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Part 1 – Statement on quality from the Chief Executive

We are delighted to share the Quality Account 2018/19 for Aintree University Hospital NHS Foundation Trust which demonstrates the improvements we have made to the quality of our services for our patients. This report details our performance over the last year whilst also highlighting our key priorities for 2019/20.

One of the key strategic priorities in 2018/19 has been work on the proposed merger transaction between Aintree University Hospital NHS FT (AURFT) and The Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT). By merging the management of the Trusts and coming together to redesign services, we believe we can:

- Deliver safer care through improved, joined-up and patient-centred healthcare
- Improve care – single, city-wide teams treating more patients will ensure that clinical staff have the best skills, and patients get the best results from their care
- Safeguard specialist services which could otherwise be moved elsewhere in the North West
- Provide patients with access to cutting-edge technologies and experimental treatments, such as new drugs, by accessing more research opportunities
- Reduce costs, for example by reducing our combined reliance on agency staff
- Support inpatient centres of excellence with outpatients in multiple hospitals, where patients spend most time
- Establish a more joined-up approach to medicines management across the number of hospitals, where patients spend most time - centralised where necessary, local where possible
- Improved opportunities for career development in a bigger service
- Support inpatient centres of excellence with outpatients in multiple hospitals, where patients spend most time
- Improve opportunities for career development in a bigger service
- A sustainable healthcare service, making best use of taxpayer’s money
- Safeguarding – a Hospital Safeguarding Group was established to oversee the implementation of the action plan and there has been positive progress made to embed and sustain actions to ensure the Trust meets its regulatory obligations.
- Medicines management – to further improve practice in medicines management across the organisation, a lead nurse for medicines safety has been appointed undertaking a more collaborative approach as well as reducing duplication and identifying themes. The Medicines Safety Group approved the improvement plan and will monitor its progress.
- Staffing – there has been a clear focus on workforce during 2018/19 with investment in a lead Nurse for Workforce to oversee recruitment and retention across the Trust. A robust Workforce Improvement Plan has been in place since 2018, this has seen significant improvements in reducing vacancy rates for registered nurses and overall vacancy rates which are better than both the regional and national average. Retention rates for registered nurses are also above regional and national average demonstrating year on year improvement. The Trust has also made a significant impact on agency spend for Health Care Assistants and nursing.
- Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) – quarterly audits have been established to monitor the quality of the completion of documentation. DNACPR is also reviewed as part of the revised Aintree Assessment & Accreditation (AAA) framework for inspection of wards.

The key elements of our quality performance for 2018/19 included:

- Incident Reporting – we have intensified our efforts to incident reporting, resulting in the Trust recording the tenth largest increase in incident reporting nationally, which is indicative of an improved reporting culture. This has been largely due to the Safety First programme identifying the importance of organisational learning and safety as the first priority.
- Falls prevention – our aim was to achieve a continued reduction in inpatient falls and falls with harm. We achieved a 5.6% improvement in all falls against a 5% improvement target and a reduction of 40.5% in the number of inpatient falls leading to moderate harm and above. We continue to work to improve a reduction in all falls in the overarching 2019/20 action plan.

What is a Quality Account Report?

The Health Act of 2009 set out guidance in relation to the production of Quality Accounts. NHS Foundation Trusts are required to produce Quality Reports. Each year the Trust reviews updated guidance published by NHS Improvement regarding the content required in the document. Aintree University Hospital’s Quality Report for 2018/19 takes into account the guidance published on December 2018.

The aim in reviewing and publishing performance about quality is to enhance public accountability by listening to and involving the public, partner agencies and, most importantly, acting on feedback received by patients, staff, families and carers. Aintree produces quarterly Quality Reports on the Trust’s priorities to show improvements to quality during the year. This is so that Aintree can regularly inform people who work for the Trust, people who use the Trust’s services, carers, the public, commissioners of NHS services, and local scrutineers of our quality initiatives and to encourage regular feedback.

Aintree recognises how important it is that the information it provides about the quality of care is accessible to all. As a report to the public, this Quality Report, and ‘easier read’ accessible versions of the Quality Report is published on Aintree’s public website.
**Pressure Ulcers** – we set ourselves improvement targets for Grade 2 & 3 pressure ulcers but did not meet either. A thematic review has been undertaken with an action to target underperforming wards using quality improvement methodology to improve our position.

**Mortality** – we have continued to see a reduction in mortality levels across all indicators with performance ‘as expected’ or ‘below expected’ both nationally and regionally. We are participating in the pilot review of Patients with Learning Disabilities (LaDe) being led by South Sefton Clinical Commissioning Group. Our sepsis mortality has fallen steadily since 2016 and our overall care exceeds the average North West care putting us in the top quartile for the region.

**Patient and family engagement** – our Patient & Family Experience Plan for 2018-20 was approved in September 2018 as an integral pillar of our Quality Strategy. Of the 28 practices identified, we were on track to successfully embed and sustain the specified objectives set within the timescales.

The increased level of demand for hospital services continued to put operational pressure on the Trust during 2018/19 and its ability to achieve a number of our key performance indicators. However, we have continuously seen improvements in our sustainable performance, much of which is better than the national average, to ensure that our patients were not adversely affected:

- **A&E four-hour standard** – increased attendances have impacted on service delivery but our ongoing work, in collaboration with the A&E Delivery Board, is supporting changes to improve patient flow. A number of schemes to support the delivery of sustainable improvement against the standard continue to be progressed internally with positive results. We are also working closely with our system partners across health and social care to resolve some of the key challenges facing the Trust. The Health Service Journal reported Aintree as the most improved performance of the A&E four-hour standard for 2018/19 compared to 2017/18.

- **18-week referral to treatment** – pressures were experienced in meeting the standard predominately due to there being significant growth in demand for services during the year but we have made inroads to improve and sustain performance around the 90% mark. When compared to the national position, Aintree continues to consistently perform at a high level.

- **Diagonstics** – this was a challenging standard for us to achieve mainly due to workforce capacity but the clinical teams have worked hard to improve the position and performance is now significantly better at 0.4% against the 1% standard. This has been achieved in February and March 2019.

- **Cancer** – substantial increases in referrals into cancer services has affected overall performance against the 2-week wait, Breast Symptomatic and 62-day standards but we have continued to do our utmost to deliver outstanding care for our patients and the performance improvements we have made would not have been possible were it not for their unwavering commitment and hard work. As ever, they are ably supported by Aintree’s dedicated volunteers who generously give their time to our staff and patients every day.

- **Inpatients Survey** – the response rate for the 2018 survey had improved from 30% to 35% and our satisfaction scores were better than the previous year. Areas for improvement have been identified and will be incorporated into an action plan and monitored by the Patient Experience Executive Led Group.

**Staff Survey** – whilst we had seen an increase in scores for staff engagement and quality of appraisals it is crucial that momentum is maintained and engagement efforts increased. The survey was conducted solely online which may have impacted on the response rate reducing by 12%. However, we fully recognise that for us to deliver high quality patient care, our staff need to feel engaged, valued and motivated with concerns raised being addressed in a timely manner. As a Trust we are committed to hearing the staff voice, and recognise that involving staff is essential in driving quality improvement and to help Aintree become a ‘Best Place to Work’.

We have an ambitious Safety First programme with its core principles of making “Safety our number one priority” and “Safety being everyone’s responsibility”. A number of work streams have been established and excellent progress has been made during its first year to deliver key milestones. This work will be further developed during 2019/20 to enhance our commitment to developing an explicit safety culture to enable safety to be the focus of everything we do at Aintree.

We also launched our End of Life & Bereavement Strategy, using the frangipani model of end of life care and the frangipani blossom as the Trust symbol for care across all services and departments. The strategy aims to provide a person-centred, individualised approach to delivering responsive end of life services by a workforce who are:

- Compassionate
- Able
- Responsive
- Engaged

The implementation of the Strategy will be progressed during 2019/20.

It has been yet another pressured year but our commitment to the quality agenda remains steadfast as we seek to realise our strategic vision:

*“to be a leading provider of the highest quality health care”*

The three elements of our approach to continuous improvement remain:

- **Culture**
- **Safeguarding**
- **Quality**

Progress highlights against the delivery of the strategy in 2018/19 include:

**Safe Care:** The Trust continues to invest in safe, patient centred care. During 2018/19:

- Safeguarding policies have been strengthened and a strategy for Cognitive Impairment has been implemented. Successful delivery of the strategy is being resourced through the appointment of a Lead Nurse and Clinical Leads.
- Deteriorating Patients – a Deteriorating Patient Safety Group has been established to drive forward improvements. Enhanced monitoring and escalation has been implemented and compliance is reviewed with immediate improvement actions identified and managed through Divisional Assurance Groups. Targeted training on the detection of the deteriorating patient has commenced and is being rolled out across key areas.

**Safety Culture:** A Steering Group has been established, chaired by the Medical Director, with oversight of the delivery of eight cross cutting work streams. More than 750 staff participated in an online conversation about the key priorities to be included within the Trust’s Safety Culture work programme and 200 patients and staff participated in questionnaires which will support the development of the Trust’s standards of behaviour framework. This behavioural framework will be launched in spring 2019. The key outcomes from the programme to date include the establishment of 30 Safety and Governance meetings in wards and departments, improved reporting on DATIX, our patient safety software system, the appointment of Investigation Support Officers, 420 theatre staff trained in National Safety Standards for Invasive Procedures (NatSSIPS) and an improved Safety Pin bulletin and Safety Huddle framework.

**Clinical Effectiveness:** An End of Life Strategy has been created and sets a clear direction for improving end of life care, supported by a comprehensive training programme. Reducing Avoidable Mortality: Mortality at Aintree is measured in three ways across all specialties: two are risk adjusted indices, the Summary Hospital-Level Mortality Index (SHMI) and Hospital Standardised Mortality Ratio (HSMR); the third is crude mortality rate expressed as a percentage of all inpatient discharges.

As a Trust we are within the expected ranges for these indicators. We are participating, with South Sefton Clinical Commissioning Group, in a mortality review pilot of patients with a learning disability. Our Sepsis Policy has been updated and sepsis mortality has fallen steadily since 2016 from 32% to 18% and is as expected nationally and regionally. Aintree is in the top quartile within the regional Advancing Quality Programme with regard to overall care to patients diagnosed with sepsis.

**Patient and Family Experience:**

A comprehensive plan has been developed with its delivery being managed through the Patient Experience Executive Led Group. A revised complaints process was implemented in June 2018, which has resulted in a reduction of formal complaints and increased local resolution.

More detailed information regarding progress against our Quality Strategy metrics for 2018-20 is provided in the table overleaf.

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**Part 2 – Priorities for improvement and statements of assurance from the Board**

**Part 2.1(i) Summary of progress against our quality improvement priorities for 2018/19**

The Trust’s Quality Strategy for 2018-20 was published in August 2018 and set out our commitment to quality and moving closer to realising our strategic vision: “to be a leading provider of the highest quality health care”.

As a Trust we are within the expected ranges for these indicators. We are participating, with South Sefton Clinical Commissioning Group, in a mortality review pilot of patients with a learning disability. Our Sepsis Policy has been updated and sepsis mortality has fallen steadily since 2016 from 32% to 18% and is as expected nationally and regionally. Aintree is in the top quartile within the regional Advancing Quality Programme with regard to overall care to patients diagnosed with sepsis.

