.
- Introduced the National Early Warning System (NEWS) across the organisation, to assist our people in the early recognition and escalation of a deteriorating patient.
- Launched the SBAR across the organisation (Situation-Background-Assessment-Recommendation) to support our people in escalating concerns in a clear and concise manner.
- All staff who use the NEWS chart have been trained on how to use the chart.
- Additional ward based training and support has been provided by the outreach team.
- Auditing compliance with the use of the NEWS chart, ensuring that patients have been escalated appropriately.
- Purchased new equipment to enable simultaneous monitoring of the fetal and maternal heart rate.
- Recruited into consultant posts (maternity) to ensure we have 98 hour consultant presence on the labour ward.
- Enhanced midwifery training focusing on CTG (continuous cardiotocography) assessments and drug calculations.
- Business plans are in place to increase our midwife: woman ratio from 1:33 to 1:28 in accordance with national guidelines.

"The NEWS chart and the SBAR tool have been well received by staff. People tell us they like it and that it gives them confidence to escalate their concern; they find it empowering."

Julie Oxton, critical care consultant nurse

Patient safety registrars

We have appointed seven registrars to act as patient safety representatives across the Trust. These roles give the post holders an opportunity to work with the governance department in the Trust on integrating junior doctors into Trust governance structures. Initiatives that the post holders will take forward include:

- serious incident review groups meeting to ensure a focused discussion on recent illustrative serious incidents involving 'failure to rescue'
- registrar volunteers on serious incident panels. Registrars have been invited through the departmental education clinical leads to sit on serious incident review panels
- registrar attendance at medical director's Friday morning serious incident meetings - excellent management experience.

The patient safety registrars in conjunction with the patient safety team run small focus groups of junior doctors to examine recent serious incidents. The sessions involve presentations and discussions of serious incidents and suggestions for changes to practice. This gives the junior doctors perspective on lessons that could be learnt from serious incidents and hopefully give constructive feedback and ideas for the future. The feedback will be fed back to the quality and safety governance teams with the aim to improve practice.

Dementia CQUIN

The aims of this CQUIN are to improve dementia care, including sustained improvement in **F**inding people with dementia, **A**ssessing and **I**nvestigating their symptoms and **R**eferring for support (FAIR);
There are three indicators that measure compliance of this CQUIN:

1. Find, assess, investigate and refer (90% compliance rate required)
2. Clinical leadership and delivery of a comprehensive training programme
3. Completion of a monthly audit of carers with dementia.

The Trust considers that the data is as described for the following reasons: we have met all elements of this CQUIN scheme. The data for the FAIR element of the CQUIN is being reviewed by internal audit (report pending) as part of the business as usual internal assurance process.

Actions

We have taken the following actions to improve this percentage and so the quality of services:

- Recruited to the dementia team to replace existing vacancies.
- Re-launching the consistent use of the blue stickers (dementia screening tool label)
- Introducing dementia training for all ward based nurses and health care assistants. We introduced this training this year and have trained 1,112 registered nurses and health care assistants to date.
- Delivering dementia awareness training as part of the junior doctors' induction programme and have included this as part of their rolling (ongoing) training programme.
- We aim to introduce this for allied health professionals (physiotherapists, occupational therapist, radiographers, dieticians, podiatrists and speech and language therapists) next year.
- All new staff now attend a dementia awareness session as part of their induction.

The dementia training has been welcomed by staff and below are some of the key feedback themes and comments we received from our people who attended the training. The 'word cloud' below highlights key words used by staff in their feedback on the dementia awareness sessions. The larger the word, the more often it was used.

- We are currently piloting a questionnaire that will help us to seek feedback from carers. We hope to use this questionnaire throughout the Trust. Once established, we will use the feedback to help us focus on what is important to carers. We will report our findings to the board twice a year.
- We are providing more information for our people on dementia care. We have a network of 45 'dementia champions' of our people across our Trust, including nurses; doctors; therapists and facilities staff. The 'champions' will help us to work on different projects to improve the care we provide to patients with dementia. Our dementia website provides information for all staff on many different aspects of dementia care. We held a National Dementia Awareness Week in May across all sites that was well received and attended. We had the opportunity to have private sessions with carers of people with dementia.

Our people told us:

"Enjoyed the day and learned a lot about dementia and how I can improve my practice." **Registered general nurse (RGN)**

"NHS staff, both clinical and non-clinical, should be given dementia training as this will be very useful in dealing with patients with dementia which staff will come across all the time." **Health care assistant**

"Well structured, gradual introduction of topics. Educative and informative. Subject matter is well presented and the tutor is very good, engaging and well informed." **RGN**

"I will be more vigilant and aware. I was very pleased I attended as there were things I was unaware of." **Ward administrator**

"Thank you for a very interesting and useful session." **Pharmacist**

"Clear and useful information on dementia. Good information regarding symptom recognition and expectations. Well presented and good scope covered." **Junior doctor**

We were recently inspected by the Care Quality Commission (CQC) as part of the national themed work looking at dementia care. CQC looked at how we were caring for our patients; how we were cooperating with other providers and how we were assessing and monitoring the quality of our services. They found we had met all of these outcomes and gave examples of how staff are trained and supported to care for people with dementia and their families.

The CQC spoke with our patients and families and were told:

"They (the nursing staff) are always there for me."
"I'm looked after absolutely perfectly."
The CQC reported that 'we saw that family members were involved in discussions about their relatives'.

Priority 2: Clinical effectiveness priorities

To remain better than the national average for mortality rates as measured by the Summary Hospital Level Mortality Indicator (SHMI)

The Summary Hospital Level Mortality Indicators (SHMI), is a mortality measure that takes account of a number of factors, including a patient's condition. It includes patients who have died whilst having treatment in hospital or within 30 days of being discharged from hospital. One of the characteristics that are measured is the palliative care indicator. This tells us the percentage of patients who died that were recorded as palliative care at diagnosis or speciality level. The SHMI score is measured against the NHS average which is 100. A score below 100 denotes a lower than average mortality rate and therefore indicates good, safe care.

Results

The Trust considers that the data is as described for the following reasons: our score of 78.4 indicates that we are in the top four trusts in the country (data published on the Health & Social Care Information Centre for the period 1 July 2012- 30 June 2013). When we compare ourselves with our peers, that being the Shelford Group (which comprises of ten leading peer NHS multi-speciality academic healthcare organisations who are dedicated to excellence in clinical research, education and patient care), we have the third lowest SHMI for the period July 2012-June 2013.

At our Trust, 28.8% (national range of 4.2-44.1) of patients who died were recorded as being palliative care patients. This number reflects the specialities that we have at the Trust and is comparable to similar NHS trusts such as Guy's and St Thomas' NHS Foundation Trust (36.2) and King's College Hospital NHS Foundation Trust (36.1).

The table below indicates site specific information.

Site	SHMI
St Mary's Hospital	**80.25**
Charing Cross Hospital	**74.28**
Hammersmith Hospital	**84.81**

We note that across our organisation, the site with the highest SHMI is Hammersmith Hospital (84.81). This may be a reflection of the types of services located at our sites as a large proportion of our cancer and specialist services are located at Hammersmith Hospital.

Action

The Trust has taken the following actions to continue to improve this rate and so the quality of its services by:

- continuing to focus on our failure to rescue (failure to prevent a clinically important deterioration) work to improve the recognition and escalation of the deteriorating patient through the ongoing training of staff
- introducing the NEWS observation chart (that is the National Early Warning Score) and setting up a task force group to monitor, develop and support this work

- establishing the SBAR (Situation-Background-Assessment-Recommendation) communication tool across all areas to provide nursing staff with a structured approach to raising concerns
- reviewing by an appropriate clinician all patients that are stepped down from the major trauma ward within two hours
- carrying out daily consultant-led ward rounds
- working to reduce our failure to rescue incidents. We anticipate this will positively impact further on our mortality rates.

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

The unplanned readmission rate for adult patients treated at Imperial College Healthcare NHS Trust is similar to the NHS average. We believe our performance reflects our status as a large Trust that treats both local patients and patients with specialist or complex medical conditions.

Results
The table below shows the number of emergency readmissions to hospital within 28 days of discharge results in 2013-14.

Indicator	Q1	Q2	Q3	Q4	Target
To reduce the number of emergency readmissions to hospital within 28 days of discharge age 0-14 years	4.55%	4.50%	5.55%	4.69%	
To reduce the number of emergency readmissions to hospital within 28 days of discharge aged > 15 years	6.79%	6.78%	6.96%	6.81%	
To reduce the number of emergency readmissions to hospital within 28 days of discharge	**6.59%**	**6.57%**	**6.84%**	**6.60%**	National average not available but peer comparator reported as 6.53 % (to be updated in May 2014)

Action
We are taking the following actions to reduce the number of patients requiring readmission:

- We are working with GPs and community teams to review patients who have been readmitted so that we can agree specific actions for these patients.
- We have established an Older Persons assessment clinic that ensures we can provide rapid ambulatory access to assessment and planned care.
- We have extended the hours of the discharge team to provide support in the evening and at weekends.

To increase patient satisfaction as measured by Patient Reported Outcome Measures (PROMs)

Patient reported outcome measures (PROMs) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following one of the four clinical procedures below:

- hip replacement
- hernia repair
- knee replacement
- varicose vein treatment.

Patients who have these procedures are asked to complete the same short questionnaire at two different time points; before and after surgery. The difference between the two is used to determine the outcome of the procedure as perceived by the patient.

The table below shows data published 8th May 2014 referring to patients questioned between April 2012 and March 2013.

Indicator	Year Total	Target
To increase PROMs participation rate for hernia surgery	55.1%	Above 80%
To increase PROMs participation rate for hip surgery	66.9%	Above 80%
To increase PROMs participation rate for knee surgery	66.4%	Above 80%
To increase PROMs participation rate for vein surgery	62.1%	Above 80%

There was an issue with the methodology used by the company who collects the PROMS data. The after surgery questionnaire was not being sent to patients until 9 months after the before surgery questionnaire had been sent. The company have changed their practice to reducing the time difference between the two questionnaires to 6 months.

The results from the questionnaires in terms of patient outcome were

Indicator	Number	Health Improvement	Health Unchanged	Health Worsened
Hip replacement	91	78 (85.7%)	4 (4.4%)	9 (9.9%)
Hernia repair	80	46 (57.5%)	17 (21.3%)	17 (21.3%)
Knee replacement	105	83 (79.0%)	13 (12.4%)	9 (8.6%)
Varicose vein treatment	199	102 (51.3%)	63 (31.7%)	34 (17.1%)

Action
We are taking the following actions to improve our response rates:

- Ensuring each PROM has a clinical lead to regularly review the scores at service level and to promote the completion of PROMs.
- Ensuring quarterly reporting of PROMs data to the divisional quality boards.
- Ensuring quarterly reporting of PROMs data to the quality committee.
- Piloting a new online system with Imperial College academic department, for all patients who have undergone knee and hip surgery called 'JointPRO'.