**Care that is Clinically Effective** – not just in the eyes of clinicians but in the eyes of patients and their families

**Care that provides a Positive Experience for patients and their families**

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Steve Warburton
Chief Executive, 22 May 2019
Quality Strategy Metric Performance
The Trust’s Quality Strategy for 2018-20 was published in August 2018 and set out our commitment to quality and moving closer to realising our strategic vision “to be a leading provider of the highest quality health care”. Performance against the key quality goals identified in that new strategy is presented below:

<table>
<thead>
<tr>
<th>Objective</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Hospital Acquired Pressure Ulcers - Grade 2</td>
<td>61</td>
<td>64</td>
<td>95</td>
<td></td>
</tr>
<tr>
<td>Grade 2 Pressure Ulcers per 1000 bed days</td>
<td>0.250</td>
<td>0.248</td>
<td>0.347</td>
<td></td>
</tr>
<tr>
<td>Number of Hospital Acquired Pressure Ulcers - Grade 3/4</td>
<td>6</td>
<td>7</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Grade 3/4 Pressure Ulcers per 1000 bed days</td>
<td>0.025</td>
<td>0.027</td>
<td>0.033</td>
<td></td>
</tr>
<tr>
<td>% of Catheter Associated Urinary Tract Infections</td>
<td>34.3%</td>
<td>31.8%</td>
<td>43.4%</td>
<td></td>
</tr>
<tr>
<td>% Patients receiving Venous Thromboembolism Risk Assessment</td>
<td>93.0%</td>
<td>92.3%</td>
<td>92.1%</td>
<td></td>
</tr>
<tr>
<td>Number of Patient Falls with harm</td>
<td>421</td>
<td>425</td>
<td>472</td>
<td></td>
</tr>
<tr>
<td>Falls per 1000 bed days</td>
<td>1.73</td>
<td>1.64</td>
<td>1.72</td>
<td></td>
</tr>
<tr>
<td>Number of cases of MRSA</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>100% compliance with Hand Hygiene</td>
<td>97.0%</td>
<td>100.0%</td>
<td>99.3%</td>
<td></td>
</tr>
<tr>
<td>Number of C-Difficile Infections &lt;=46</td>
<td>27</td>
<td>43</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>C-Difficile infections per 1000 Bed days</td>
<td>0.11</td>
<td>0.17</td>
<td>0.10</td>
<td></td>
</tr>
<tr>
<td>Ensure the improvement in monitoring and escalation of deteriorating patients</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Safeguarding and Mental Capacity Act

<table>
<thead>
<tr>
<th>Objective</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase compliance and assurance with Safeguarding policy and procedures</td>
<td>-</td>
<td>97.5%</td>
<td>93.1%</td>
<td></td>
</tr>
<tr>
<td>Improve Trust delivery of care to patients with a cognitive impairment</td>
<td>-</td>
<td>-</td>
<td>Partial</td>
<td></td>
</tr>
<tr>
<td>95% of staff to have appropriate level of safeguarding training for children</td>
<td>-</td>
<td>98.1%</td>
<td>90.2%</td>
<td></td>
</tr>
<tr>
<td>Achieve higher compliance with CQC regulation 13</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Review and implement Safeguarding Level 3 for Adults and Children training to Trust staff</td>
<td>-</td>
<td>97.10%</td>
<td>94.70%</td>
<td></td>
</tr>
</tbody>
</table>

Acting on clinical results

<table>
<thead>
<tr>
<th>Objective</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent any future backlog to unacknowledged clinical investigation results</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Standardise the management of abnormal results and normal results</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Governance, learning and preventing harm

<table>
<thead>
<tr>
<th>Objective</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver regulatory compliance with CQC fundamental standards</td>
<td>-</td>
<td>-</td>
<td>Amber</td>
<td></td>
</tr>
<tr>
<td>Increase incident reporting as measured by number of incidents reported</td>
<td>6,369</td>
<td>8,047</td>
<td>7,779</td>
<td></td>
</tr>
<tr>
<td>Improve consistency and timeliness of investigations, sharing learning</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Improvement in patient journey

<table>
<thead>
<tr>
<th>Objective</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve the (4-hour) emergency access standard</td>
<td>89.9%</td>
<td>81.6%</td>
<td>84.7%</td>
<td></td>
</tr>
<tr>
<td>Implement an intensively supported programme to roll out SAFER and patient flow bundle</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
### Learning from Harm

<table>
<thead>
<tr>
<th>Objective</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve zero never events</td>
<td>1</td>
<td>9</td>
<td>1</td>
<td><img src="image1" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Achieve 100% compliance with the WHO Checklist</td>
<td>69.50%</td>
<td>62.90%</td>
<td>97.30%</td>
<td><img src="image2" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Mitigate risk of Never Events occurring</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td><img src="image3" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Increase visibility of theatre leadership</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td><img src="image4" alt="Progress Indicator" /></td>
</tr>
</tbody>
</table>

### Reducing Avoidable Mortality

<table>
<thead>
<tr>
<th>Objective</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the prevention, early detection and treatment of Acute Kidney Injury (AKI)</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td><img src="image5" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>AQ measure - Ensure identification and management of pneumonia</td>
<td>93.9%</td>
<td>95.0%</td>
<td>92.1%</td>
<td><img src="image6" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>AQ measure - Ensure identification and management of sepsis</td>
<td>89.4%</td>
<td>93.2%</td>
<td>91.6%</td>
<td><img src="image7" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Achieve early recognition and management of the deteriorating patient</td>
<td>98.6%</td>
<td>96.3%</td>
<td>97.9%</td>
<td><img src="image8" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Deliver improvements in end of life care</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td><img src="image9" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Commence Structured Judgement Review</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td><img src="image10" alt="Progress Indicator" /></td>
</tr>
</tbody>
</table>

### Deliver reliable effective care

<table>
<thead>
<tr>
<th>Objective</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve Cancer 62 day target for 85% of the time</td>
<td>81.1%</td>
<td>85.6%</td>
<td>80.0%</td>
<td><img src="image11" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Deliver Stroke improvements</td>
<td>56.1%</td>
<td>82.0%</td>
<td>70.6%</td>
<td><img src="image12" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Achieve Incomplete RTT pathways for 90% of pathways</td>
<td>92.5%</td>
<td>90.1%</td>
<td>89.0%</td>
<td><img src="image13" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Achieve diagnostics &lt; 6 week target</td>
<td>1.2%</td>
<td>1.4%</td>
<td>0.9%</td>
<td><img src="image14" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Improve End of Life Care pathways</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td><img src="image15" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Improve Dermatology pathways</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td><img src="image16" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Improve Severe Asthma pathways</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td><img src="image17" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Improve Cardiology care pathways</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td><img src="image18" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Improve Gastro care pathways</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td><img src="image19" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Reduce last minute cancellations from theatre</td>
<td>183</td>
<td>258</td>
<td>271</td>
<td><img src="image20" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>% last minute theatre cancellations</td>
<td>0.35%</td>
<td>0.52%</td>
<td>0.87%</td>
<td><img src="image21" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>AQ measure - Acute Kidney Injury CPS target 94%</td>
<td>92.0%</td>
<td>92.8%</td>
<td>95.1%</td>
<td><img src="image22" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>AQ measure - Alcohol Related Liver Disease CPS target 78%</td>
<td>-</td>
<td>94.9%</td>
<td>78.6%</td>
<td><img src="image23" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>AQ measure - Hip and Knee Replacement CPS target 95%</td>
<td>94.8%</td>
<td>96.8%</td>
<td>95.5%</td>
<td><img src="image24" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>AQ measure - Pneumonia target 95%</td>
<td>93.9%</td>
<td>95.0%</td>
<td>91.6%</td>
<td><img src="image25" alt="Progress Indicator" /></td>
</tr>
</tbody>
</table>

### Drive performance in Patient Experience

<table>
<thead>
<tr>
<th>Objective</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement a Patient &amp; Family Experience Plan 2018-2020</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td><img src="image26" alt="Progress Indicator" /></td>
</tr>
</tbody>
</table>

### Co-create improvements

<table>
<thead>
<tr>
<th>Objective</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver 4 Always Events</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td><img src="image27" alt="Progress Indicator" /></td>
</tr>
<tr>
<td>Involve patients in Quality Improvement areas</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td><img src="image28" alt="Progress Indicator" /></td>
</tr>
</tbody>
</table>
Part 2.1(ii) Priorities for improvement in 2019/20

The Trust’s Quality Strategy for 2018-20 reinforces the three overarching priorities for improving patient care. These overarching priorities aim to ensure that care delivered by the Trust is safer, more effective and provides positive patient experience.

Priority 1: Care that is Safe
working with patients and their families to reduce avoidable harm and improve outcomes.

Priority 2: Care that is Clinically Effective
not just in the eyes of clinicians but in the eyes of patients and their families.

Priority 3: Care that provides a positive experience for patients and their families
The delivery of these priorities will continue to be underpinned by a portfolio of key quality goals as set out on the right.

Key Quality Goals:
- Care that is safe
  - Reducing harm
  - Safeguarding processes and Mental Capacity Act
  - Acting on clinical results
  - Governance, learning and preventing harm
  - Improvement in patient journey
  - Learning from harm.
- Care that is clinically effective
  - Reducing avoidable mortality
  - Care pathways
  - Advancing Quality Programme.
- Patient and family experience
  - Patient feedback
  - Co-create improvements.

How the views of patients, the wider public and staff were taken into account:
The Trust’s Quality Strategy (2018-20) and the key quality goals were agreed by taking into account the views of:
- People who use the Trust’s services and carers; for example, through receipt of feedback from activities such as the Friends and Family Test, patient and carer surveys.
- Staff and senior clinicians; for example, through discussion at the Trust’s Divisional governance meetings.
- Staff and senior clinicians; for example, through discussion at the Trust’s Divisional governance meetings.
- Governors and Foundation Trust Members; through Quality Account Meetings and the governor-led Quality of Care Committee.
- Commissioners of NHS services; through contract negotiation and monitoring processes.
- Local Healthwatch; through feedback from visits to services, at quarterly informal meetings and via the Patient Experience Executive-led Group.
- Stakeholders and the wider public; for example through activities such as Quality Priorities Engagement Events.

How progress to achieve the quality improvement priorities will be reported:
Progress against the Trust’s Quality Strategy for 2018-20 will continue to be reported to the Quality Committee. It will also be shared widely with governors, members and local Healthwatch organisations.
Part 2.2 Statements of Assurance from the Board

To assure the public that we are performing to essential standards, providing high quality care, measuring clinical process and are involved in initiatives to improve quality, we offer the following statements:

Common content for all Quality Accounts nationally is contained in a double line border like this.

Information of the review of services

During 2018/19, the Aintree University Hospital NHS Foundation Trust provided and/or sub contracted 39 relevant health services. The Aintree University Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in 39 of these relevant health services. The income generated by the relevant health services reviewed in 2018/19 represents 98.5% of the total income generated from the provision of relevant health services by the Aintree University Hospital NHS Foundation Trust for 2018/19.

Information on participation in clinical audits and national confidential enquiries

During 2018/19, 48 national clinical audits and 3 national confidential enquiries covered relevant health services that Aintree University Hospital NHS Foundation Trust provides. During that period Aintree University Hospital NHS Foundation Trust participated in 98% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Aintree University Hospital NHS Foundation Trust was eligible to participate in during 2018/19 are as follows:

- BAUS Urology Audits - Nephroscopy
- BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)
- Case Mix Programme (CMP)
- Elective Surgery (National PROMs Programme)
- Endocrine and Thyroid National Audit
- Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service Database
- Falls and Fragility Fractures Audit programme (FFFAP) - Inpatient Falls
- Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database
- Head and Neck Cancer Audit
- Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit
- Learning Disability Mortality Review Programme (LeDeR)
- Major Trauma Audit
- Mandatory Surveillance of Bloodstream infections and Clostridium Difficile Infection
- National Adult Community Acquired Pneumonia (CAP) Audit
- National Adult Non-Invasive Ventilation (NNV) Audit
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Chronic Obstruction Pulmonary Disease (COPD) Secondary Care
- National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Adult Asthma Secondary Care
- National Audit of Breast Cancer in Older People (NABACP)
- National Audit of Cardiac Rehabilitation
- National Audit of Care at the End of Life (NACEL)
- National Audit of Dementia (in General Hospitals)
- National Cardiac Arrest Audit (NCAA)
- National Cardiac Audit Programme (NCP) - Cardiac Rhythm Management (CRM)
- National Cardiac Audit Programme (NCP) - Myocardial Ischaemia National Audit Project (MINAP)
- National Cardiac Audit Programme (NCP) - National Heart Failure Audit
- National Comparative Audit of Blood Transfusion Programme - Management of Massive Haemorrhage
- National Comparative Audit of Blood Transfusion Programme - Use of Fresh Frozen Plasma and Cryoprecipitate in Neonates and Children
- National Diabetes Audit - Adults - National Core Diabetes Audit
- National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDia) - reporting data on services in England and Wales
- National Diabetes Audit - Adults - National Diabetes Foot Care Audit
- National Diabetes Audit - Adults - National Diabetes Inpatient Audit (NaDia) Harms - reporting on diabetic inpatient harms in England
- National Early Inflammatory Arthritis Audit (NEIAA)
- National Emergency Laparotomy Audit (NELA)
- National Gastrointestinal Cancer Programme - National Bowel Cancer Audit (NBOCA)
- National Gastrointestinal Cancer Programme - National Desophage-gastric Cancer (NOGCA)
- National Joint Registry (NJR)
- National Lung Cancer Audit (NLCA)
- National Ophthalmology Audit (NOD)
- National Prostate Cancer Audit
- NCEPOD Long-term ventilation in children, young people and young adults
- NCEPOD Pulmonary embolism
- NCEPOD Acute Bowel Obstruction
- Reducing the Impact of Serious Infections (Antimicrobial Resistance and Septis) - Antimicrobial Stewardship
- Reducing the Impact of Serious Infections (Antimicrobial Resistance and Septis) - Antibiotic Consumption
- Sentinel Stroke National Audit Programme (SSNAP)
- Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme
- Seven Day Hospital Services Self-Assessment Survey
- Surgical Site Infection Surveillance Service
- Vital Signs in Adults (Care in Emergency Departments)
- VTE Risk in Lower Limb Immobilisation (Care in Emergency Departments)