JointPRO is an on-line system that allows the Trust to interact with our patients to:

- score and track patients health over time
- set motivational targets
- share scores with clinical staff
- share experiences with similar patients, offering practical advice.

We anticipate that this new interactive tool will directly impact on our patient's experience and in the longer term will:

- support real time access to PROMS
- actively monitor patients
- support clinical decision making reducing the need for hospital appointments
- enable 'smart' targeted patient reviews
- engage patients in their own care.

Priority 3: Patient experience priorities

To improve patient satisfaction with waiting times to be seen in outpatient clinics

The Trust considers that the data is as described for the following reasons: we have not been able to report against our target as we intended to measure this through the National Outpatient Survey and this has not been undertaken in 2013-14. We did however, continue to survey local views across our outpatient clinics and review our results using the Trust's own I-track system, asking the question 'how long after the appointment time did the appointment start?'. We found that we had improvements in this area with 60-75 % of appointments starting on time.

Although we cannot report against this priority, we have been working to improve our waiting times and communication within the departments. We are rolling out new 'check-in booths' in all outpatient departments, to reduce queuing and speed up the 'check in' process. We have worked with our people to identify ways of improving communication with patients that are waiting. We will roll out the patient Friends and Family Test (FFT) in all outpatient areas by October 2014 and will look to include this data for our 2015-16 Quality Accounts.

To improve the responsiveness to inpatients' needs

We measure responsiveness to inpatients' needs through the National Inpatient Survey. This enables us to make direct comparisons with other NHS trusts. In addition, we monitor important aspects of this through our own real-time feedback patient survey using the I-track device, that is an electronic system, including hand held devices and booths, that are used to collect the data.

Responsiveness to inpatient results 2013-14

The Trust considers that the data is as described for the following reasons: we have met our target to improve on our responsiveness to inpatients' needs.

National Inpatient Survey results

Indicator	2012-13	**2013-14**
Responsiveness to inpatient needs	6.64	**6.78**

Action

The Trust has taken the following actions to continue to improve these scores:

- Actively monitoring performance against key questions using the real-time (I-track) devices.
- Initiated a high profile poster campaign indicating our commitment to improve patient experience.
- In cancer wards, implementing a project focusing on embedding the behaviours outlined in the Macmillan Values Based Standard.
- The Trust is also revising its patient centredness strategy with a view to launching this in May 2014.

We continue to closely monitor our reporting and include these measures as part of the compliance monitoring of the Trust's patient and carer strategy. In addition, we intend to continue work around patient discharge, including a review of the information given to patients.

To have caring and compassionate staff

The Trust considers that the data is as described for the following reasons: we measured this target for the first three-quarters of the year and the last two quarters of the previous year as shown in the table below). In December 2013, we reviewed all of our I-track questions as we have been implementing the FFT tests and wanted to include more specific questions related to areas of concern raised by the chief inspector of hospitals. This included focusing on pain and eating and drinking. In light of the number of questions we were asking our patients, we decided to remove this question for quarter 4 and to include those areas identified as a result of feedback from the chief inspector of hospitals inspection. We have therefore reported our data for this priority, for the quarters it was collected.

Caring and compassionate staff results 2013-14

	2012-13		2013-14				
Indicator	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Target**
To have caring and compassionate staff	94%	94%	94%	95%	94%	Not recorded	

We have taken the following actions to continue to improve these scores:

- Patient stories are now part of our Trust board reports.
- Since May 2013, six patient stories have been shared with the board. Below is an extract from one family's experience at one of our hospitals that was presented to the board in May 2013.

A family's experience

In June, a pregnant couple attended Queen Charlotte's Hospital. The patient's waters had broken and were meconium stained and they were obviously very anxious.

On arrival at the delivery suite they were introduced to their first midwife. The couple described that she was fantastic and spent time addressing their fears and concerns and getting them settled. They expressed that they felt confident in her and reassured that everything was under control and proceeding as expected. Without exception, she was always professional, caring and understanding, which is difficult to achieve in a busy environment like the delivery suite, in their experience.

At shift change, another midwife was allocated to look after them. Again, they expressed that she was amazing, spending time explaining the process, making sure the patient had a chance to discuss her wishes for the birth. When baby arrived, it was all relatively sudden and he had the cord around his neck. In their view, the midwife was very calm, dealt with it efficiently and only told them about it after baby was safely out (which was absolutely the right time to tell them in their opinion).

They describe that their care in the delivery suite was absolutely faultless and especially the work of the midwives who they would like to know what a great job they did and that it is really appreciated.

Key features that gave a positive experience:

- personalised care
- explanation
- involvement in decision making and care
- reassurance.

To remain above the national average for staff who recommend the Trust as a place to work/receive treatment

We have reported against this indicator using the National Staff Survey findings. This indicator is calculated based on the findings of question 12d from the national survey, that being 'If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation'. We have begun rolling out the Friends & Family staff test from April 2014 ahead of national guidance, within our own Trust engagement survey that was launched in October 2013 and which surveys a quarter of our people each quarter.

Staff survey results – recommend as a place to work/receive treatment

The Trust considers that the data shown in the table below demonstrates that we have met our target to be above the national average for staff who would recommend the Trust to friends/family as a place to work or be treated, based on question 12d from the national staff survey. We believe the willingness of our people to recommend the Trust as a place to work or be treated is a strong and positive indicator of the standard of care provided to our patients.

Indicator	National average for all acute Trusts	Imperial College Healthcare NHS Trust 2012	Imperial College Healthcare NHS Trust 2013
Question 12.d: If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	**64**	**69**	**69**

Action

We intend to take the following actions to further improve this result and so the quality of our services. We will do this by sharing our Trust quarterly survey findings with each division to ensure there is local ownership and engagement of our people. We have developed our Trust engagement survey to enable us to closely monitor our people's views and have identified three key priorities as a result of our first two quarters' results. These are:

- **Improving staff health and wellbeing**
  The health and wellbeing of our people is vital to the Trust. Research shows healthy, happy staff are more productive and deliver better patient care. In the coming months, the Trust will be launching a new health and wellbeing programme, which will give people better access to resources such as training and support. This will build on the iMove programme which is already helping people stay fit and healthy. We will also be implementing changes to our occupational health services this year which will enhance the service for our people.
- **Empowering and inspiring our staff**
  We are actively discussing the results from our first two quarters' engagement surveys with all our people. Divisions and departments have established open forums and communication tools over the last quarter, and we will continue to work with teams to build on this.
- **Making opinions count**
  We launched a new monthly people and organisation development forum in January 2014. It is open to all our people to seek views and feed back on a range of initiatives within people and organisation development. In addition, director of people and organisation development, Jayne Mee has hosted her second live web chat. This was very well attended and has given our people the chance to talk to Jayne on the issues which matter most to them.

We are now working towards delivering on these priorities and are continuing to monitor our people's feelings about working in the Trust, whether that is quarterly, or as new joiners and leavers, who will be invited to share their initial and final thoughts with us.

"These results have given us an insight into how our people feel about working at our Trust. The senior leadership team is fully committed to making changes so our people feel valued and supported, and that they have a positive experience.

As we get more responses we will continue to analyse the themes and changes in the feedback and report back on what we learn from these. Importantly, we will also describe the actions being taken as a result of what we've heard.

We have quite a way to go, and together I believe we can make the Trust a great place to work.

Our surveys are completely anonymous and confidential. We do not know who is being sent them or who replies – but we're counting on our people to tell us what more we need to do. I look forward to hearing real and honest views as I am out and about in the Trust and also on the next webchat".

Jayne Mee, director of people and organisation development

To achieve the minimum Department of Health target* of 15% response rate for the Friends and family test (FFT) – Patient perspective

The Trust launched the national Friends and Family Test (FFT) on 1 April, 2013 to obtain feedback from patients in our acute inpatient services and A&E departments. As of 1 October 2013, this requirement extended to include maternity services. All inpatient wards, A&Es and maternity services must now ensure that all eligible patients are given the opportunity to respond to the question and each ward or department must collect a minimum of 20% (although this was 15% up until the end of December 2013). Going forward, this will be used as a key measure of patient experience with all wards expected to achieve a target level.

We capture this data through our I-track device and more recently though booths located throughout the hospital. Patients are asked to complete this in the A&E department and the wards and we have recently begun rolling this out in our outpatient departments.

The devices support the collection of anonymous data as patients do not enter personally identifiable information. The DH guidance relevant to the collection of FFT data stipulates that the data should be anonymous. The devices however are located and tracked to each ward or department so we can be confident of where they are being completed. This system of data collection is used in many NHS trusts.

We monitor the responses closely to ensure that the data we report within the trust and to NHS England is accurate. As the data is anonymous, we err on the side of caution, for example we will remove responses from the data that could be unreliable or duplicated. This may happen where responses appear to have been completed within too short a timeframe or have identical free-text comments. All changes to our data are logged to evidence why we removed them.

FFT results – patient perspective

The FFT is measured in two ways. The national benchmark measurement, against which we have a target, is the response rate. The score that tells us if our patients would recommend our hospital does not have a national target set at present.

Over the past year, we have measured and shared our scores with wards and departments in the Trust. This second measurement is measured using a nationally agreed scoring method as outlined by the DH. The score is not a percentage and is based on a range of: -100 to +100, with above 0 indicating a positive response. The higher the score is above 0, the more positive the finding. In relation to how likely our patients would be to recommend our hospital to a friend or family member who needed similar treatment, we found:

- 68-72 (range = -100 to +100) for inpatient areas
- 43-69 (range = -100 to +100) for A&E departments
- 53-65 (range = -100 to +100) for maternity departments (based on an incomplete year of data).

We are currently above average when compared with other London trusts.

In relation to the nationally benchmarked measurement, that being the response rate, the Trust considers that this data is as described for the following reasons; we have met the DH target of a greater than 15 % response rate to the FFT question in A&E and in-patient areas as displayed in the table below.

Indicator	Q1	Q2	Q3	Q4	YTE	Target
FFT combined response rate (A&E and inpatient areas)	20%	22%	20.4%	28.3%	22.6%	>15%

Actions

We have taken the following actions to improve this percentage:

- Reviewing the I-track questionnaire and including the FFT question in this to make it more accessible.
- Reviewing the questions we ask our patients to avoid asking them too many questions and focusing on key questions.
- Including results and response rates in divisional and ward based scorecards to identify areas of poor compliance and enable our people to focus on improving response rates in these areas.
- Displaying themes from FFT comments, such as those in the box overleaf.

Sample of comments received through our patient FFT test:

“Very good response time, extremely attentive team of doctors and nurses, considerably friendly”.

“Very caring staff from reception to nurses and doctors.”

“The service is very good. I am 75 years old and never been in hospital but treated with extreme love. V clean, extremely satisfied in all areas.”

“Treated very well staff explained to me the problem very clear I am very happy with my visit thank you.”

“I have been here on numerous occasions and always been looked after quickly and effectively.”

“They treated me very kindly and quick. Very pleased of how they solved my problem sure I would recommend this service to everybody.”

“Everyone has been so caring and attentive throughout. They really understood how scared I was and tried to put me at ease.”

“The doctors and nurses were very accommodating, helpful, patient and kind. I am very satisfied with the care they provided. I can highly recommend St. Mary's A&E. Great staff.”

“Very pleasant, 100% brilliant.”

Current view of the Trust's position on quality

During 2013-14 we continued in our commitment to making quality central to all we do. We developed, published and implemented our new quality strategy including agreeing our new meeting structures based on Berwick's six domains of quality. Over the next year we will be working on embedding these new structures into practice and setting divisional level targets for improvement.

We provided services that met Care Quality Commission (CQC) essential standards as evidenced through three inspections. We have continued to report and learn from patient safety incidents, developing new divisional roles to lead on this.

All of our inpatients have been cared for in single sex accommodation and we have maintained one of the lowest mortality rates in the country.

Working as an academic health science centre (AHSC) with our academic partner Imperial College London, we have harnessed clinical care, innovative practice, research and development.

Below are some examples of our continued work to improve the quality of healthcare in our Trust. These are reported under the new key headings of our Quality Strategy.

Quality Strategy

Hospital Standardised Mortality Ratio (HSMR)

The Trust has been recognised as a centre of very safe care. The Dr Foster Guide 2013 listed the Trust as among the best in the country for the Hospital Standardised Mortality Ratio (HSMR). This measures the expected number of deaths in a hospital against the actual number, taking into account many details and variables. It is used as a trusted measure to evaluate the safety of a hospital. In addition, the Trust is proud to report that mortality rates were also lower than expected for patients admitted as an emergency, during both weekdays and weekends.

Never events

Never events are a subset of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'. The trust works to the definitions in the never events list 2013/14 update published by NHS England.

One incident has occurred in the past 12 months which met the criteria and was reported as a 'never event'. This was categorised as wrong site surgery. A second case has been reported as a 'never event' and is under investigation at the time of writing these accounts. The Trust anticipates this case will be downgraded from a 'never event' to a serious incident as the patient did not experience long term harm (never event definition). This case was a misplaced nasogastric tube.

All of the ‘never events’ are treated as serious incidents and are fully investigated using Root Cause Analysis (RCA). Actions put in place to reduce the risk of the wrong site surgery ‘never event’ happening again include:

- revision of the WHO checklist to provide specific accountability for each part and to include checking and written consent
- a process for formal handover of patients from ward areas to theatres in the Riverside suite using the pre-intervention checklist
- preference cards for consultant surgeons now include locums so as to avoid late requests and redeployment of staff to collect equipment.

The second ‘never event’ is currently being investigated. The patient is now home without any associated problems, but we need to learn and understand how the event happened and what we need to do differently.

The trust is also investigating one incident where a pack was deliberately left in place to prevent further bleeding after suturing of childbirth tears but was not removed before the patient went home. This event does not appear to meet the national criteria for never events but is being investigated as a serious incident.

Surgery first
In a world first, interventional radiologists used new robotic technology to treat fibroids, a common condition which affects one in three women. The robotic system means patients can potentially avoid excessive radiation and is safer, as it enables more precise treatment and shorter procedure times.

Pioneering brain scan
In December last year, the Trust became the first centre in the UK to perform a new type of brain scan which can lead to more accurate diagnosis of Alzheimer’s disease and other dementia conditions. This marked a significant breakthrough in diagnosis as the test identifies amyloid plaques in the brain which is one indication of Alzheimer’s disease. Until now diagnosis has been impaired as there has not been a test to show whether someone has the condition.

Patient experience
Below are examples of work which has already commenced over the past few months:

- Patient experience toolkit
  The toolkit was designed in April 2013 to provide staff with important and useful patient information templates to help provide patients and visitors with essential information about their stay.

- Information and photo boards
  All wards now have information boards and photo boards to say who's who and a welcome board with photos of the staff patients will be most likely to interact with on the ward.

- Patient headboards
  In order to improve patient experiences, and in response to the Francis Inquiry recommendations, headboards which record a patient's preferred name, anticipated discharge date (ADD), consultant and named nurse were launched in December 2013.

Complaints
Over the past year, the Trust has focused on its complaints management following the Francis Inquiry report and Ann Clwyd MP and Professor Tricia Hart's review into NHS complaint handling. The Patient Advice and Liaison Service (PALS) and the central complaints team reviewed each recommendation.

Following an internal restructure, four patient safety managers now lead complaint management in each of the four clinical divisions. This allows the Trust to consider information not only from complaints and PALS but also claims and incidents to help ensure that we learn from various forms of feedback.

The management of the central complaints team has been strengthened by the appointment of the Trust's first service quality manager, who works closely with the PALS manager and patient safety leads. This has established a strong foundation which will help ensure the Trust continues to place the patient at the centre of everything we do.

We have ensured that our patients and their families know who they can speak with by making complaints information accessible at ward level. During 2013-14 the Trust investigated 884 formal complaints, 93% of which were responded to within the timescale agreed by the patient. PALS dealt with 3,519 informal concerns in the year.

Award winning work

In January 2014 a team of six midwives won the Lansinoh Team Award from the Royal College of Midwives for their work with vulnerable women at St Mary's Hospital.

The team work with women with several complex risk factors, such as severe mental illness, domestic abuse, drug and alcohol misuse and learning difficulties. Many of the women are from traveller, refugee, and asylum seeker communities. The midwives are key coordinators of care for all the women and liaise with obstetricians, doctors, health visitors, social workers and other agencies.

The judges said: "This is an inspirational model of midwifery care, which demonstrates choice and one-to-one care throughout the whole maternity pathway for a group of vulnerable women. It addresses local priorities for local women working in a multi-agency way – a well-deserved winner."

Divisional director of nursing and midwifery, Professor Jacqueline Dunkley-Bent and head of midwifery, Pippa Nightingale were at the ceremony to see the team receive their award.

Professor Dunkley-Bent said: "Pippa and I are both extremely proud of the team who are an inspiration and a real credit to our maternity service. Their passion, dedication and expertise ensures women who have complex social needs are provided with continuity of midwifery care throughout their pregnancy, birth and postnatal period. This is a model of care we aim to provide for all women in the future."

Chief executive of the Royal College of Midwives, Cathy Warwick said: "To win an award is a real achievement. Without midwives, their teams and colleagues from other health professions pushing at the boundaries of practice we would not see the care they are able to give to women, babies and their families improve and move forward. This is innovation in action which will help maternity services everywhere to deliver safer, better and continually improving care. I congratulate the team on this achievement and thank them and their colleagues for their dedication, skill and commitment to women and their babies."

Improvements to outpatient flow
We have introduced patient self-check-in kiosks in the reception areas of outpatient departments enabling more stream-lined check-ins, as well as providing useful demographic information about our patients. This helps to reduce queuing at the reception areas of outpatients, enabling patients to get to the right area quicker.

Improvements to our cancer services
The Trust appointed a new oncology consultant at Charing Cross Hospital to help us to develop more cancer ambulatory care services, meaning patients do not have to spend the night in hospital.

This year the Trust breast cancer nurse, Victoria Harmer, triumphed at the Nursing Times Awards winning the esteemed Cancer Nurse of the Year award. Victoria was nominated by the breast cancer support group which she has been running for several years now. One of Victoria's latest projects is an innovative disposable MP3 player which provides information as a pre-recorded podcast to help patients undergoing chemotherapy.

The Macmillan Information Centres at Charing Cross Hospital and the Macmillan pod at Hammersmith Hospital are providing patients with information about their condition and treatment and explaining where they can get further help and information.

Implementing Cerner
In 2013-14 the Trust worked towards the milestone of implementing Cerner, an electronic patient administration system. The transfer took place over the 2014 Easter period to take advantage of a lower level of planned activity during the holiday period.

The new system affects both clinical and non-clinical staff across the Trust and was supported by a significant communication programme. During the preparations for the launch, the system was rigorously tested and the planning incorporated lessons learnt from other implementation programmes. The Trust also rolled out a module for electronic maternity patient records. The new system will ultimately allow the Trust to improve data quality and patient care. It also provides the opportunity to consolidate patient records on a single NHS number, and gives the Trust a foundation to move towards electronic patient records.

Case study illustrating how a timely, efficient service can improve patient experience

Over the past year we have reviewed and redesigned some of our patient pathways. One example is the development of rapid access clinics for patients with suspected prostate cancer. The purpose of this new pathway is to provide a 'one stop' service for our patients. This means that patients can visit the hospital once to have a specialist review, an examination, an ultrasound and biopsies all taken on the same day.

In order to support this new pathway, the Trust has recruited a clinical nurse specialist to manage the patient pathways. The clinical nurse specialist works closely with the consultant to ensure a high quality service is delivered.

The new pathway is being evaluated from a patient and operational perspective. Our initial findings (based on a small sample size of 34 patients) suggest that the new pathways have impacted positively on both the patient and operational experience. We have noted that follow up and 'did not attend' (DNA) rates have improved dramatically and that patient satisfaction has increased.

In our patient questionnaires, we found the patients' experience had significantly improved for every question. They told us: they had enough information about the clinic and the length of time of their appointment; the majority received their results before leaving the clinic; they would recommend the service to family or friends and that overall they rated the service as very good or excellent.

We will continue to monitor our patients experience and continue to develop this service. We are currently working through the London Cancer Alliance to review the two week wait referral form as we have identified that in order for this pathway to work, the general practitioner needs to include additional tests prior to the patient attending the rapid access clinic.

Quality Strategy

We are in the process of reviewing our Quality Goals and will report against these in our next Quality Accounts, to ensure that people using our services know the areas we will continue to focus on and that our people that work within the organisation are focused on the same.