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- BAUS Urology Audits - Nephroscopy
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- Seven Day Hospital Services Self-Assessment Survey
- Surgical Site Infection Surveillance Service
- Vital Signs in Adults (Care in Emergency Departments)
- VTE Risk in Lower Limb Immobilisation (Care in Emergency Departments)
The national clinical audits and national confidential enquiries that Aintree University Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

### Audit/Enquiry

<table>
<thead>
<tr>
<th>Audit/Enquiry</th>
<th>Cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAUS Urology Audits – Nephrectomy</td>
<td>80 (66%)</td>
</tr>
<tr>
<td>BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)</td>
<td>53 (no requirement data)</td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>1401 (% unknown)</td>
</tr>
<tr>
<td>Elective Surgery (National PROMs Programme)</td>
<td></td>
</tr>
<tr>
<td>• Pre-operative questionnaires returned</td>
<td>542 procedures</td>
</tr>
<tr>
<td>• Post-operative questionnaires returned</td>
<td>377 (69.6%)</td>
</tr>
<tr>
<td>• 216 (57.4%)</td>
<td></td>
</tr>
<tr>
<td>Endocrine and Thyroid National Audit</td>
<td>66 (% unknown)</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service Database</td>
<td>Final position awaited</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit programme (FFFAP) - Inpatient Falls</td>
<td>1 (aiming for 0)</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database</td>
<td>404 (% unknown)</td>
</tr>
<tr>
<td>Head and Neck Cancer Audit</td>
<td>Final position awaited</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit</td>
<td>41 (100%)</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme (LeDeR)</td>
<td>11 (100%)</td>
</tr>
<tr>
<td>Major Trauma Audit</td>
<td>939 (% unknown)</td>
</tr>
<tr>
<td>Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection</td>
<td>39 (100%)</td>
</tr>
<tr>
<td>National Adult Community Acquired Pneumonia (CAP) Audit</td>
<td>149 (% unknown)</td>
</tr>
<tr>
<td>National Adult Non-Invasive Ventilation (NiV) Audit</td>
<td>In progress</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Secondary Care</td>
<td>In progress (latest figure 1196)</td>
</tr>
</tbody>
</table>

### Audit/Enquiry

<table>
<thead>
<tr>
<th>Audit/Enquiry</th>
<th>Cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Pulmonary Rehabilitation</td>
<td>In progress</td>
</tr>
<tr>
<td>National Audit of Breast Cancer in Older People (NABCOP)</td>
<td>Final position awaited</td>
</tr>
<tr>
<td>National Audit of Cardiac Rehabilitation</td>
<td>Final position awaited</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEIL)</td>
<td>80 (100%)</td>
</tr>
<tr>
<td>National Audit of Dementia (in General Hospitals)</td>
<td>54 (100%)</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>86 (% unknown)</td>
</tr>
<tr>
<td>National Cardiac Audit Programme (NCA) - Cardiac Rhythm Management (CRM)</td>
<td>In progress</td>
</tr>
<tr>
<td>National Cardiac Audit Programme (NCA) - Myocardial Ischaemia National Audit Project (MINAP)</td>
<td>In progress (latest figure 521)</td>
</tr>
<tr>
<td>National Cardiac Audit Programme (NCA) - National Heart Failure Audit</td>
<td>In progress (latest figure 477)</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion Programme - Management of Massive Haemorrhage</td>
<td>10 (100%)</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion Programme - Use of Fresh Frozen Plasma and Cryoprecipitate in Neonates and Children</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>National Diabetes Audit – Adults - National Core Diabetes Audit</td>
<td>Final position awaited</td>
</tr>
<tr>
<td>National Diabetes Audit – Adults - National Diabetes Inpatient Audit (NaDia) - reporting data on services in England and Wales</td>
<td>Final position awaited</td>
</tr>
<tr>
<td>National Diabetes Audit – Adults - National Diabetes Inpatient Audit (NaDia) - reporting on diabetic inpatient harms in England</td>
<td>Final position awaited</td>
</tr>
<tr>
<td>National Early Inflammatory Arthritis Audit (NEIAA)</td>
<td>In progress</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>144 (100%)</td>
</tr>
<tr>
<td>National Gastrointestinal Cancer Programme - National Bowel Cancer Audit (NBCCA)</td>
<td>Final position awaited</td>
</tr>
<tr>
<td>National Gastrointestinal Cancer Programme - National Oesophago-gastric Cancer (NOGCA)</td>
<td>Final position awaited</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>658 (% unknown)</td>
</tr>
<tr>
<td>National Lung Cancer Audit (NLCA)</td>
<td>Final position awaited</td>
</tr>
<tr>
<td>National Ophthalmology Audit (NOD)</td>
<td>1327 procedures, 1059 patients</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>Final position awaited</td>
</tr>
<tr>
<td>NCEPOD Long-term ventilation in children, young people and young adults</td>
<td>In progress</td>
</tr>
<tr>
<td>NCEPOD Pulmonary embolism</td>
<td>1 Organisational Questionnaire, 6 Clinical Questionnaires &amp; Case Notes</td>
</tr>
<tr>
<td>NCEPOD Acute Bowel Obstruction</td>
<td>In progress</td>
</tr>
<tr>
<td>Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis) - Antimicrobial Stewardship</td>
<td>Final position awaited</td>
</tr>
<tr>
<td>Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis) - Antibiotic Consumption</td>
<td>Final position awaited</td>
</tr>
</tbody>
</table>
The reports of 40 national clinical audits were reviewed by the provider in 2018/19 and Aintree University Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

<table>
<thead>
<tr>
<th>CAMS ID</th>
<th>Title</th>
<th>Action required to achieve change</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>National Diabetic Foot Care Audit</td>
<td>Successful business case and subsequent funding for additional 1.0 WTE Band 6 podiatrist to increase capacity and reduce the wait time for new patients to be seen to 5 working days.</td>
</tr>
<tr>
<td>2262</td>
<td>National Adult Community Acquired Pneumonia</td>
<td>To generate blood results for inpatients twice a day and to make them available at handover providing a real time review.</td>
</tr>
<tr>
<td>2643</td>
<td>National Anaesthetic Audit Project 5: Accidental Awareness under General Anaesthesia (AAGA)</td>
<td>Internal departmental alert issued to all staff to address sedation and record keeping.</td>
</tr>
<tr>
<td>2919</td>
<td>National Ophthalmology Audit</td>
<td>Completion of e-documentation disseminated &amp; discussed at Ophthalmology directorate governance meeting. All co-morbidities to be documented.</td>
</tr>
<tr>
<td>4715</td>
<td>National Heart Failure Audit 2016-2017</td>
<td>Initiate talks with A&amp;E/Acute Medicine Unit to educate new staff. Create and disseminate flyers to remind new staff or junior doctors regarding ambulatory model and to prompt appropriate actions.</td>
</tr>
<tr>
<td>4664</td>
<td>College of Emergency Medicine: Fractured Neck of Femur (Care in Emergency Departments)</td>
<td>Targeted education regarding pain scores, the importance of timely administration of analgesia and re-evaluation of pain.</td>
</tr>
<tr>
<td>4645</td>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: Secondary Care</td>
<td>Standards of care will be improved and maintained by: the Respiratory Specialist Nurses visiting the Acute Medicine Unit and wards on a daily basis; implementing a quality improvement project on specialist review and by increasing smoking cessation advice and referral.</td>
</tr>
<tr>
<td>3300</td>
<td>National: Diabetes Audit 2016-17</td>
<td>Ongoing focus on meeting treatment targets for HbA1c, blood pressure and lipids. Education and feedback to teams to encourage ongoing accurate and complete data submission. Improve the recording of diabetes education programmes.</td>
</tr>
</tbody>
</table>

The reports of 222 local clinical audits were reviewed by the provider in 2018/19 and Aintree University Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