Statements from stakeholders

Imperial College Healthcare NHS Trust – Quality Accounts 2013/14

Health and Adult Social Services Standing Scrutiny Panel, Ealing Council statement in response to Imperial College Healthcare NHS Trust Quality Accounts 2013/14

General

The Panel welcomes Imperial College's determination to provide safe, high quality and patient centred care and treatment for all patients. The Panel strongly agrees with Imperial's position that this responsibility sits with every staff member within the organisation irrespective of their position within the organisation. We note that this is reflected within Imperial by the organisation's Chief Executive and Chairman taking part in regular ward visits to meet staff and talk with patients, and the implemented monthly leadership walks.

The Panel congratulates Imperial on (i) being named in the top four hospitals trusts in England for Summary Hospital Level Mortality Indicator (SHMI) ratios, (ii) meeting all essential standards of quality and safety as assessed by the Care Quality Commission (CQC) in inspections, (iii) achieving "above average" engagement score, compared to other acute trusts around the country in the annual NHS Staff survey.

Quality Actions for 2014 – 2015

The Panel notes Imperial's intended plans to (i) set up a safety and quality improvement network, (ii) introduce global comparator networks in appropriate areas, (iii) update incident and effectiveness systems, (iv) set up targets and tracking QG15 (Quality Goals 2015), (v) embed and review meeting structures for quality. At an appropriate time in the future, the Panel looks forward to Imperial providing a progress report in respect of these plans.

Priorities for Quality Improvement in 2013 – 2014

The Panel considers it good practice on the part of Imperial to have developed the priorities in consultation with stakeholders; members of the public, patients, shadow foundation members, Healthwatch and local authority overview and scrutiny committees. It would however have been helpful if the priorities as identified by each major stakeholder were outlined, and why if any such identified priority was not adopted. If this is best presented to the Panel at an appropriate time in future this would be welcomed.

With reference to specific priorities, the Panel feels that the importance of "zero tolerance of breaches of mixed sex accommodation" could have been expounded upon for example as relates to "dignity in care".

Trust response – We accept this comment. Next year's report will reflect the importance of "dignity in care" in relation to mixed sex accommodation.

During the reporting period 2013-2014, Imperial sub-contracted 75 NHS services. The Panel wonders whether this is a trend continued from or to be extended over a number of years,

and the associated percentage of overall services which this sub-contracting constitutes. Also helpful would be the assessed performance overall of these services since sub-contraction.

Trust response – Thank you for your comment, please note in our report we state that Imperial College Healthcare NHS Trust provided and/or sub-contracted 75 NHS services. This is a continued trend.

Participation in Clinical Research

Imperial's commitment to encouraging innovation and partnership working in advance of this such as in the Imperial College Healthcare Partners (ICHP) is commendable. However as relates to the NIHR Health Informatics Collaborative it needs to be briefly outlined the measures put in place and or observed by Imperial in safeguarding patient data.

Trust response – The NIHR Health Informatics Collaborative (HIC) is working closely with Imperial College Healthcare NHS Trust Information Governance Team and the Caldicott Guardian to ensure the safeguarding of patient data. Only anonymised data will be accessible to researchers conducting research with NHS patient data. Research conducted with data not collected routinely will require informed consent (fair processing, documented) or Section 251 exemption.

Access and monitoring will be in accordance with existing ICT Standard Operating Procedure for processing data access requests from researchers. These require querying by the Imperial College Research Office, Ethics approval, REC number, honorary contract, NHS PC/drive to place files requested, ISO27002 compliance. Data is only provided through an NHS network drive or an encrypted USB.

Data sharing agreements are compliant with the Department of Health Information Governance policies and standards as well as with Imperial College Healthcare NHS Trust. The NIHR HIC policies and standards will be put in place prior to sharing data with other Trusts. To date, no data has been provided as the NIHR HIC is still in a building stage.

CQUIN Performance

The Panel commends Imperial for the CQC not having had any reason to take enforcement action, and for being fully compliant with the Essential Standards of Quality and Safety that were assessed by the CQC.

The Panel notes that access to a dashboard of quality indicators is via the organisation's intranet site and is promoted regularly to staff through internal communications and training sessions. What would however be helpful is whether this particular approach has been found to be effective by staff through for example their feedback. This should be outlined in the report. The Panel feels that only if this is known by Imperial can the organisation have any re-assurance that staff have access to and utilise quality data.

Trust response. Imperial College Healthcare NHS Trust is further developing Qlikview (system where staff can easily access and view data) and also the approach we take to

communicating important messages relating to performance. Staff will be engaged in these developments.

The Panel is pleased that Imperial has delivered on the18 week referral to treatment (RTT) standards. The Panel hopes that this will continue to be the case in future, and current good performance will still be built upon going forward. This hope extends to Imperial's information governance, whereas the current 72% "satisfactory" performance means that there is scope for improvement.

Progress against Priorities for 2013-2014

The Panel is of the view that Imperial's full achievement of 7 of 15 targets means that additional work is needed for greater target attainment for example in patient safety and clinical effectiveness.

Trust response – Imperial College Healthcare NHS Trust note that in the draft report we stated there were 15 targets, when in fact there were 14. We continue to work to improve our performance against the targets and they will be monitored as a part of the 2014/15 Quality Accounts.

Quality Strategy

Imperial has reported that the organisation experienced only 2 "never events" over the past 12 months. The Panel feels that Imperial's performance in this area will be better understood if the number of occurrence of these events in prior periods and especially the most recent period is provided. This will enable identification of any upward or downward trend over a period.

The Panel takes seriously "never events" and support Imperial's efforts in addressing shortcomings/failures which lead to these events. However disciplinary sanctions should be included in these actions, and as such the report would be improved if this was made explicitly clear in the report.

Trust response - Imperial College Healthcare NHS Trust has reported 6 never events in 2011/12, 2 in 2012/13 and 2 in 2013/14. The Trust anticipates one case reported in 2013/14 will be downgraded from a 'never event' to a serious incident because on investigation, the case does not meet the never event definition.

All Never Events are investigated using root cause analysis techniques, therefore lessons, recommendations and actions from the incident can be identified, disseminated and monitored.

Complaints

The Panel commends Imperial's efforts in focussing on complaints management. Greater insight should however be provided as to the structural change being instituted by Imperial. For example is the four new patient safety managers an increase in number or a total change with their introduction, and to whom does the first service quality manager report? This will reveal the level of that person's seniority especially to take action.

Trust Response: The complaints team has been strengthened on two fronts. Firstly the central complaints team has recruited a service quality manager (band 8b from band 7) who reports to the associate director service quality (band 8d). Also the central complaints team will shortly appoint a senior complaint coordinator (band 7 from band 5).

The four Divisional Governance Leads (banded 1x 8a and 3x 8b), who are responsible for risk and quality, are line managed by their respective director of nursing (band 9) and report to the associate director service quality for complaint management. Two divisional governance leads are further supported by a band 7 complaints manager and a band 6 complaint co-ordinator to reflect the size of their division. This approach, in each of our four divisions, will help us to improve our analysis of complaints and allow us to compare this analysis with that from serious incidents and inquests: there is more we can and will do to learn from these forms of patient feedback.

The Trust has not yet increased the total number of staff dealing with complaints but has significantly increased the level of expertise. From June complaints will fall under the remit of the director of nursing. This will enable us to look in the round at how our PALS, Complaints Department and Patient Experience Department work together.

A non-executive led review of our complaints process is being undertaken to help ensure continuous improvement occurs and that lessons have been embedded.

The Panel looks forward to continuing to work with the Trust in the forthcoming year.

Westminster City Council and Royal Borough of Kensington and Chelsea Adult Services and Health Policy Scrutiny Committee statement in response to Imperial College Healthcare NHS Trust Quality Accounts 2013/14

Imperial College Healthcare NHS Trust: Response to Quality Account 2013/2014

Executive Summary

- Overall, the Trust's progress has been encouraging this year. In particular, it has done well to improve clinical effectiveness, patient safety and experience in a range of areas. However, there are continuing concerns which we have raised on more than one occasion, some of which are highlighted in this response, which we would welcome further improvement upon.
- We are disappointed to note in the CQC's Intelligent Monitoring Report, the Trust had a Band 4 risk rating with risks identified in relation to MRSA, secondary prevention medication, having hospital staff to talk to, meeting the 62 day wait for cancer treatment, staff receiving health and safety training and staff stability.
- We are disappointed that for the target of '95% of A&E patients [will be] seen within four hours of arriving at hospital,' Imperial failed to meet this in each of the nineteen weeks over the winter.
- We are concerned that across sixty-three NHS trusts, the average vacancy rate for nurses was 11.1% in contrast to a national average of 6.3%.
- We are quite disappointed that the Trust has set a low target (60%), which has already achieved, for the measurement which indicates whether staff would recommend the Trust to their friends and family.
- We await and expect the full publication of Imperial's Outline Business Case for the meeting of the Imperial College Healthcare NHS Trust Board. Whilst the option appraisals and site strategies will be of interest to all of our Boroughs individually, we would all urge the Trust to share the culmination of the planning work with your statutory health committee partners in our boroughs as soon as is possible. It is critical for Imperial College Healthcare NHS Trust to maintain a dialogue with their local authority partners at this important time.

Imperial College Healthcare NHS Trust: Response to Quality Account 2013/2014

We welcome the opportunity to comment on the Imperial College Healthcare NHS Trust Quality Account 2013/14. Please find the responses of the statutory health overview and scrutiny committees in the Tri-Borough areas of Westminster and the Royal Borough of Kensington and Chelsea.

Performance

Priority One – Patient Safety

Venous Thromboembolism
The Trust has successfully improved on venous thromboembolism assessments so that 95 percent of patients are now assessed for their risk of thrombosis (clotting) and bleeding on admission. This target was set at an ambitious 95%, but the Trust has exceeded the target in each quarter, despite achieving only 91% in 2012 / 2013. However, whilst the improvement is positive, the target for 2014 / 2015 has not been indicated in the Quality Account, we would hope that this would be set to higher than that set in 13 / 14.

Trust response – At the time of the draft report we were not in a position to confirm the target. VTE performance is not a CQUIN for the forthcoming year, and will be included in our safety thermometer target of 95% harm free care. Imperial College Healthcare NHS Trust will continue to aim for >95% patients assessed on admission and to perform RCA on hospital acquired VTEs.

Falls and Pressure Ulcers
We are pleased that falls and fall related harm are meeting the targets set last year and Imperial are less likely to harm patients through falls than in other NHS Trusts. Similarly with pressure ulcers, Imperial performs better than most other NHS Trusts and patients are much less likely to develop pressure ulcers whilst in the Trust's care. For both of these issues, we would like to see the Trust continue to drive down incidents and become a national leader in patient safety.