<table>
<thead>
<tr>
<th>CAMS ID</th>
<th>Title</th>
<th>Action required to achieve change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1158</td>
<td>Pilates Class for Treatment of Low Back Pain</td>
<td>Audit results of the “Advanced Back” class using the same PROMs and compare results.</td>
</tr>
<tr>
<td>2679</td>
<td>Tracheostomy Care Bundle</td>
<td>Emergency pathways to be made available at the bedside. Change the Tracheostomy care bundle audit data collection tool and inform all staff.</td>
</tr>
<tr>
<td>2747</td>
<td>Woodlands Discharge</td>
<td>Establishment of Discharge Task and Finish Group to review and improve discharge process from the inpatient unit. The group will report back to the multi-disciplinary team with recommendations regarding improving the quality of discharge planning. Review of current multi-disciplinary discharge pathway used on Woodlands Inpatient Unit. Relaunch once review complete with training for the multi-disciplinary team and audit of its use.</td>
</tr>
<tr>
<td>2752</td>
<td>Woodlands Nutrition</td>
<td>To update nutritional education and training package at Woodlands Hospice.</td>
</tr>
<tr>
<td>2769</td>
<td>Patient Satisfaction: Aintree Weigh Management</td>
<td>Focus on goal setting in appointments and groups and devise new goal setting sheet to hand out. Check patients are aware of appropriate contact numbers/highlight on the information sheet given. Look into other potential contact points for patients and discuss at team meeting. Portable scales to be sourced and used in cubicles when the gym is in use.</td>
</tr>
<tr>
<td>3082</td>
<td>Completeness and Knowledge of Anaesthetic Standard Operating Procedures</td>
<td>Individuals in each area to have responsibility for updating the guidelines on an annual basis. Guidelines to be included in the induction pack for all new staff members. Locations of standard operating procedure files have been expanded to include ALL areas where a general anaesthetic is administered.</td>
</tr>
<tr>
<td>3212</td>
<td>Neutropenic Sepsis 2016</td>
<td>Consider if Acute Medicine Unit can help with the streaming of this patient group. Link nurses of all grades to help with “Suspected Neutropenic Sepsis Door to Needle Time” improvement.</td>
</tr>
<tr>
<td>3242</td>
<td>NICE CG 69: Respiratory Tract Infections</td>
<td>To signpost patients with respiratory tract infections to the patient.co.uk website where there is written information about their condition.</td>
</tr>
<tr>
<td>3293</td>
<td>Patient Satisfaction: Inpatient Menus</td>
<td>Meet with catering to discuss how we can ensure all patients receive a copy of the menu. Liaise with catering and specialist dietitians to look at current provision and review menus. Update the questionnaire to ensure they capture the data required. Meet with catering to discuss snack provision and how patients order their meals when off the ward.</td>
</tr>
<tr>
<td>3388</td>
<td>The effect of an Ambulatory Heart Failure Clinic on Patient Outcomes and Length of Stay</td>
<td>To introduce the Aintree Heart Failure Passport ‘app’ to provide further education and supporting information to all patients with this condition.</td>
</tr>
<tr>
<td>3459</td>
<td>Liverpool Diabetes Partnership Documentation Audit</td>
<td>Meet with IT teams to discuss letter template and request that certain fields of the template are made mandatory. Presentation of findings to management team. Changes to be made to the consultation template to ensure more specific prompts for some fields. Staff to be encouraged to provide feedback regarding any issues with templates or letters to facilitate change. Meetings and discussions with staff to identify and address issues with templates or letters.</td>
</tr>
<tr>
<td>CAMS ID</td>
<td>Title</td>
<td>Action required to achieve change</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3464</td>
<td>Nasogastric Tube re-audit</td>
<td>Update Trust Nasogastric Tube protocol, especially to include requirement for ALL doctors in relevant positions to be competency assessed on interpreting chest x-ray for the purpose of nasogastric tube check. Update Radiology Department Nasogastric Tube protocol, especially to include immediate removal of nasogastric tube placed in the lung before patient leaving Radiology Department.</td>
</tr>
<tr>
<td>4494</td>
<td>The Management of Unprovoked Deep Vein Thrombosis</td>
<td>To actively raise awareness across haematology department and all other involved departments to improve their documentation of reviews that are taking place but not being captured or clearly documented in clinic letters / patients notes. Communication and monitoring process of all cases, to ensure that all reviews are fully documented. Review of Clinic letters to be included in the next audit to ensure change has been captured.</td>
</tr>
<tr>
<td>4529</td>
<td>Constipation Management</td>
<td>Laxatives to be printed on prescription charts. Daily management sheet to include ‘bowels’ on daily checklist. Change the constipation guidelines. To inform all nurses to change their documentation regarding bowel movements or lack of it.</td>
</tr>
<tr>
<td>4588</td>
<td>Assessment of Fracture Clinic Services Against BOAST 7 Guidelines</td>
<td>Feasibility plan to set up virtual fracture clinics.</td>
</tr>
<tr>
<td>4625</td>
<td>Re-audit of Lipid Management in Acute Coronary Syndrome</td>
<td>To establish a form of education (or meetings) with members of staff to reinforce the importance of treatment dose statin/Acute Coronary Syndrome treatment as well as to disseminate appropriate information. To provide further documentation in the discharge letter to prompt GP action to recheck lipid profile in 3 months’ time. To create and provide a leaflet to staff to encourage checking patients’ lipid profiles on admission bloods. To introduce an admission bloods package to allow members of staff to group lipid profile into Acute Coronary Syndrome investigations.</td>
</tr>
<tr>
<td>4666</td>
<td>NICE CG 1E: Self Harm</td>
<td>Design a deliberate self-harm proforma for use in A&amp;E and submit for approval by the Trust. Deliver educational lecture to A&amp;E staff about the need to take a full psychiatric clerking including mental state examination and risk assessment when clerking deliberate self-harm patients.</td>
</tr>
<tr>
<td>4721</td>
<td>Stable Angina</td>
<td>A poster to be put up in the Cardiology department to encourage adherence to NICE guidelines and a reminder of full documentation keeping. To educate the Cardiology department on best practice and NICE guidelines to ensure patient safety and to further increase adherence to measures.</td>
</tr>
<tr>
<td>4735</td>
<td>Deaths within 24 Hours of Critical Care Admission</td>
<td>Develop strategies to deal with inappropriate admissions and document reasons for non-clinical admissions so that this can be audited/reviewed on a future date. Email to all consultants about better documentation for non-clinical admissions to critical care. Better monitoring in all patients accepted for multi organ support. Email to all colleagues about cardiac output monitoring where appropriate. Initial aggressive therapy for at least 24-48 hours before decision making if plan to limit therapy. Email to all colleagues about the above principle. Escalate to appropriate authorities if substandard care seen from other institutions-pathway. This includes a clinical lead, clinical head of Division and Medical Director email to all colleagues about the above principle.</td>
</tr>
<tr>
<td>4749</td>
<td>End of Life Care Documentation</td>
<td>Amend care plan to ensure relative and carer needs are addressed regularly. Amendments to End of Life Care Plan and liaising with printers. Review of Palliative Care study days topics and lesson plans.</td>
</tr>
<tr>
<td>4771</td>
<td>GG141 Gastrointestinal Bleeding: The Management of Acute Upper Gastrointestinal Bleeding</td>
<td>The gastro-intestinal bleed “tab” should be utilised and a document has been disseminated to explain this. Alter Medway SIGMA request so that the Glasgow-Blatchford score is requested rather than the Rockall score. Endoscopy lists could be carried out over the weekend in order to reduce waiting times between presentation and procedure.</td>
</tr>
<tr>
<td>4788</td>
<td>Management of Clinically Critical Results by Radiologists</td>
<td>Disseminate audit results and emphasise the need to pick up the phone, when reporting significant/unexpected findings, to all new Consultants and Registrars joining the radiology department.</td>
</tr>
<tr>
<td>4803</td>
<td>Discharge summaries standards.</td>
<td>On-going education of junior doctors completing the discharge summaries. Alter the electronic discharge summary template in EPMA to include specific components; medication change and rationale behind medication changes.</td>
</tr>
<tr>
<td>4943</td>
<td>Spirituality Audit</td>
<td>Improvement of wording in end of life clinical care record to prompt appropriate questions to ask regarding spiritual needs. Teach at medical education study skills sessions, and in house teaching and support to be on-going on Acute Medicine Unit.</td>
</tr>
<tr>
<td>4950</td>
<td>Lumbar Puncture Practice and Documentation on the Acute Medicine Unit</td>
<td>Lumbar puncture proforma to be included in all lumbar puncture packs and combined with the RLBUHT proforma, with Xanthochromia testing moved over to the RLBUHT laboratory. Ongoing communication with laboratories are required as joint lumbar puncture packs have been launched with laboratories merging, lumbar puncture packs need to continue with the appropriate documentation. Review of literature and evidence to support this as a safe practice. Include confusion in the coding to extract data for audit. Review of current guidelines and changes to be made after discussion. Review of evidence and discussions with Clinical Lead. Teach at medical education study skills sessions, and in house teaching and support to be on-going on Acute Medicine Unit.</td>
</tr>
<tr>
<td>5031</td>
<td>Management of Hospital Acquired Pneumonia</td>
<td>Pharmacy to review all newly started antibiotics for indication, appropriate drug and duration prescribed. Encourage Trust to promote awareness of risk factors and education towards prevention of hospital acquired pneumonia in high-risk groups in order to reduce overall disease burden and associated morbidity and mortality. Re-disseminate antibiotic guidelines (accessible via hospital intranet) to all relevant staff in order to improve choice, duration and appropriateness of antibiotics in hospital acquired pneumonia management. Ensure indication for antibiotic therapy clearly labelled on EPMA at time of prescription, which enforces administration duration and aids pharmacy review. Improve appropriateness of use of empirical antibiotics for hospital acquired pneumonia management through radiological justification and review therapy post-imaging.</td>
</tr>
</tbody>
</table>
Liaise with RLBUHT regarding blood culture collection packs.

Incident Reporting

Weight Loss in Older

Podiatry Professional

Sepsis Re-audit 2017

Trust Compliance with

Pulmonary Embolism

Pain Assessment Tool for

Patients with Dementia

Outpatient CT

Pulmonary Angiogram

in the Management of

Pulmonary Embolism

5074

Snapshot: Deaf Champions on Aintree's Wards
To email all Matrons again and for them to advise if they have a ‘Deaf Champion’ in place.
Email all Deaf champions to ensure they have re-visited the guidelines and have cascaded this information to other ward staff.
Create and distribute posters.

5085

Do Not Attempt Cardiac-Pulmonary Resuscitation (DNACPR) Decision Making
Acquire DNACPR leaflets and make staff aware of availability.

5088

Incident Reporting Amongst Dietitians
A local Dietetics Trigger list of incidents has been developed to prompt staff about the types of incidences that can and should be submitted.
At local level a resource pack has been developed for new staff.
A dietetic incident group has been launched.

5129

Sepsis Re-audit 2017
Liaise with RLBUHT regarding blood culture collection packs.
Education about the Sepsis 6 golden hour and the use of the screening tool via the F1 induction and teaching sessions in July and August of each year. 4 monthly updates done for Acute Medicine Unit and A&E trainees.
Further blood culture training for the nursing staff.
Consider training the medical team to administer IV antibiotics.

5175

Trust Compliance with Nasogastric Tube Position Confirmation
Feedback of results to the Nutrition Link Nurses to embed and raise awareness of the importance of this documentation among nursing colleagues in widespread practice. Liaison with senior nurses and theatre staff for the Head and Neck patients.
Ensure Dietitians are providing the nasogastric tube checklist with new enteral feeding regimes and advising nursing staff about its completion. Dietitians will be reminded of this in acute team meetings.
Input into gap analysis documentation around Trust compliance with confirmation of nasogastric tube position which was then fed back to the Clinical Risk Department for review.

5204

Podiatry Professional Standards Audit
“Spot check” audits to be undertaken to ascertain that staff are wearing their ID badges with details visible to patients. An ad hoc spot check audit of ID badge wearing is to be completed.
All staff will be reminded that it is a requirement to wear visible ID badges. In particular the four individual staff members that failed to meet this requirement when audited.

5211

Pulmonary Embolism Management & Outcomes
Clinicians to be reminded of the importance of using risk stratification scores in suspected pulmonary embolism as per the guidelines.
Signs placed on Acute Medicine Unit / Ambulatory Emergency Care / Medical Assessment Unit to remind clinicians to use the guidelines.
Ongoing informal discussions to other medical staff by Department of Medicine for the Elderly SpRs whilst on call or working out of hours or at handover. Department of Medicine for the Elderly SpRs will raise awareness of the importance of listing unwell patients from Ward 34 to an acute bed and encourage the medical on call team to handover to the day team when patients become unwell. This should continue as the opportunity arises at each handover for any patients that are discussed from Ward 34. We should continue to do this when the new cohort of doctors arrive in August.
Discussions are needed with the ward manager and clinical director of Department of Medicine for the Elderly regarding the appropriateness of a document clearly listing the patient for transfer to an acute bed. And a proposed standardised system in which to ensure a patient is listed and that the transfer is chased on at least a daily basis.

5384

Weight Loss in Older Adults
Liaise with colorectal surgeon and gastroenterologist to create a common framework for investigations.

6418

Pain Assessment Tool for Patients with Dementia
The PAINAD score will be implemented in A&E for dementia patients either by a sticker or as an extra sheet in the Casualty Card.

6566

Outpatient CT Pulmonary Angiogram in the Management of Pulmonary Embolism
Apixaban loading packs to be available in A&E and Acute Medicine Unit to cover patients from the time of suspicion of diagnosis to result of imaging.
Once a regionally approved leaflet is available this will be reviewed and adapted for local use to support verbal communication around treatment and monitoring decisions with these patients.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Aintree University Hospital NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 2,836.

Participation in clinical research demonstrates Aintree’s commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest available treatment possibilities and active participation in research leads to successful patient outcomes.

Aintree was involved in conducting 322 clinical research studies in 33 clinical areas during 2018/19. There were over 190 clinical staff participating in research approved by a research ethics committee at Aintree during 2018/19. These staff participated in research covering 33 medical specialties.

Use of CQUIN framework

A proportion of Aintree University Hospital NHS Foundation Trust’s income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Aintree University Hospital NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at NHS England » Commissioning for Quality and Innovation (CQUIN) Guidance for 2019-2020

During 2018/19 the total income associated with the achievement of quality improvement and innovation goals amounted to £7.75 million. Aintree University Hospital NHS Foundation Trust received £3.59 million income for the associated payment in 2018/19.