Urinary Catheter Related Infections
We express concern that whilst Imperial have reported data on urinary catheter related infections to the NHS Safety Monitor, the Trust has not provided information in the Quality Account to indicate that Imperial performs below the national average in 13 / 14. The proportion of patients with a urinary catheter is almost 20% against a national average of 13%. It is important to ensure that catheter related urinary tract infections (UTI) remain low, and we are concerned that the high levels of catheterisation at the Trust may have caused the poor performance of Imperial between June and September 2013. Whilst Imperial appears to now perform better than average for catheter-related UTIs, we would note the relation between the two targets and stress that transparency around performance with stakeholders is critical.

Trust response - Imperial College Healthcare NHS Trust is committed to the prevention and monitoring of urinary tract infections and will undertake a prevalence audit identifying those patients who are being treated for a UTI in hospital who also have a urinary catheter. In addition, targeted surveillance of E. coli bacteraemia continues at the Trust which seeks to identify catheter associated urinary tract infections as the source of infection.

Clostridium Difficile

We are pleased to note that rates of Clostridium Difficile are below the number set by the Department of Health. We are glad that the Care Quality Commission (CQC) has assessed infection control at the Trust and found areas of good practice. However, we would hope that Imperial sets itself challenging internal targets to continue driving down hospital-acquired infections.

Methicillin resistant staphylococcus aureus (MRSA)

Whilst we are concerned that Imperial College Healthcare NHS Trust have breached the national targets set by the Department of Health in relation to MRSA, we appreciate that an **absolute zero-tolerance approach** was an ambitious target for central government to introduce, given that Imperial is a large acute Trust with more patients than the majority of NHS Trusts. We are more concerned with the year-on-year increase in MRSA cases given the action plan associated with the aseptic non-touch technique which we have welcomed in the past. We would hope that the Trust continues to take actions to reduce the rates of MRSA and note that Imperial have called on international experts to provide recommendations on good practice.

Trust response – Imperial College Healthcare NHS Trust continues to take the reduction of all healthcare associated infection seriously and has a comprehensive action plan in place to reduce rates of MRSA infection. We do not share the view that there has been a year on year increase in MRSA blood stream infections at the Trust.

During 2010/11 and 2011/12 the Trust had 13 cases allocated to it, then 8 cases in 2012/13.

In 2013/14 there were 13 cases allocated, however a new process had been introduced from 1st April 2013. This new method was introduced for the allocation of MRSA BSI cases, which involved a post infection review process between the acute Trust and CCG that replaced the previous method for allocation, therefore it is not possible to compare the number of cases in 2013/14 to previous years.

Of the 13 cases were allocated to the Trust during 2013/14:
• Four of these cases were reallocated to the Trust using the new process, even though the infection may not have been associated with care received at our hospitals.
• Since 1st April 2014 an option to allocate the case to a third party has been available, this is where the source of the infection cannot be attributed to either an acute Trust or the CCG, if this had been in place during 2013/14 one case would have been attributed to a third party.

The Trust continues to deliver the ANTT competency assessment programme for all clinical staff, with over 11,000 staff being exposed to the programme since it commenced in December 2011.

Anti-infective

We note that Imperial conducted two Trust-wide audits in 2013-14. The Trust made significant progress with 93% of prescriptions having a documented reason for starting anti-infective medications and 90% for prescribing in line with the Trust antibiotic policy or having prescriptions reviewed by an infection specialist. However, the Trust need to continue to

improve on the documentation of start-stop dates as Imperial achieved 66 % against this measure.

We note the presentation to the Westminster Adults, Health and Community Protection Committee, which shows the range of work undertaken on antibiotic stewardship and welcome Imperial's serious concern to tackle the associated issues.

Patient Safety Incidents
We are disappointed that Imperial has not met targets to be 10 % above the national average for patient reporting safety incidents or to be 10 % below the national average for reporting patient safety incidents resulting in death (graded extreme). We consider that an important measure of an organisation's safety culture is its willingness to report adverse events and learn from them. **It has been a continuing theme in responses to Imperial that the local authorities in the Tri-Borough area consider it crucial to ensure patient safety is paramount and would expect Imperial to make a sustained and concerted effort in 2014 / 2015 to boost the reporting of incidents.**

Trust Response - Imperial College Healthcare NHS Trust recognises that incident reporting rates need to be improved and this is a key improvement target for 2014/15. The incident reporting system (Datix) has been upgraded in April 2014 making reporting quicker and more user friendly. A campaign to improve reporting has commenced and trajectories set for the year.

Incidents resulting in death: The trust consistently has achieved excellent mortality rates during 2013/14 and therefore although incident data shows the Trust to be above the national average for incidents resulting in death this should be taken in the wider context. The Trust has worked hard during 2013/14 to improve reporting of serious incidents and the coding of their outcome and believe that our rate is reflective of this.

Dementia CQUIN
We are pleased that Imperial College Healthcare NHS Trust has achieved the CQUIN aiming to improve care for those with dementia. We would expect the Trust to become more ambitious in achieving compliance whilst continuing to meet the targets set.

Priority Two – Clinical Effectiveness

Summary Hospital Level Mortality Indicators (SMHI)
We consider that we are fortunate to have one of the highest performing Trusts in the country located within our Boroughs, with exceptionally good clinical performance. We would note that the figures across the three sites may reflect the types of activity at each hospital rather than demonstrating mixed performance at the Trust.

Reduced emergency readmissions within 28 days
We are concerned that Imperial still has an emergency readmission rate (within 28

days) of approximately 6.5%. Given the move to more integrated care we are particularly concerned that the quality of discharge at the Trust is not as it should be. The list of mitigating actions provided in the Quality Account does not appear as extensive as it should be in these circumstances.

Trust response - Imperial College Healthcare NHS Trust agree this is a priority area for focus and we are working jointly with commissioners and other health care providers to develop specific plans for 2014/15 on how best to improve services to avoid admissions e.g. access to hot clinics, provision of ambulatory medicine pathways, as well as better integration with community facilities and the piloting of initiatives such as the virtual ward.

Priority Three – Patient Satisfaction

We note the delay in the publication of data which would help Imperial College Healthcare NHS Trust to report against targets under the heading of 'Priority Three – Patient Satisfaction'.

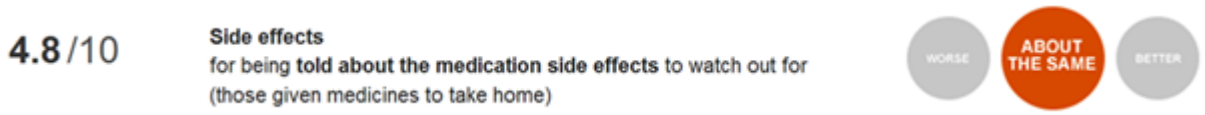
To improve the responsiveness to inpatient's needs

We note and welcome that the Trust is '*becoming more responsive to inpatient needs'* based on the latest data in the National Inpatient Survey. However we would also flag that Imperial performed poorly on the survey (relative to peers and the national average) in areas relating to discharge, echoing our concerns about emergency readmissions.

National Inpatient Survey 13 / 14	Average of ALL trusts across the country	Chelsea and Westminster Hospital NHS Foundation Trust	Guy's and St Thomas' NHS Foundation Trust	Imperial College Healthcare NHS Trust	University College London H. NHS FT
On the day you left hospital; was your discharge delayed for any reason?	**63.1**	55	62.6	54.8	62.7
Did a member of staff tell you about any danger signals you should watch for after you went home?	**54.1**	51.8	56.9	47.4	55
Did a member of staff tell you about medication side effects to watch for when you went home?	**49.3**	45.7	57.2	47.5	51.9

Trust Response: Imperial College Healthcare NHS Trust note that the figures given in the table above are out by a factor of 10 – Picker and CQC now report scores out of 10. We are unclear by the RAG rating that has been applied in the table above. Both

the CQC and Picker use the "worse than", "about the same as" and "better than" categories. Imperial is rated "about the same" as other trusts for the 3 questions cited; illustrated below in a screenshot from the CQC website:



Whilst we would acknowledge that 4.8 is a low score, this is a nationally low scoring question and we do not believe it is possible to say that Imperial performed poorly relative to peers and the national average. Or at least that is not the opinion of the statisticians at Picker.

Imperial College Healthcare NHS Trust do recognise that discharge is a critical point in our patients' journey and that we need to improve on a number of aspects in this area. One of the key objectives in the draft patient centredness strategy, which will be up for board approval in the autumn, is about supporting patients through transitions in care with discharge from hospital being a critically important aspect of this. We anticipate that there will be a small number of co-designed improvement projects related to discharge commencing later in the year.

To have caring and compassionate staff
We note and welcome that the results of the survey, which show that the results of the question about caring and compassionate staff, were consistently high (95%)

Staff recommending Imperial as a good place to work
We note and welcome that the results of the survey, which asked if staff would recommend the Trust as a place to receive treatment, were good (69%) when compared to the national average (64%).

Friends and Family Test
We welcome that Imperial have achieved a good response rate to the Friends and Family test and look forward to the future actions boosting this response rate higher.

Targets for 2014 / 2015
We welcome the majority of targets set by the Trust in relation to 2014 / 2015. However we have further comments in the following areas:

- We think that the Trust have become less ambitious in their plans to increase the levels of serious incident reporting, as the targets for 2014 / 2015 only to aim to better **our local academic hospital peers** rather than the **national average** (which was the target in 2013 / 2014).

Trust response - The rationale for using a peer rate is that no published national rate exists. The NRLS (National Reporting and Learning System) group Trusts into clusters based on the size and type of organisation. Our rate is not local, it is national acute teaching Trusts. A national rate would not compare like for like, therefore the NRLS group trusts into clusters which we compare ourselves against.

- We, **once again**, restate that the Trust should have more ambitious targets to continually improve Standardised Mortality Rates and Standardised Hospital-level Mortality Indicators, given that the Trust is one of the most clinical effective in the country.

Trust response - Our Standardised Hospital- level Mortality indicators are currently amongst the best in the country and as stated we aim to continue this trend and to sustain our excellent performance.

- We welcome the bold goals to increase the response rates for the Friends and Family survey.
- We are quite disappointed that the Trust has set a low target (60%), which has already achieved, for the measurement which indicates whether staff would recommend the Trust to their friends and family. **In setting goals it is often typical to hope to attain a higher score in a subsequent year.** Achieving 69% in 2013 / 2014 should have meant setting a higher feasible target for 2014 / 2015.