An overview of the initiatives and performance during 2018/19 is outlined overleaf.
### Improving Staff Health and Well-being
- **5% improvement of staff health and well-being**: Partial Achievement (62.5%)
  - Healthy food for NHS Staff, visitors and patients: Achieved (100%)
  - 75% uptake of flu vaccinations by front line staff: Achieved (82%)

### Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)
- **Timely identification of sepsis in emergency departments and acute inpatient settings (90%)**: Fully Achieved in Q1, Q2 and Q3, Q4 Not Achieved
  - Timely treatment of sepsis in emergency departments and acute inpatient settings (90%): Partial Achievement (66%)
  - Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours (90%): Partial Achievement (77%)
  - Reduction in antibiotic consumption per 1,000 admissions and increase in antibiotic usage within the AWaRe (Access, Watch, Reserve) antibiotic groups: Partial Achievement

### Improving Services for People with Mental Health Needs who Present to A&E
- **Maintain a 20% the number of attendances to A&E for patient's within a selected cohort of frequent attender's who would benefit from mental health and psychosocial interventions**: Achieved (-59%)
- **Reduce by 20% the number of attendance's to A&E for patient's within an additional selected cohort of frequent attender's who would benefit from mental health and psychosocial interventions**: Achieved (-46%)

### Offering Advice and Guidance
- **Advice and guidance services operational for specialities covering at least 75% of total GP referrals**: Achieved (74%)

### Healthy Lifestyles
- **Tobacco consumption screening, brief intervention/ advice and offer of onward referral**: Achieved
  - Q1-Q3 Achieved, Q4 Not Achieved
- **Alcohol consumption screening, brief intervention/ advice and onward referral**: Q1-Q3 Achieved, Q4 Not Achieved

### Adult Critical Care Timely Discharge
- **65% of patients discharged from critical care within 4 hours of being clinically ready for discharge to a ward bed**: Not achieved
- **35% of patients discharged from critical care between 4 hours and 24 hours**: Not achieved
- **No patients discharged from critical care to be delayed more than 24 hours**: Not achieved
- **Cancellation of elective care requiring a critical care bed to be reduced to 3%**: Achieved

### Nationally Standardised Dose-banding for Adult Intravenous Anticancer Therapy (SACT)
- **Collection of baseline-data for the range of drug doses that are to be standardised**: Achieved
  - Local Drugs & Therapeutics Committee have agreed and approved principles of dose standardisation and dose adjustments required: Achieved
  - Targets to be agreed for end of year achievement in relation to the % of doses standardised per drug: Partial
  - Trust agreement and adoption of standard product descriptions for individual chemotherapy drugs: Partial

### Hospital Medicines Optimisation
- **Faster adoption of prioritised best value medicines as they become available**: Achieved
- **Cost effective dispensing routes**: Partial
- **Reporting of all NHS England excluded drugs data**: Achieved

### Multi-system Auto-immune Rheumatic Diseases MDT Clinics, Data collection and Policy Compliance
- **Initiation of hub and spoke network arrangements to review treatment plans of specialised rheumatology patients**: Achieved
- **All specialised rheumatology patients to be discussed by a multi-disciplinary team and have an outcome recorded**: Achieved
- **Patients' treatment plans to comply with national policies and clinical information is collected on national disease registries to determine the impacts of the network and commissioning policies**: Partial

### Local Clinical Utilisation Review CQUIN
- **Local clinical utilisation review mobilisation plan to be implemented**: Achieved
- **85% compliance for wards areas where clinical utilisation review has been implemented**: Achieved
- **Reporting of internal and external delay themes and improvement in internal discharge delays**: Achieved
- **Submission of performance report and minimum data sets to the Commissioner utilisation review**: Achieved

### Diabetic Eye Screening, Bowel Screening and Dental Services
- **Staff health and well-being support**: Achieved
- **Improving staff engagement**: Achieved
- **Deliver new integrated dental service pathways and patient centred care**: Achieved
The table below shows the CQC ratings grid for the services provided at the Trust following the last full inspection in October 2017. The Trust has worked with the CQC to implement a significant improvement plan to evidence the substantial changes in practice since the Trust was last inspected. This progress is outlined in more detail in Part 2.1(i) which provides a summary of progress against our quality improvement priorities for 2018/19.

**Overall rating**

<table>
<thead>
<tr>
<th>Medical care (including older people’s care)</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent and emergency services (A&amp;E)</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intensive/critical care</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>End of life care</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatients</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>Not rated</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>

On 12 February 2019, the CQC carried out a focussed unannounced inspection of ward 25. The findings of this focused inspection were:

- Patient risk assessments and patient observations had been undertaken in a timely manner on most occasions, in line with trust policy. For example, the majority of falls risk assessments had been completed correctly.
- Staff had kept detailed records of patient’s care and treatment.
- There was a clear leadership structure in place to oversee the management of ward 25.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

As this was a focused inspection, the CQC did not inspect all domains therefore this inspection had no impact on the overall rating of the Trust from the previous inspection in October 2017.

**Information on the quality of data**

**NHS Number and General Medical Practice Code Validity**

Aintree University Hospital NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient’s valid NHS Number:
  - 99.8% for admitted patient care;
  - 99.9% for outpatient care; and
  - 98.9% for accident and emergency care.
- Which included the patient’s valid General Medical Practice Code:
  - 100.0% for admitted patient care;
  - 100.0% for outpatient care; and
  - 99.9% for accident and emergency care.

**Data Security Protection Toolkit attainment levels (Information Governance)**

For 2018/19 the new Data Security and Protection Toolkit final assessment is “Standards Met” compliant in all 10 Data Security Standards by 31 March 2019.

**Clinical coding error rate**

Aintree University Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during April 2018 to March 2019 by the Audit Commission.

**Statement on relevance of data quality and actions to improve data quality**

Good quality information underpins the effective delivery of the care of people who use NHS services and is essential if improvements in quality of care are to be made.

Aintree University Hospital NHS Foundation Trust will be taking the following actions to improve data quality:

- Central referral to treatment and data cleansing team feedback to local areas where poor data quality themes emerge.
- Data quality responsibilities within job descriptions of key members of staff.
- Data quality training module available online via Trust training tracker system.
- Clinical coding audit plan.
- Development and delivery of the Data Protection and Security Toolkit requirements.
- Monthly meeting with Commissioner with a view to external assurance of Trust data.
- Assurance gained from the use of external audits across a number of subjects, including Referral to Treatment, Cancer, Accident & Emergency and Clinical Coding.
- Using Secondary Uses Service data quality dashboards for monitoring and benchmarking the quality of data submitted externally.
- The Trust performs above average on a key number of Secondary Uses Data items submitted to NHS Digital.

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Aintree University Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during April 2018 to March 2019 by the Audit Commission.
During 2018/19, 1,456 of Aintree University Hospital NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 378 in the first quarter;
- 315 in the second quarter;
- 375 in the third quarter;
- 388 in the fourth quarter.

By 31 March 2019, 1,000 case record reviews and 41 investigations have been carried out in relation to 1,456 of the deaths included above. In 41 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 5 in the first quarter;
- 12 in the second quarter;
- 15 in the third quarter;
- 9 in the fourth quarter.

Two cases representing 0.14% of 1,456 of the patients’ deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using the Mortality Review System which runs on a monthly basis. The system (database) includes demographics and other quality indicators which are used, along with the patients’ notes, to gain an informed view to see if any lessons can be learnt.

If there is an incident identified resulting in a death then an investigation will be carried out in line with the Trust’s incident management and reporting process. This process is led by the Clinical Governance Team along with the Divisional Teams and with the support of the Consultant (who was leading on the care) and their Team to determine lessons learnt. The final report is then submitted to the Safety & Risk Executive-led Group for review and outcomes and learning then shared widely throughout the Trust.

During 2018/19 the two cases were reviewed and the identified avoidable factors were:

- The importance of early recognition and management of sepsis.
- The importance of multiple specialty review in complex cases.
- The importance of patient medical sensitivities.
- The importance of acting on documented observations.

One death was subject to a serious incident review.

Actions have been taken in response to these mortality review findings as follows:

- Established work programmes to:
  - Improve the prevention, early detection and treatment of Acute Kidney Injury (AKI)
  - Improve the identification and management of pneumonia
  - Improve the identification and management of sepsis
  - Achieve early recognition and management of the deteriorating patient
- Improve the delivery of end of life care.
- When avoidable factors are identified which cut across the NHS organisations, Aintree and other local provider Trusts utilise a cross-Trust mortality review process to request a mortality review in the other organisation.

An assessment of the impact of the actions described above include:

- The internal work on avoiding unnecessary delays in the discharge process has improved patient flow and allowed the Trust to manage admissions better than previously. The external limitations have not been resolved, but work is ongoing.
- Joint mortality reviews have taken place with other provider Trusts; this has strengthened governance links between Trusts.
- Mortality listings are now published on a daily basis to ensure timely review post-mortem.

233 case record reviews and investigations completed after 31 March 2018 which related to deaths which took place before the start of the reporting period.

Zero representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Mortality Review System which runs on a monthly basis. The system (database) includes demographics and other quality indicators which are used, along with the patients’ notes, to gain an informed view to see if any lessons can be learnt.

Three representing 0.21% of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Part 2.3 – Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to Trusts by NHS Digital.

The following tables show our performance for at least two reporting periods and, where the data is made available by NHS Digital, a comparison with the national average and the highest and the lowest performing Trusts.

However, it is not always possible to provide the national average and best and worst performance for some indicators due to the way the data is provided. In addition the most recent national data is not always available for the most recent financial year. Where this is the case, the time period used is noted.
## Summary hospital-level mortality indicator (SHMI)

<table>
<thead>
<tr>
<th>NHS Outcome Framework Domain</th>
<th>Indicator</th>
<th>Trust rate noted for reported period</th>
<th>National average</th>
<th>Top Performer</th>
<th>Worst Performer</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent people from dying prematurely</td>
<td>SHMI value and banding</td>
<td>(Oct 16 - Sept 17) SHMI value: 1.0222 Banding: 2 (as expected)</td>
<td>72.70</td>
<td>134</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Oct 17 – Sept 18) SHMI value: 0.9975 Banding: 2 (as expected)</td>
<td>SHMI value: 100 Banding: 2 (as expected)</td>
<td>69.19</td>
<td>126.81</td>
<td></td>
</tr>
</tbody>
</table>

The Aintree University Hospital NHS Foundation Trust considers that this data is as described for the following reasons: the data has been extracted from NHS Digital and the outputs are regularly reviewed and through the Trust's Executive-led Trust Avoidable Mortality Reduction Group.

The Trust has an ‘as expected’ mortality rate as measured by the Summary Hospital-level Mortality Indicator (SHMI) at 0.9975 for the period Oct 17-Sept 18, as demonstrated in the table above. Unlike the Hospital Standardised Mortality Ratio (HSMR), the SHMI includes deaths 30 days after discharge and therefore patients, including those on palliative care end of life pathways, who are appropriately discharged from the hospital.

The Aintree University Hospital NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by a structured programme of work focused on the reduction of avoidable mortality which includes:

- Continuing Structured Judgement Reviews to investigate and learn from in hospital deaths in order to improve the quality of care.
- Established work programmes to:
  - Improve the prevention, early detection and treatment of Acute Kidney Injury (AKI)
  - Improve the identification and management of pneumonia
  - Improve the identification and management of sepsis
  - Achieve early recognition and management of the deteriorating patient
  - Improve the delivery of end of life care.

## Patient Reported Outcome Measures (PROMs)

<table>
<thead>
<tr>
<th>NHS Outcome Framework Domain</th>
<th>Indicator</th>
<th>Trust rate noted for reported period</th>
<th>National average</th>
<th>Top Performer</th>
<th>Worst Performer</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent people from dying prematurely</td>
<td>Patient reported outcome measure for: (i) Groin hernia surgery</td>
<td>(Apr 2016 – Mar 2017) Aintree: 0.074</td>
<td>0.086</td>
<td>0.135</td>
<td>0.006</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Apr 2017 – Sept 2017) Aintree: 0.077</td>
<td>0.089</td>
<td>0.137</td>
<td>0.038</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient reported outcome measure for: (ii) Hip replacement surgery</td>
<td>(Apr 2016 – Mar 2017) Aintree: 0.434</td>
<td>0.437</td>
<td>0.533</td>
<td>0.335</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Apr 2017 – Mar 2018) Aintree: 0.504</td>
<td>0.458</td>
<td>0.550</td>
<td>0.357</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient reported outcome measure for: (iii) Knee replacement surgery</td>
<td>(Apr 2016 – Mar 2017) Aintree: 0.316</td>
<td>0.323</td>
<td>0.398</td>
<td>0.249</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Apr 2017 – Mar 2018) Aintree: 0.346</td>
<td>0.337</td>
<td>0.399</td>
<td>0.263</td>
<td></td>
</tr>
</tbody>
</table>

The Aintree University Hospital NHS Foundation Trust considers that this data is as described for the following reason: the data has been extracted from NHS Digital.