Trust response - The target we set for our staff response to whether they would recommend the trust to their family and friends is based on our Quality Strategy goal to remain above 60 %. We will always report past trends and aim for improvements but recognise this could have been more explicit in the report.

General comments

We await and expect the full publication of Imperial's Outline Business Case for the meeting of the Imperial College Healthcare NHS Trust Board. Whilst the option appraisals and site strategies will be of interest to all of our Boroughs individually, we would all urge the Trust to share the culmination of the planning work with your statutory health committee partners in our three boroughs as soon as is possible. It is critical for Imperial College Healthcare NHS Trust to maintain a dialogue with their local authority partners at this important time.

Band 4 CQC Risk Monitoring Report

We are disappointed to note in the CQC's Intelligent Monitoring Report (13 March 2014) http://www.cqc.org.uk/public/hospital-intelligent-monitoring the trust had a Band 4 risk rating with 'elevated risk' in:

- **'Incidence of Meticillin-resistant Staphylococcus aureus (MRSA)'**

And general 'risks' in:

- Proportion of patients who received all the secondary prevention medications for which they were eligible
- Inpatient Survey 2012 Q34 "Did you find someone on the hospital staff to talk to about your worries and fears?" (Score out of 10)

- All cancers: 62 day wait for first treatment from urgent GP referral
- NHS Staff Survey - KF10. The proportion of staff receiving health and safety training in last 12 months
- Composite risk rating of ESR items relating to staff stability

Trust Response - We have already made improvements to our cancer services and the trust is very focused on ensuring excellent patient experience. We have plans in place to ensure that all the risks identified through CQC intelligent monitoring have been addressed and we expect to see this reflected in the next quarterly report.

Accident & Emergency
We are disappointed that for the target of '95% of A&E patients [will be] seen within four hours of arriving at hospital,' Imperial failed to meet this in each of the nineteen weeks over the winter.

LBC (18 Mar 14): All But One London NHS Trust Misses A&E Target http://www.lbc.co.uk/all-but-one-london-nhs-trust-misses-ae-target-87549

Trust Response - Nationally the performance measure used for A&E performance is "95% *all-types* patients treated/admitted/discharged within four hours of arriving at hospital". Imperial College Healthcare NHS Trust met this standard consistently throughout the winter achieving the position monthly, quarterly and for the annual calculation and this is the standard against which we are performance managed contractually.

There is a further A&E standard which states "95% type-1 patients treated/admitted/discharged" within four hours arriving at hospital. We did miss this standard. Chelsea & Westminster who were the only Trust to meet the standard have permission to record their data differently to other Trusts. As a Trust we remain committed to improving our pathways so that we can meet this standard too and this is a big area of focus and priority for 2014/15.

Nurse vacancies
We are concerned that Freedom of Information requests by The Sunday Telegraph across 63 NHS trusts, reported on 4 January 2014, found that average vacancy rates for nurses are 6.3 %. At ICHT, however, the figure was significantly higher at 11.1%.

Telegraph (4 Jan 14): NHS hospitals suffer staffing crisis on top of scandals
http://www.telegraph.co.uk/health/healthnews/10551257/NHS-hospitals-suffer-staffing-crisis-on-top-of-scandals.html

The figures provided by the Trust in response to the FOI in October 2013 were based on the total qualified Nursing & Midwifery establishment across the whole Trust, for all areas, and did not reflect recruitment activity associated with those vacancies nor cover by temporary workers. Since October 2013, significant progress has been made in the recruitment of qualified nurses and midwives to our vacancies through various

strategies including successful rolling recruitment programmes, dedicated Nursing & Midwifery recruiters and international recruitment campaigns.

At the end of April 2014, we had a non-recruited to vacancy rate of 6.48% for all of our qualified Nursing & Midwifery posts across the Trust. All vacancies within our ward and inpatient areas are put forward for cover by our Nursing & Midwifery bank to ensure safe staffing levels for our patients.

Concluding comments

We are pleased the trust has improved its financial performance in the last year and we are pleased Imperial College Academic Health Science Centre has had its AHSC status confirmed for a further five years. Overall, the Trust's progress has been encouraging this year. In particular, it has done well to improve clinical effectiveness, patient safety and experience in a range of areas. However, there are continuing concerns which we have raised on more than one occasion, some of which are highlighted above, which we would welcome further improvement upon.

Each of our Boroughs look forward to continuing our working relationships with Imperial College Healthcare NHS Trust but would ask the Trust to continue to seek improvements in communicating with local authorities and other stakeholders.

Councillor David Harvey,
Chairman, Adult Services and Health Policy Scrutiny Committee,
Westminster City Council

Councillor Robert Freeman,
Chairman, Adult Social Care and Health Scrutiny Committee,
Royal Borough of Kensington and Chelsea

Healthwatch Central West London response to the Imperial College Healthcare NHS Trust Quality Account 2013-2014

Since our inception in April 2013, Healthwatch Central West London has strived to develop a strong working relationship with Imperial College Healthcare NHS Trust. Our joint working to date has focussed around a number of key themes relating to the quality of services namely:

Healthwatch Central West London was invited to comment on the May 2nd draft of the quality account and we have requested improvements to the accessibility and usability of the document. For example, Part 3 and the glossary explain much of the terminology but the lay reader must persevere through jargon and strategic positioning in Parts 1 and 2 to read this helpful guidance. We have also requested the inclusion of relevant sign-posting guidance and greater operational detail throughout the final version.

Trust response – We have signposted the glossary on page 2 of the document.

Patient experience

We are aware the Trust is developing a lot of good initiatives regarding dementia care. However, this are continues to be of significant concern for our members. Further to our work on the recent PLACE assessments and our dignity champion visits, we would welcome further detail on steps being taken to ensure the estate is dementia compliant.

Trust Response - Imperial College Healthcare NHS Trust has appointed a new dementia lead and the team is currently in the process of developing a 4 year dementia strategy which will include significant changes to the environment. We are aware of the challenges of the estate, particularly on the St Mary's site and are therefore supplementing our environmental changes with social ones such as developing programmes of meaningful activity and facilitated social interaction. The full strategy will be out in draft form at the end of June. We will also train our Dementia Clinical Nurse Specialist in Enhancing the Healing Environment for People with Dementia which is a course run by the King's Fund. She will be attending in October. She will use her expertise to ensure that we make the best possible use of our spaces for people with dementia.

Under caring & compassionate staff, the section is marked as partially achieved and the explanation offered is the trust has stopped asking this question causing the data to be incomplete. We suggest additional information should be included on the use of agency staff. The impact of staff experience on patient experience is an area of concern for us especially in the current climate of uncertainty.

Trust response - Imperial College Healthcare NHS Trust are aware that a stable, regular and engaged workforce will lead to a better patient experience and are

therefore taking action to reduce the amount of temporary staff we use to staff our wards and departments. We are actively recruiting to permanent posts, monitoring and reporting our daily ward staffing levels and have introduced a new staff appraisal system.

Although we had a helpful presentation on the proposed changes to the local Imperial hospital sites in January, local patients would very much welcome further information in this report on the reconfiguration. We are aware the public expressed considerable interest in this area through the recent trust consultation on foundation status. Healthwatch also looks forward to working with the trust on their planned public information campaign from July to ensure our local residents can access safe and timely urgent and emergency care.

Further to our joint work on Whole Systems Integrated Care, we very much look forward to working with the trust and other stakeholders to address the concerns we have had in 2013/14 about the patient experience of discharge from Imperial hospitals and the hospital transport service.

In light of the performance of the trust on cancer waiting times in 2013/14 and as highlighted in our statement in 2012/13, we would welcome far greater detail in the account on the trust performance on cancer waiting times. Whilst we appreciate there is a backlog to clear, trust performance against the 62 day waiting time in particular is still most concerning.

Trust response - Imperial College Healthcare NHS Trust met all 8 national standards in February and March and as a consequence in Q4. We expect to deliver on all 8 in April and May.

The continued poor performance of the trust in the Macmillan patient cancer experience survey is concerning. However, Healthwatch was pleased to have had the opportunity to assess the real time experience on the cancer wards in Charing Cross hospital and we note the improvements being made. We hope the work of the trust on the pre- and post- inpatient experience results in positive improvement this year.

Patient safety

We are concerned that re-admission rates within 28 days are high. We note the list of actions but also suggest this should be investigated further and in partnership with local services. In line with our concerns about the patient experience of admittance to and discharge from Imperial, further information on:

- discharge performance should be published to support people to live safely out of hospital and
- outpatient performance should be included.

Trust response - Imperial College Healthcare NHS Trust agree this is a priority area for focus and we are working jointly with commissioners and other health care providers to develop specific plans for 2014/15 on how best to improve services to avoid admissions e.g. access to hot clinics, provision of ambulatory medicine pathways, as well as better integration with community facilities and the piloting of initiatives such as the virtual ward.

A lot of the patient stories, we receive and are sharing, are from people using the outpatient departments and expressing concerns about waiting times, staff training, patient transport, medication management, communication and facilities. This is especially important as outpatient services are a significant and increasing service with the trust commitments to Shaping a healthier future. The timely resolution of complaints and achieving outcomes from this learning are essential to improving pathways for all.
The improvements in anti-infective prescribing are positive but we would like to see further efforts in this area to improve performance on stop and review dates.

Trust response - Imperial College Healthcare NHS Trust are pleased that Healthwatch have commented that the improvement in anti-infective prescribing is positive however note they would like to see further effort in this area to improve performance on stop and review dates.

The Trust fully acknowledges and absolutely endorses the importance of 'Stop and Review Dates' with the prescribing of anti-infectives. The opportunity to assess the need for continuation and change is a vital part of ensuring good anti-infective prescribing and practice. We are committed to promoting at every opportunity the Department of Health 'Start Smart Then Focus' initiative highlighting the importance of and encouraging the regular review of anti-infective prescribing. In addition in 2013/14 we reviewed our monitoring of compliance and in 2014/15 are changing from twice yearly to quarterly review. We believe that this will facilitate greater feedback and engagement in the organisation in a more timely and focused way.

In summary and as stated in our response to the Imperial consultation1, we recognise the trust is a leading provider of care nationally and offers a unique combination of secondary and tertiary services. We welcome the enhanced focus on wellbeing and on partnership working in the last year. We would hope this approach includes a greater focus on pathways in to and out of Imperial services, leading to greater integration and improved outcomes as well as improved patient experience in the challenging year ahead.
1 http://healthwatchcwl.co.uk/wp-content/uploads/2014/01/ImperialConsultationResponseHealthwatchCWL100214Final.pdf

Contact: Mel Christodoulou

Hammersmith and Fulham Clinical Commissioning Group response to the Imperial College Healthcare NHS Trust Quality Account 2013-2014

Hammersmith and Fulham Clinical Commissioning Group welcomes the opportunity to provide this statement on Imperial College Trust's Quality Accounts. We confirm that we have reviewed the information contained within the Quality Account and checked this against data sources where this is available to us as part of existing contract/performance monitoring discussions and is accurate in relation to the services provided. We have taken particular account of the identified priorities for improvement for the Trust and how this work will enable real focus on improving the quality and safety of health services for the population they serve.