PROMs measure patients’ health gains after surgery for groin hernia surgery, hip replacement surgery, knee replacement surgery and varicose vein surgery. The information is gathered from patients who complete a questionnaire before and after surgery. From the data available, the case mix adjusted average health gain shows that the Trust is not an outlier when compared nationally. PROMs data on varicose vein surgery is not available for Aintree University Hospital NHS Foundation Trust. The Aintree University Hospital NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Continuing the work within Orthopaedics and General Surgery to ensure that the best patient outcomes are achieved.
- As part of Trust merger proposals clinical teams from Aintree University Hospital NHS Foundation Trust and The Royal Liverpool and Broadgreen University Hospitals NHS Trust have been meeting to share best practice and to put in place service delivery proposals which will improve clinical outcomes for patients.
### Readmission rates for children and adults

<table>
<thead>
<tr>
<th>NHS Outcome Framework Domain Indicator</th>
<th>Indicator</th>
<th>Trust rate noted for reported period</th>
<th>National average</th>
<th>Top Performer</th>
<th>Worst Performer</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period (i) Aged 0 to 15</td>
<td>(Apr 2011 – Mar 2012)* Aintree: 0</td>
<td>10.01%</td>
<td>5.10%</td>
<td>13.58%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period (ii) Aged 16 or over</td>
<td>(Apr 2011 – Mar 2012)* Aintree: 11.76%</td>
<td>11.45%</td>
<td>8.96%</td>
<td>13.50%</td>
<td>NHS Digital</td>
<td></td>
</tr>
<tr>
<td>% of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period (ii) Aged 16 or over</td>
<td>(Apr 2010 – Mar 2011) Aintree: 12.11%</td>
<td>11.42%</td>
<td>7.60%</td>
<td>12.94%</td>
<td>NHS Digital</td>
<td></td>
</tr>
</tbody>
</table>

* Most recently available data

The Aintree University Hospital NHS Foundation Trust considers this data is as described for the following reason: the data has been extracted from NHS Digital and is derived from the National Inpatient Survey.

### Patient Experience

<table>
<thead>
<tr>
<th>NHS Outcome Framework Domain Indicator</th>
<th>Indicator</th>
<th>Trust rate noted for reported period</th>
<th>National average</th>
<th>Top Performer</th>
<th>Worst Performer</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring people have a positive experience of care</td>
<td>Responsiveness to the personal needs of its patients</td>
<td>(Aug 2016 – Jan 2017) Aintree: 67.0%</td>
<td>68.1%</td>
<td>85.2%</td>
<td>60.0%</td>
<td>NHS Digital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Aug 2017 – Jan 2018) Aintree: 67.7%</td>
<td>68.6%</td>
<td>85.0%</td>
<td>60.5%</td>
<td>NHS Digital</td>
</tr>
</tbody>
</table>

The Aintree University Hospital NHS Foundation Trust considers that this data is as described for the following reasons: the data has been extracted from NHS Digital.

Aintree is focused on improving the experience of patients. As per the data above, the Trust performs in line with the national average in terms of responsiveness to the personal needs of its patients. The Aintree University Hospital NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Implementing a Patient & Family Experience Plan 2018-20 in September 2018. This plan sets out five bold ambitions for improving patient and family experience. These are:
  - Ambition 1: Keeping patients informed
  - Ambition 2: Shared decision making
  - Ambition 3: Knowing what matters to our patients
  - Ambition 4: Listening and responding to our patients
  - Ambition 5: We will work in partnership with patients and families.

- Relaunching our patient and family shadowing and engagement project is in place to help understand patients’ experience of the Trust and identify areas for improvement.

- Putting in place informal and early intervention to respond to patient concerns and questions which has resulted in a reduction of formal complaints and increased local resolution.

### National Staff Survey

<table>
<thead>
<tr>
<th>NHS Outcome Framework Domain Indicator</th>
<th>Indicator</th>
<th>Trust rate noted for reported period</th>
<th>National average</th>
<th>Top Performer</th>
<th>Worst Performer</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring people have a positive experience of care</td>
<td>% of staff who would recommend the Trust to their family or friends</td>
<td>(Sept 2017 – Nov 2017) Aintree: 69%</td>
<td>70%</td>
<td>86%</td>
<td>47%</td>
<td>NHS Digital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Sept 2018 – Nov 2018) Aintree: 72%</td>
<td>70%</td>
<td>87%</td>
<td>41%</td>
<td>NHS Digital</td>
</tr>
</tbody>
</table>

The Aintree University Hospital NHS Foundation Trust considers that this data is as described for the following reasons: the data has been extracted from NHS Digital.

The Trust is performing in line with the national average and the Aintree University Hospital NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Co-creation of a shared values and behavioural framework with our workforce to ensure that we have a shared vision and expectations of the future and the transition to merger with The Royal Liverpool and Broadgreen University Hospitals NHS Trust.

- Establishing our ‘Safety First’ campaign which puts safety at the heart of our culture.

- Developing our leadership potential through an agreed leadership framework and investment in leadership development. Including investment in Affina Organisational Development to support leaders to improve team performance.

- Developing localised team based improvement plans which are supported by the Trust’s Division of People and Corporate Affairs.

* Most recently available data

The Aintree University Hospital NHS Foundation Trust considers this data is as described for the following reason: the data has been extracted from NHS Digital and is derived from the National Inpatient Survey.
Venous thromboembolism (VTE blood clot)

The Aintree University Hospital NHS Foundation Trust has taken the following actions to improve this indicator, and so the data has been extracted from NHS Digital.

The Aintree University Hospital NHS Foundation Trust considers that this data is as described for the following reason:

- Continuing to provide comprehensive training in the completion of VTE Proformas.
- Ensuring all breaches in compliance are validated and contact made with Doctors when risk assessments are found to be incomplete.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Trust rate noted for reported period</th>
<th>National average</th>
<th>Top Performer</th>
<th>Worst Performer</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients who were admitted to hospital and who were assessed for venous thromboembolism</td>
<td>(Oct 17 – Dec 17) end of Q3 Comparison</td>
<td>Aintree: 92.29%</td>
<td>95.36%</td>
<td>100%</td>
<td>76.08%</td>
</tr>
<tr>
<td>(Oct 18 – Sept 18) end of Q3 Latest Data</td>
<td>Aintree: 91.06%</td>
<td>95.65%</td>
<td>100%</td>
<td>54.86%</td>
<td></td>
</tr>
</tbody>
</table>

The Aintree University Hospital NHS Foundation Trust considers that this data is as described for the following reason: the data has been extracted from NHS Digital.

Clostridium difficile (C.difficile) infection

The Aintree University Hospital NHS Foundation Trust considers that this data is as described for the following reason: the data has been extracted from NHS Digital.

The data shows an overall reduction in the total number of cases reported to Public Health England since March 2016.

The Aintree University Hospital NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Continuing to provide comprehensive training in the completion of VTE Proformas.
- Ensuring all breaches in compliance are validated and contact made with Doctors when risk assessments are found to be incomplete.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Trust rate noted for reported period</th>
<th>National average</th>
<th>Top Performer</th>
<th>Worst Performer</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude count of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over</td>
<td>(Apr 2017 – Mar 2018) Aintree: 66*</td>
<td>34</td>
<td>0</td>
<td>150</td>
<td>NHS Digital</td>
</tr>
<tr>
<td>(Apr 2016 – Mar 2017) Aintree: 46</td>
<td>30</td>
<td>0</td>
<td>116</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Most recently available data (crude cases only) available from NHS Digital.

The Aintree University Hospital NHS Foundation Trust considers that this data is as described for the following reason: the data has been extracted from NHS Digital.

The data shows an overall reduction in the total number of cases reported to Public Health England since March 2016.

The Aintree University Hospital NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by establishing our Safety First Programme which is chaired by the Medical Director and is managing the delivery of eight cross cutting work streams. The key outcomes from the programme to date include:

- The establishment of 22 Safety and Governance meetings in wards and departments
- Improved reporting on DATIX our patient safety software system
- The appointment of Investigation Support Officers
- 420 theatre staff trained in National Safety Standards for Invasive Procedures (NatSSIPS)
Part 3: Other Information

3.1 An overview of the quality of care

This section provides an overview of the quality of care offered by Aintree based on performance in 2018/19 against additional indicators selected by the Board in consultation with stakeholders. These indicators have been selected as they demonstrate our ongoing commitment to the three overarching priorities outlined in our Quality Strategy 2018-20:

**PRIORITY 1:**
- Care that is Safe - working with patients and their families to reduce avoidable harm and improve outcomes.

**PRIORITY 2:**
- Care that is Clinically Effective - not just in the eyes of clinicians but in the eyes of patients and their families.

**PRIORITY 3:**
- Care that provides a positive experience for patients and their families.

Our Patient Safety Initiatives

Safety and Governance Meetings

As part of the Trust’s Safety First programme, we have introduced safety and governance meetings as a forum to discuss safety and governance topics in wards and departments. A Safety and Governance meeting is a weekly 30 minute meeting with a key focus on safety and improvement. The team reviews performance data and discusses what has been good over the last week, what has been less good, what actions the team need to take forward and the Trust’s key messages. The meetings provide an opportunity to resolve issues, together as team, as well as celebrating success. These meetings are multidisciplinary, open, transparent and non-hierarchical. Ensuring the widest breadth of job role representatives at the meetings is essential for providing an equal voice.

The outcome evidence from the early adopting wards highlights a positive increase in incident reporting which supports organisational learning. The Respiratory Clinical Business Unit which has meetings on three of its wards has received an improved staff engagement result in the staff survey (2018) that is above Trust average.

Aintree’s Results to Action Campaign

Aintree’s Results to Action Campaign has been successful in ensuring that patient’s results are read and acted on in a timely manner.

This campaign started as there were a small number of incidents where a failure to read and act on test results affected patient safety. The Radiology clerical team have driven the campaign in collaboration with clinicians within Surgery and Medicine. Recent figures show that over 96% of all tests since 2016 have now been viewed and acted on. The improvement in the percentage of acknowledged results is encouraging given the background of increased activity and results ordering in the Trust during the last two years. Radiology diagnostics alone has seen a 20% year on year growth in demand.

To achieve these impressive results the Radiology team has worked across the Trust clearing results and training teams to manage their own results.

Future plans to train all non-medical referrers to acknowledge results are continuing with support from the Aintree Quality Improvement Team.

Live ‘Results to Action’ data is now provided on the intranet homepage and results are now presented and discussed at the Divisional Assurance Meetings and quarterly reviews for scrutiny and challenge.

A Trust wide safety campaign helped to raise awareness with messages sent out in local briefs, on the intranet and in the form of a sticker campaign on all computers.
Infection Prevention and Control

Clostridium difficile infection (C. Difficile) can cause unnecessary suffering to our patients and their families and over several years the Trust has made significant improvements in reducing the number of patients with the infection. The Trust’s national objective set by NHS England for there to be no more than 46 patients with C. difficile in 2018/19. There is an acknowledgement that despite all preventative measures being put in place, some patients may develop C. difficile. The C. difficile objective is performance monitored by the CCG on those cases where lessons could be learned to prevent the infection. From 2017/18 to 2018/19 there was a 32% reduction in the total number of infections and a 21% reduction in cases where lessons were identified. The two main principles to prevent C. difficile are good antibiotic stewardship and robust infection prevention and control (IPC) practice.

Antimicrobial point prevalence audits are carried out each month. Performance on the documented indication for the antibiotic and the stop/review is consistently high. Details are discussed at the Infection Prevention and Control Group, and at the Divisional Assurance Groups for feedback to prescribers. There is a robust programme of cleanliness and infection prevention control audits. More recently a multidisciplinary programme has been developed which focused on Infection Prevention and Control practice and the environment. This is led by the specialist Infection Prevention and Control Team and supported by domestic, maintenance and senior nurse colleagues. A baseline of all wards has been undertaken and a programme developed based on audit scores.

There is a weekly multi-disciplinary C. difficile ward round. All patients now receive Fidaxomicin for treating their Clostridium difficile infection. Fidaxomicin is aimed at reducing the risk or reoccurrence of C. difficile for the patient, and also has the ability to inhibit spore production. Since the implementation of its use there has been a marked decrease in periods of increased incidence of C. difficile on the ward/departments.

Our Clinical Effectiveness Initiatives

Urgent and Emergency Care Programme

As a Trust we have continued our improvement programme to support the achievement of the national 4 hour A&E waiting time standard. Our non-elective flow improvement programme has included three key workstreams: A&E, assessment areas and patient flow. Rapid improvement events within the ‘See and Treat’ areas have focused on having the correct workforce in place to maximise skills appropriately.

The team has taken part in a 90 day rapid improvement initiative hosted by the North West Ambulance Service with five other NHS Trusts. These Trusts, the ‘Super Six’, were selected based on the volume of patients entering their organisations through ambulance conveyance and thus improvements will give a much greater return on investment in terms of the key currency of time saved during handover of patients in A&E. The focus was to improve time to initial assessment, time to see 1st doctor and time to specialty review. This collective improvement work has culminated in Aintree hosting its own 3 day rapid improvement workshop that aimed to combine ambulance handover with ‘pit-stopping’ by a senior clinician and triage nurse. The results are significant and we have been able to demonstrate much more rapid and safe handover of patients with a much quicker release of ambulance crews.

The results of this improvement work have demonstrated:
- 0.91% improvement in the percentage of patients receiving initial assessment within 15 minutes.
- 2.1% decline in the percentage of patients receiving 1st doctor review within 60 minutes.
- 31.16% improvement in the percentage of patients remaining in the department for prolonged periods (over 12 hours).
- 5.43% improvement in non-admitted performance.
- 13.14% improvement in admitted performance.

We have been able to demonstrate much more rapid and safe handover of patients with a much quicker release of ambulance crews.

All of this has been achieved in the backdrop of an 8.6% increase in attendances between November to February 2017/18 and November to February 2018/19. This has led to a staffing review in order for the workforce to be adequate to meet demand at all times. There is still a significant amount of work to do to improve the patient pathway through the department to ensure patients are streamed to the correct area. The programme is now focusing on consistent ‘pit-stop’ which will improve the time patients will receive their initial doctor review, direct conveyancing to assessment areas when appropriate and completion of the Site Team Dashboard to ensure accurate reporting.

The latest national figures show that Aintree’s A&E had the most improved performance over the last two years of any Trust in England. Only ten Trusts reported 10 percentage point improvements on their performance. Aintree recorded a 19.4 point increase.

Figure 3: Infection Prevention and Control

![Cases](chart.png)

<table>
<thead>
<tr>
<th>Month</th>
<th>C Diff 18/19</th>
<th>Last Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>May</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Jun</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Jul</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Aug</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Sep</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Oct</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nov</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dec</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jan</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Feb</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mar</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Data Source: PHE Data Capture System

- Number of patients with C.difficile
- Number of cases with lessons learnt

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Number of Patients with C.difficile</th>
<th>Number of cases with lessons Learnt</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/18</td>
<td>63</td>
<td>43</td>
</tr>
<tr>
<td>2018/19</td>
<td>39</td>
<td>27</td>
</tr>
</tbody>
</table>

Data Source: Local audits

<table>
<thead>
<tr>
<th>Month</th>
<th>Ambulance Handover Times</th>
<th>Patients seen within 4 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2018</td>
<td>20:37 mins</td>
<td>81.61%</td>
</tr>
<tr>
<td>March 2019</td>
<td>14:17 mins</td>
<td>84.74%</td>
</tr>
</tbody>
</table>

Data Source: Medway SIGMA

- Ambulance handover times
- Patients seen within 4 hours
The Ventilation Inpatient Centre

Aintree has provided a specialist service for ventilatory failure for a number of years. We provide care for patients over the age of eighteen with a variety of complex problems including:

- Neuromuscular diseases such as Duchenne Muscular Dystrophy, Myotonic Dystrophy, Motor Neurone Disease, Charcot Marie - Tooth, Spina Bifida and Post-Polio Disorders
- Restrictive respiratory disorders such as Kyphoscoliosis and Post Tuberculosis Thoracoplasty
- Obesity Hyperventilation Syndrome
- Chronic Obstructive Pulmonary Disease (COPD), Bronchiectasis in Type 2 Respiratory Failure
- Prolonged weaning from critical care due a variety of conditions, including patients requiring long term invasive ventilation.

We have a team of skilled clinicians who deliver acute and long-term non-invasive ventilation (NIV) set up and optimisation.

We have a team of skilled clinicians who deliver acute and long-term non-invasive ventilation (NIV) set up and optimisation.

liberating patients from full mechanical ventilation and facilitate their discharge home. We provide rehabilitation and have specialist therapy input.

We also care for patients temporarily needing non-invasive ventilation to overcome an acute illness. We initiate patients requiring long term non-invasive ventilation and provide on-going care in the community through clinic appointments, outpatient appointments and inpatient admission for troubleshooting where needed. We also provide a telephone help line and we have approximately 1,050 patients using long term non-invasive ventilation in the community.

Our new inpatient centre was opened during 2018 and includes four weaning beds.

An audit of the acute non-invasive ventilation service for 2018 at Aintree reports that 97% of patients needing non-invasive ventilation received it. The service is overseen by a respiratory consultant 100% of the time. In-hospital mortality was 6.2% compared to 25% nationally (NCEPOD 2017) and 30 day mortality is excellent at 9.2%.

Improving Heart Failure Services at Aintree

Aintree has established an Ambulatory Atrial Fibrillation Service and an ambulatory heart failure service. Both of these services are delivered by our specialist nursing team with Consultant supervision.

They provide day-case ‘outpatient’ care for patients presenting with acute symptomatic problems that would hitherto be hospitalised and managed as inpatients. The majority of the patients with atrial fibrillation (up to two thirds) will have more than one readmission in their first year of diagnosis and it is the most common cause of emergency admission and readmission for cardiac arrhythmias. A total of 4,571 patients with primary diagnosis of atrial fibrillation were seen in our atrial fibrillation service between April 2011 and April 2018. The clinical effectiveness of this service is demonstrated by the following outcomes:

- 79% of patients were referred to the service from the A&E or the acute medical unit, 11% of patients were referred following an open access ECG, outpatient clinic attendance and 10% of patients self-referred
- 51% of patients attending the ambulatory heart failure service were discharged the same day avoiding a hospital admission
- 20% of 2,239 patients who needed hospital admission for clinical reasons were discharged within 24 hours of their admission
- The average length of inpatient stay prior to the establishment of the ambulatory atrial fibrillation service was 7.3 days. The average length of stay post the establishment of the atrial fibrillation service is less than 3 days
- 87% of the patients were discharged directly from the service to a GP.

A total of 4,571 patients with primary diagnosis of atrial fibrillation were seen in our atrial fibrillation service between April 2011 and April 2018.

<table>
<thead>
<tr>
<th>Availability of Specialist Respiratory Consultant Cover</th>
<th>In-hospital Mortality for COPD Patients Requiring NIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Units</td>
<td>Aintree</td>
</tr>
<tr>
<td>75% of other units &lt;50% of the time</td>
<td>Aintree</td>
</tr>
<tr>
<td>100% of the time</td>
<td>25.1%</td>
</tr>
<tr>
<td>Aintree</td>
<td>6.2%</td>
</tr>
</tbody>
</table>

Data Source: Local audit and NCEPOD 2017

Ambulatory atrial fibrillation average length of stay

- April 2011: 7.3 days
- April 2018: 3 days
- Feb 2014: 17%
- Dec 18: 9%

Data Source: Local in-house registry

Ambulatory heart failure in hospital mortality

<table>
<thead>
<tr>
<th>Ambulatory heart failure in hospital mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2011: 17%</td>
</tr>
<tr>
<td>April 2018: 9%</td>
</tr>
</tbody>
</table>

Data Source: National Heart Failure Audit Report
Promoting Healthy Lifestyles and Making Every Contact Count

Many long-term diseases in our population are closely linked to known behavioural risk factors including smoking, alcohol misuse, being overweight or being physically inactive. Making changes such as stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption can help people to reduce their risk of poor health significantly.

Aintree has implemented the NHS Health Education England strategy of making every contact count. This strategy is an approach to behaviour change that utilises the day to day interactions that NHS staff have with people to support them in making positive changes to their physical and mental health and well-being. The approach maximises the opportunity within routine health and care interactions for a brief discussion on health and well-being factors over a few minutes. These discussions can include:

- Stopping smoking
- Drinking alcohol only within the recommended limits
- Healthy eating
- Being physically active
- Keeping to a healthy weight
- Improving mental health and well-being.

Rather than telling people what to do, Making Every Contact Count is about recognising opportunities to talk to people about their well-being using the skills of asking and listening. It’s about enhancing the conversations we have with our patients. Within the Trust we have focussed on tobacco and alcohol screening, brief intervention/advice and onward referral management. We have introduced a number of initiatives for our staff and patients which include:

- Development and implementation of a smoking cessation electronic referral system
- Development of Smoking Cessation Guidelines (Clinical)
- Development of a Nicotine Replacement Therapy Prescribing Standard Operating Procedure.
- Successful bid for the CURE Project
- Development of a ‘Stop Smoking’ intranet page with access to e-learning
- Support for staff via Occupational Health and Well-being
- Established a Smoke Free Group (open forum for staff, patients, visitors, local residents)
- Quit Kits available for staff upon request

Quality Excellence Support Team Initiatives (QuEST)

Improving the quality of care, patient experience and safety is a key Trust objective. The approach to delivering continual improvements is through the use of formal quality improvement techniques, recognising that sustainability is achieved through capacity and capability training, to enable staff at all levels to bring about changes in care. QuEST is a multi-professional and cross functional team including colleagues from Nursing & Quality, Human Resources, Organisational Development and Infection Prevention and Control.

The aim is to provide expert support and advice to colleagues to help them in delivering consistent, safe patient-focused care. The team works collaboratively with colleagues wanting to make improvements and/or accelerate outstanding practice and works with wards and teams to develop and achieve their goals. The QuEST approach was implemented with Aintree 2 Home, Ward 21 and 33 with a year-end evaluation for 2018/19 being completed to assist in the identification of other wards and departments for next year. The identification of the improvement priorities for each of selected areas was based on an initial baseline assessment and staff engagement informed through a Safety Cultures Questionnaire, supported by Advancing Quality Alliance.

The voice of the patients /carers was also central to the decision making and specific patients’ questionnaires were used to capture detailed feedback as to where improvements could be made. The baseline assessment and engagement results were then used to design the appropriate improvement interventions, which would be agreed with the staff team. Key interventions differed based on the diagnostic assessment.

The key improvement activities delivered include:

- Leading for Quality – Coaching, Staff roles and responsibilities, Team building
- Documentation – Core Nursing Documentation, Training
- Communication – Safety & Governance meetings, Improvement huddles, pain relief training
- Discharge planning – Discharge criteria, Nurse Led Discharge, Safer
- Falls Reduction – Falls training
- Infection Control – Management of patients with MRSA
- Inter team working – Revised office space.
End of Life Care

The Trust’s Palliative Care Service is led by a team of highly specialised and experienced Palliative Care Consultants who provide a range of support and treatment that includes:

• Providing relief from pain and other distressing symptoms
• Integrating the psychological and spiritual aspects of patient care
• Providing support early in the course of an illness in conjunction with other treatments
• Offering a support system to help patients to live as actively as possible until death and to help families to cope during a patient’s illness and in their own bereavement
• Providing support to cancer specific multidisciplinary teams
• Providing an education programme for hospital and community staff and colleagues.

In February 2019, the Trust launched a new strategy for End of Life and Bereavement Care. As part of this strategy the “SAFE TRANSFER” checklist has been developed for use when discharging patients who have a palliative diagnosis from hospital to a community setting. This document is to be used when an individual is considered to be in the last days, weeks, or short months of life.