This Quality Account has been reviewed within Hammersmith and Fulham Clinical Commissioning Group, Associate Commissioners, colleagues in the CWHHE Collaborative of Clinical Commissioning Groups and NHS North West London Commissioning Support Unit.

We have reviewed the content of the Quality Account and confirm that this complies with the prescribed information, form and content as set out by the Department of Health. We believe that the Account represents a fair summary and a representative and balanced overview of the quality of care at the Trust. We have discussed the development of the Quality Account with The Trust and have been able to contribute our views on consultation and content.

We welcome the focus on patient safety particularly to increase incident reporting rates and reduce their reported harm to meet NRLS (National Reporting Learning System) peer targets. We also look forward to the work being undertaken to improve Dementia awareness and assessments.

We are very pleased to see the range of participation in the National Clinical Audit Programme.

We welcome the focus on communication and delivering safe and compassionate care to all patients and look forward to an increased focus on the patient and staff experience agenda this coming year. We also look forward to the work being undertaken to improve choice and quality in End of Life Care.

We look forward to seeing improvements in backlogs in specialty performance this year with a more robust approach to the management of waiting lists. We would also like to see more focus on addressing on-going themes identified.

We are very happy to work collaboratively with you to help shape how we move the quality agenda forward both from a commissioner and provider perspective. Given the publication of the Francis Inquiry and subsequent Berwick, Keogh and Cavendish reports clearly our agendas will continue to evolve further as we embed the recommendations.

We are keen to see how the new Quality Strategy will be embedded in the Trust and how this will be reflected in the 14/15 Quality Accounts with timescales.

Overall we welcome the vision described within the Quality Account, agree on the priority areas and will continue to work with the Trust to continually improve the quality of services provided to patients.

We look forward to receiving the final version which will include an easy read format.

Independent auditor's limited assurance report to the directors of Imperial College Healthcare NHS Trust on the annual Quality Accounts

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

We are required by the Audit Commission to perform an independent assurance engagement in respect of Imperial College Healthcare NHS Trust's Quality Account for the year ended 31 March 2014 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

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

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the following indicators:

- Rate of clostridium difficile infections; and
- Percentage of patient safety incidents resulting in severe harm (0.1% as disclosed in the Quality Account) or death (0.2%).

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

Respective responsibilities of Directors and auditors

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

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

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

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

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

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

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

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

- Board minutes for the period April 2013 to June 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback from the Commissioners;
- feedback from Local Healthwatch dated 02/06/2014;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey;
- the latest national staff survey;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 20/05/2014;
- the annual governance statement dated 03/06/2014;
- Care Quality Commission Intelligent Monitoring Report dated 13/03/2014;

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

Assurance work performed

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

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

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

Limitations

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

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

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

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have not been determined locally by Imperial College Healthcare NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

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

Deloitte LLP

Deloitte LLP
St Albans, UK
3 June 2014

Appendix 1 – Statement of directors' responsibilities in respect of the Draft Quality Account

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

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

1. the Quality Account have been prepared in accordance with Department of Health guidance and present a balanced picture of the Trust's performance over the period covered

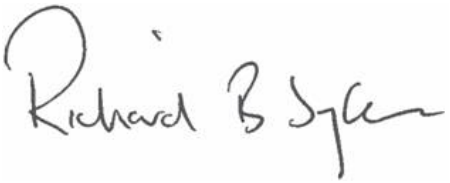
2. the content of the Quality Account is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2013 to March 2014
    - papers relating to Quality reported to the Board over the period April 2013-March 2014
    - feedback from NHS Central London, West London, Hammersmith and Fulham, Ealing and Hounslow Clinical Commissioning Groups (CCGs)
    - feedback from local scrutineers including HealthWatch; local authority overview and scrutiny committees
    - the Head of Internal Audit's Annual Opinion April 2014
    - the national inpatient survey 2013
    - the national staff survey 2013
    - CQC Registration 'without conditions' across all Trust sites
    - mortality rates provided by external agencies (Health & Social Care Information Centre and Dr Foster).

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

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

The directors have reviewed the Draft Quality Accounts at the Management Board meeting on April 22nd and confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Accounts. The Quality Accounts were reviewed at the Trust board meeting held on 28 May 2014, where the authority of signing the final Quality Accounts document will be delegated to the chief executive and chair.

By order of the Trust board

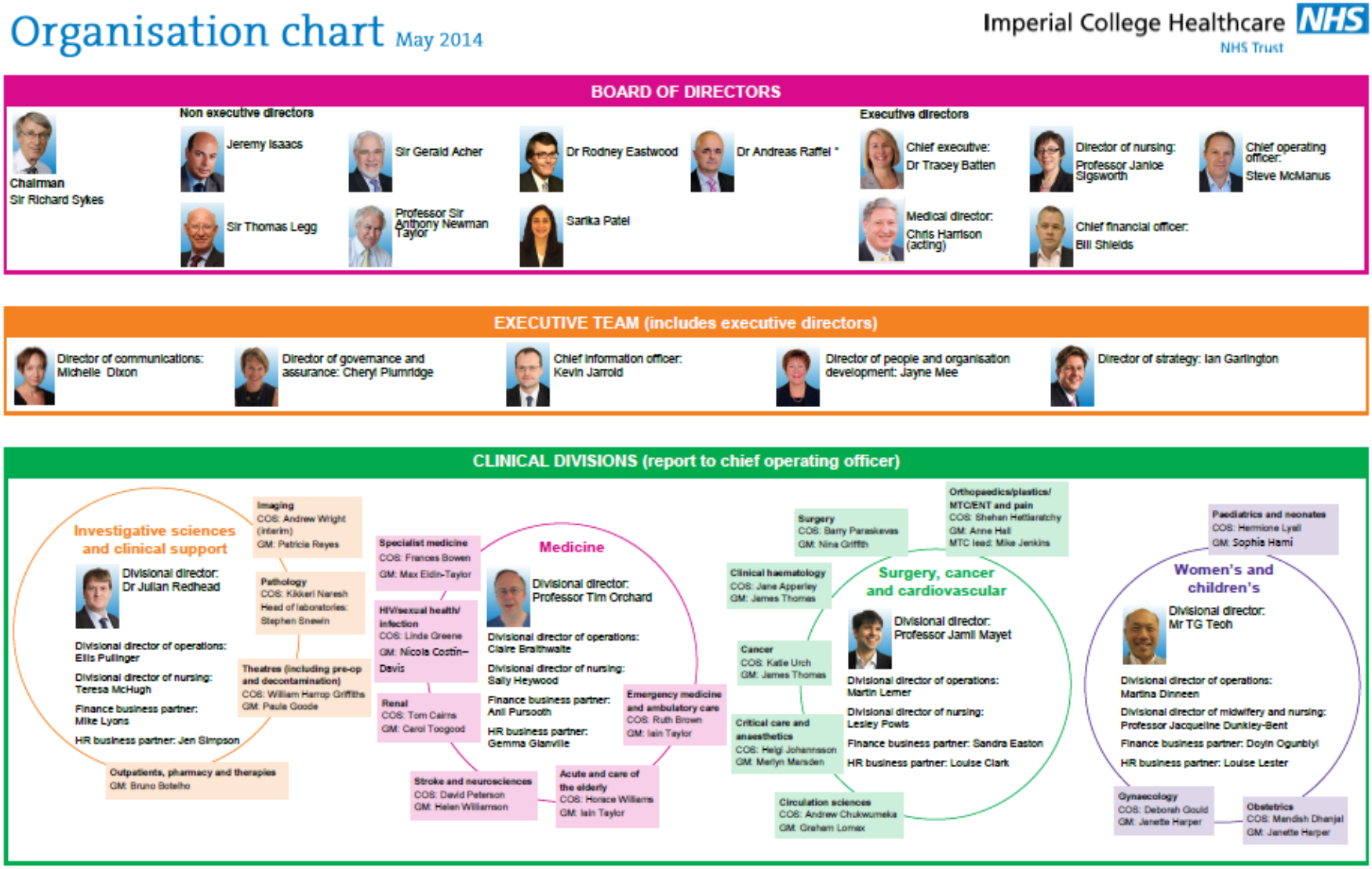


Chief Executive Chairman

Appendix Two

Organisation chart May 2014

Imperial College Healthcare NHS Trust



Respect our patients and colleagues | Encourage **innovation** in all that we do | Provide the highest quality **care** | Work together for the **achievement** of outstanding results | Take **pride** in our success

The latest version of the chart is available on the Source. If there are changes to personnel, please contact Keith Loveridge or Dawn Morris in HR.
Updated: May 2014

* Non-voting designate NED
COS: chief of service
GM: general manager

Appendix Three: Performance indicators 2013-14

The Trust has had an encouraging year making good progress on challenging targets along with maintaining good performance on key targets. Throughout the year, staff have strived to balance patient safety, quality and efficiency with excellent patient outcomes, whilst maintaining performance against these targets.

The Trust's performance is externally monitored against a range of national standards and targets. In the final quarter of 2013-14 the Trust met all eight cancer waiting times standards. This was the first time in recent years that the Trust has achieved all eight standards for the quarter and the organisation is in a good position to be able to sustain this performance in 2014-15.

This year the Trust has delivered, in all but one month, the three national referral to treatment (RTT) standards. The Trust continues to identify areas for improvement and has put robust plans in place to enable us to meet our targets.

Meeting national targets

Referral to treatment

This year, the Trust has continued to work hard so that most of our patients are seen within 18 weeks. The Trust achieved each of the three Referral to Treatment (RTT) standards (admitted treatments, non-admitted treatments and for patients waiting for treatment) in every month in 2013-14 except in March for admitted treatments. This includes consistently maintaining having very few patients waiting over 52 weeks for treatment. At the end of the year there were no patients waiting over 52 weeks for treatment.

The Trust recognises that there are some patients who wait longer than 18 weeks for treatment and a comprehensive action plan has been put in place to tackle the longest waits, which are concentrated in a small number of specialist areas.

Accident and emergency

The Trust continues to experience exceptional demand in our accident and emergency (A&E) departments and has also seen an increase in patients attending with complex needs. Despite these challenges, the Trust consistently met the 95 % four hour A&E wait national standard each month in 2013-14.

During the year, the Trust has reviewed how patients move through our emergency department and through the hospital if they need tests or inpatient care so that it can plan effectively for the future and improve care for its patients.

The Trust has introduced measures to improve the ability of its A&E department to respond at times of peak activity, and to ensure that patients are able to leave hospital safely as soon as they are ready so that beds are available for other patients. These measures include increasing capacity and starting winter planning earlier.

National cancer targets
The Trust continued to see improvements in its performance against the national cancer targets throughout 2013-14. In common with trusts receiving referrals for specialist diagnosis and treatment from other hospitals, the most challenging cancer waiting time standard is the 62 day maximum referral to treatment target.

Over 2013-14, the Trust eliminated its backlog of patients waiting for treatment and improved pathways of care, for example: patients having multiple appointments on the same day that previously would have been spread over a number of weeks. The Trust has also worked with hospitals that refer to us to ensure that delays are minimised for patients.

In quarter four of 2013-14, the Trust achieved all eight cancer waiting times standards and is in a position where this performance can be sustained. This means that our cancer patients have a faster pathway from referral to treatment and can expect to have treatment within national guidelines.

Cancelled operations for non-clinical reasons
Since the start of 2014, the rate of cancelled operations for non-clinical reasons has risen above the national standard. This is due to a number of reasons including pressures on bed availability after surgery and theatre capacity. The Trust recognises that this is an important standard for patient experience and is committed to improving our performance in this area in 2014-15. For those patients who are cancelled, the Trust has improved on the rate of patients who are re-booked within 28 days throughout the year.

Infection prevention and control
Infection prevention and antimicrobial stewardship are considered to be core aspects of patient safety. The Trust continues to be committed to preventing and reducing healthcare associated infections, including MRSA, C.*difficile*, norovirus and surgical site infections.

Since 1 April 2013, the aim and external expectation for any NHS organisation has been for zero MRSA blood stream infections (BSIs). In 2013-14, the Trust had 13 MRSA BSIs allocated to it.

This year, the Trust reduced the number of C.*difficile* infections in its hospitals. It reported 58 cases, against a threshold of 65 cases agreed with our commissioners.

Over the past year, the Care Quality Commission (CQC) reviewed the Trust's infection control practices in one of their planned inspections. They found the wards they inspected to be clean and that the right systems were in place to prevent and control the risk of infection. The CQC inspection team found many examples of good practice in the care our teams provide and did not require the Trust to carry out any additional actions.

A key priority for the Trust in 2014-15 is embedding into clinical practice the recently published national acute trust toolkit for the early detection, management and control of carbapen resistant enterobacteriaceae to meet the emerging risk identified by the Chief Medical Officer of multi-drug resistant carbapenemase-producing organisms.

CQUIN Targets

Commissioners hold the NHS budget for their area and decide how to spend this on hospital care and other health services. Our commissioners set us goals based on quality and innovation, and a proportion of our income is conditional on achieving these goals. The system is called the Commissioning for Quality and Innovation or the CQUIN payment framework.

Last year, 2.5 % of our clinical income was conditional upon achieving quality improvement and innovation goals agreed with clinical commissioning groups and NHS England.

Venous thromboembolism (VTE) risk assessment forms one of our CQUIN schemes. The Trust satisfied the 2013-14 CQUIN VTE target, of more than 95% of patients assessed for VTE risk for all patients within 24 hours of admission to hospital. This is a 5% improvement compared with 2012-13.

All patients suffering a hospital acquired VTE are identified according to an agreed protocol and their care is subjected to a formal root cause analysis (RCA) with the responsible clinician. The outcome is reviewed in each case by the VTE lead. The CQUIN targets for RCA for 2013-14 have been met in full.

VTE risk assessment compliance will not be a CQUIN scheme in 2013-14. However, performance against the 95 % threshold will be monitored through the contract as it remains a high priority for the Trust to continue to deliver.

	Threshold	Q1	Q2	Q3	Q4
A&E maximum waiting times 4 hours	95%	96.24%	96.68%	95.97%	95.97%
18 weeks referral to treatment – admitted	90%	92.50%	93.35%	93.18%	90.77%
18 weeks referral to treatment – non admitted	95%	96.85%	96.80%	95.88%	95.28%
18 weeks referral to treatment – incomplete pathway	92%	95.96%	95.96%	95.05%	94.58%
2 week wait from referral to date first seen all urgent referrals	93%	98.27%	98.37%	98.51%	95.70%
2 week wait from referral to date first seen breast cancer	93%	97.63%	97.60%	97.28%	95.25%
31 days standard from diagnosis to first treatment	96%	94.43%	96.89%	96.07%	97.95%
31 days standard to subsequent Cancer Treatment – Drug	98%	100%	99.47%	100%	100%
31 days standard to subsequent Cancer Treatment – Radiotherapy	94%	97.50%	98.73%	98.06%	99.60%
31 days standard to subsequent Cancer Treatment – Surgery	94%	96.07%	95.47%	95.42%	95.35%
62 day wait for first treatment from NHS Screening Services referral	90%	91.27%	95.57%	92.23%	93.00%
62 day wait for first treatment from urgent GP referral	85%	74.27%	74.00%	80.10%	86.2%
Clostridium Difficile (C-Diff) Post 72 Hours	65	26	11	10	11
MRSA	0	5	4	2	2
VTE	95%	95.1%	96.1%	96.3%	96.8%
Cancelled operations for non-clinical reasons	0.8%	0.75%	0.73%	0.70%	1.21%
Rebooking non-clinical cancellations within 28 days	5%	8.38%	4.71%	3.35%	2.85%

Glossary

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

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

Clinical Programme Group (CPG) – was the name given to the way we used to use to clinical service groupings, as they are divided according to different specialities.

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

Clot – a soft thick lump or mass.

Dementia – dementia is a syndrome (a group of related symptoms) that is associated with an ongoing decline of the brain and its abilities. It is used to describe a collection of symptoms including memory loss, problems with reasoning and communication skills, and a reduction in a person's abilities and skills in carrying out daily living activities. Dementia affects the whole life of a person who has it as well as their family.

Duty of candour – full disclosure, not to withhold information.

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

Failure to rescue – failed to prevent a clinically important deterioration.

Falls – unintentionally coming to rest on the ground floor/lower level, includes fainting, epileptic fits and collapse or slip.

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

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

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

Grade One – Discolouration of intact skin not affected by light finger pressure
Grade Two – Partial thickness skin loss or damage
Grade Three – Full thickness skin loss involving damage of subcutaneous tissue
Grade Four – Full thickness skin loss with extensive destruction and necrosis (dead tissue).

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

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

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

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

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

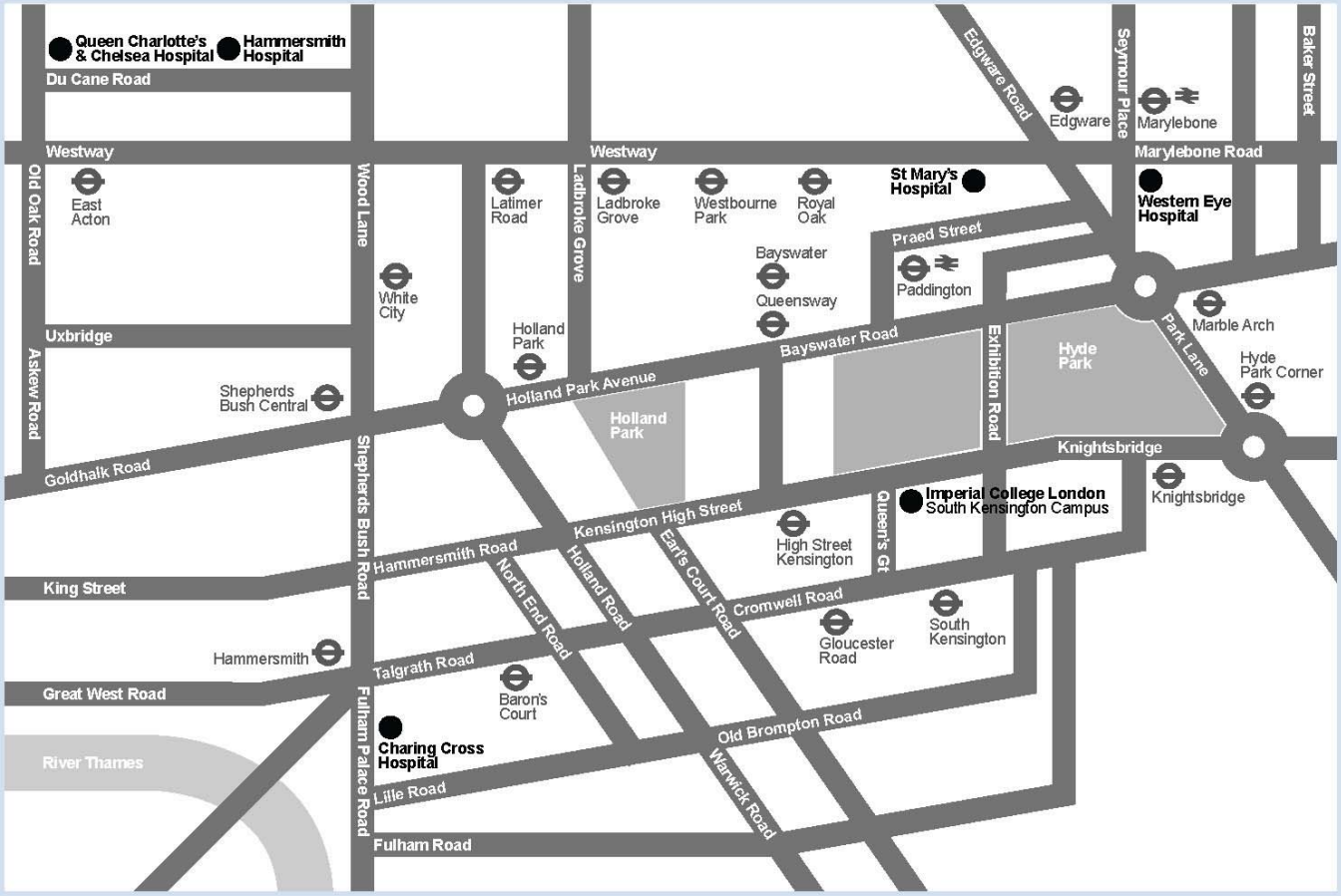
Urethra – a tube that connects the bladder to the outside of the body.

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

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

Vein – blood vessel that carries blood towards the heart.

Contact us and map of Trust sites



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