The checklist provides essential guidance and acts as an aide memoire for staff to ensure all of the necessary resources such as anticipatory medications, care, equipment and unified DNACPR forms are in place to enable the individual to be supported in their preferred place of care and death. It provides advice on what to do if a syringe driver is in use and will guide health professionals as to who they should contact in the community to ensure everyone involved in the patient’s care is aware of the plan.

Once discharged, the primary care team will review and complete their section of the checklist and ensure everything is updated and communicated to the teams involved in the person’s care outside of the hospital setting.

Our Patient Experience Initiatives

In February 2019, the Trust launched a new strategy for End of Life and Bereavement Care. As part of this strategy the “SAFE TRANSFER” checklist has been developed for use when discharging patients who have a palliative diagnosis from hospital to a community setting. This document is to be used when an individual is considered to be in the last days, weeks, or short months of life.

The checklist provides essential guidance and acts as an aide memoire for staff to ensure all of the necessary resources such as anticipatory medications, care, equipment and unified DNACPR forms are in place to enable the individual to be supported in their preferred place of care and death. It provides advice on what to do if a syringe driver is in use and will guide health professionals as to who they should contact in the community to ensure everyone involved in the patient’s care is aware of the plan.

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Department of Medicine for Older People and Stroke – NHS 70th Anniversary Celebrations

The Department of Medicine for Older People and Stroke consistently has a cohort of patients waiting for community placement or support at home. This group of patients can often become restless and disoriented. Consequently, the nursing teams set up a programme of events and activities to provide a different model of care that enhances the well-being of their patients and allows them to remember special events such as Remembrance Day, Valentine’s Day, Pancake Tuesday and many others. The programme also incorporated tea dances, afternoon tea, musical entertainment and games such as play your cards right and bingo.

The Armed Forces day is an example of a particularly successful event which had a positive impact on staff morale and staff engagement which is directly related to patient experience.

Feedback from patients and their relatives:

“It’s been brilliant, very nice. I live alone so it’s helped me to meet new people which I love.”

“I thought the entertainers were professionals and couldn’t believe they were the ward staff. The singing and dancing was brilliant.”

“I am amazed by what happened today. I am used to being on my own since the passing of my wife and it brings back lovely memories.”

“This event made me cry, seeing my Mum really enjoying herself and talking about her experiences when she was younger. I thought the afternoon was fantastic.”
Specialist Weight Management Services (SWMS) – Service User Forum

Aintree provides community based weight management services across a range of locations including Liverpool and Wigan. These services aim to support service users in losing weight. They also aim to increase awareness and personal resilience to weight stigma and encourage self-management using a health coaching model. One of the key success factors in providing specialist weight management services is service user engagement. One key method of engaging service users, adopted by the Wigan specialist weight management service, is to hold an annual open forum which is open to all service users at any stage in their journey. Open questions are used at the forum using the key themes that have emerged through satisfaction questionnaires, verbal feedback, Wigan Council initiatives and changes within the local and national landscape (e.g. new guidance/obesity strategies).

Feedback from each forum is shared with the team and staff work within project groups to ensure the feedback is listened to and acted on. This feedback directs the team’s service development work and influences changes to service delivery to meet the needs of service users and improve their weight management journey. The forum facilitates feedback to service users at the next forum in a ‘you said, we did’ format, so that they are aware their feedback is valued and the service has responded. Feedback from the Wigan Service User Forum has directly led to numerous improvements in service delivery through 2018/19. These include:

- A phase 2 evening group was set up and runs based upon service-user demand
- Postcard feedback forms and post boxes were made available in all SWMS venues
- A SWMS personalised plan information form is now given to service users at their first appointment. SWMS pathways including timelines are on display at SWMS venues (including a simplified bariatric surgery pathway)
- SWMS service-users act as ‘lay readers’ of new/updated leaflets and resources. Adjustments are made based on feedback, before the resource is sent to Aintree Information Governance team for ratification

Part 3.2 Performance against relevant indicators and performance thresholds set by NHS Improvement

Aintree is required to report its performance with a list of published key national priorities, against which the Trust is judged. Aintree reports its performance to the Board and the Trust’s regulators throughout the year. Actions to address any areas of underperformance are put in place where necessary. These performance measures and outcomes help Aintree to monitor how it delivers its services. Based on the most recently available benchmarked data Aintree is performing as reported for all of the metrics highlighted below. The increased level of demand for hospital services continued to put operational pressure on the Trust during 2018/19 and its ability to achieve a number of our key performance indicators. The following indicators have been subject to an independent audit. These audits did not highlight any data quality concerns.

- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge - Reported indicator performance has been calculated based on all patients recorded as having attended A&E. Completeness of this information is therefore dependent on the complete and accurate entry of data at source by the clinician who carries out initial assessment or by A&E reception. Patients leaving the department without being registered correctly will not form part of this indicator calculation.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Threshold</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment (RTT) to aggregate – patients on an incomplete pathway</td>
<td>&gt;=92%</td>
<td>90.1%</td>
<td>89.0%</td>
<td>89.6%</td>
<td>89.0%</td>
<td>89.0%</td>
</tr>
<tr>
<td>A&amp;E: maximum waiting time of four hours from arrival to admission/transfer/discharge</td>
<td>&gt;=95%</td>
<td>86%</td>
<td>87%</td>
<td>87%</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>All cancer: 62-day wait for first treatment from: • Urgent GP referral for suspected cancer</td>
<td>&gt;=85%</td>
<td>78.3%</td>
<td>74.9%</td>
<td>71.7%</td>
<td>74.9%</td>
<td>75.2%</td>
</tr>
<tr>
<td>• NHS Cancer Screening Service referral</td>
<td>&gt;=90%</td>
<td>71.4%</td>
<td>81.8%</td>
<td>65.8%</td>
<td>76.7%</td>
<td>73.8%</td>
</tr>
<tr>
<td>Clostridium Difficile (C.difficile) – Total cases</td>
<td>46</td>
<td>8</td>
<td>7</td>
<td>0</td>
<td>12</td>
<td>27</td>
</tr>
<tr>
<td>Clostridium Difficile (C.difficile) case variance from plan</td>
<td>N/A</td>
<td>-3.5</td>
<td>-4.5</td>
<td>-11.5</td>
<td>+0.5</td>
<td>-19</td>
</tr>
<tr>
<td>SHMI A</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>99.75</td>
</tr>
<tr>
<td>6 week diagnostics</td>
<td>1%</td>
<td>1.1%</td>
<td>2.7%</td>
<td>5.2%</td>
<td>0.88%</td>
<td>0.88%</td>
</tr>
<tr>
<td>VTE</td>
<td>95%</td>
<td>92.1%</td>
<td>92.4%</td>
<td>91.1%</td>
<td>92.2%</td>
<td>91.9%</td>
</tr>
</tbody>
</table>

* Latest position report in relation to Summary Hospital-level Mortality Indicator (SHMI) is as reported above. This performance is a rolling 12 month position updated on a quarterly basis and covers the period of the last 12 months, as per NHS Digital.
Part 3.3 Additional information for 2018/19

Delivery of Seven Day Services

There are ten national standards for the provision of seven day services; four of these are designated as a priority for delivery by March 2020.

- Standard 2: Consultant review within 14 hours of admission
- Standard 4: Seven day access to diagnostic tests
- Standard 6: 24 hour access, seven days a week to key Consultant-directed interventions
- Standard 8: Daily Consultant reviews.

The Trust is fully compliant with the four priority seven day service standards for major trauma, critical care, and heart attack and stroke services.

Overall, Aintree’s performance against Standard 5 (diagnostics) and Standard 6 (Consultant directed interventions) compares well against national benchmarks.

Freedom to Speak Up

The Trust is committed to an open and honest culture where staff feel confident to speak up when things go wrong, recognising this as a key component for safe and effective working. Lorraine Heaton is the Trust’s nominated Freedom to Speak Up Guardian.

The Trust’s performance against Standard 2 also compares generally well against national benchmarked data although results from the national Case Note Review suggest a slight drop in performance. Case Note Review performance on Standard 8 (twice daily and daily senior reviews) suggests a decrease in performance although feedback reports no change to work patterns.

Current service delivery improvement projects which will be supported by the implementation of seven day services include the on-going work streams linked to patient flow (SAFER programme, led by the Chief Operating Officer) and the review of medical on-call being undertaken by the Deputy Medical Director. A proforma has been developed to support the review and identification of patients in acute areas each Friday, to ascertain weekend treatment requirements or the potential for discharge. Close liaison is required between working groups to ensure that new initiatives satisfy seven day service requirements.

Managing our Medical Workforce

The workforce challenges at Aintree reflect the national picture including meeting increasing demand with reduced supply and turnover with particular pressure in the nursing workforce. Rota gaps, long-term staff vacancies and intensifying workload are major issues across the NHS, and this is felt locally at Aintree.

The average medical rota carries at least one gap, with between 32 – 42 WTE gaps recorded per rotation in 2018/19 across 24 main rotas. The two main hot spot rotas for gaps are General Medicine and General Surgery, which cover generalist on-call for a range of specialties within the respective Divisions.

Aintree is moving to take positive steps to improve the situation around rotas and gaps, in a number of ways. Work is underway to implement E-Rostering for medics. The increased visibility of rotas will allow for better gap management and help to control doctors working hours to ensure they are working safely. The E-Roster system improves visibility by highlighting the gaps on the rota straight away, giving medical staffing departments more time to fill gaps, helping to improve safety and deliver efficiency savings.

In January 2019, Aintree put into operation a new application called Patchwork which enables doctors to book onto available shifts through the bank via their mobile phones. The aim is to increase staff bank fill rates rather than relying on premium spend agency staff to fill the gaps.

Where there is a long term gap created by vacancies in Health Education England Deanery training posts, the Trust continues to appoint locally employed doctors. As a Trust we have also looked at alternative options available to reduce workforce risks. Across 2018/19, a Multi-professional Programme Workforce Group looked at alternative roles available to support medical rotas. Roles such as Advanced Nurse Practitioners, Medical Support Workers and Physician Associates were identified to work on hybrid rotas, supporting the medical workforce and improving capacity.

Aintree currently hosts four sessions of clinical time recruited in 2018 as part of a two year programme, rotating around Acute Medical Unit and Surgical Assessment Unit, two areas that see regular gaps within the generalist on-call rotas that cover a range of specialties within the area. The feedback from these areas is that the roles have been a great support, with Consultants and Junior Doctors describing them as ‘invaluable’ to the service.

Equally, medical support workers have been praised within the services, and improve not just workload of doctors, but allow for them to focus on the task of more educational value.
South Sefton, Liverpool and Knowsley CCGs welcome the opportunity to jointly comment on Aintree University Hospital NHS Foundation Trust’s Quality Account for 2018/19. The CCGs have worked closely with the Trust throughout 2018/19 to gain assurances that the services delivered were safe, effective and personalised to service users. The CCGs share the fundamental aims of the Trust and support their strategy to deliver high quality, harm free care.

It is noted that the Quality Account that is being reviewed is a draft version and the CCGs look forward to receiving the finalised account. The work the Trust has undertaken and described within this Quality Account continues to promote patient safety and the quality of patient experience and endorses the Trust’s commitment to promote safety and quality of care.

The Commissioners acknowledge the two year Quality Strategy for 2018-20 and the continued focus on work on the three elements to continuous improvement:

- Care that is Safe
- Care that is Clinically Effective
- Care that provides Positive Experiences for Patients and their families

Commissioners welcome the progress on the Quality Strategy and note:

- For Care that is Safe, progress in relation to safeguarding policies and enhanced monitoring and escalation of patients at risk of deterioration. The CCGs recognise the significant work the Trust has undertaken over the last year in implementing its Safety First Approach including the workstreams on safety culture, human factors and psychological safety of staff. The CCGs have also noted the investment of nursing leadership at divisional level and the planned patient engagement work to ensure feedback on the Trust’s Quality Strategy. We also recognise the continued improvement of incident reporting and the learning disseminated specifically from serious incidents within the Trust.

- For Care that is Clinically Effective, the CCGs welcome the development of the End of Life Strategy and training programme to support staff in its implementation.

- Care that provides Positive Experiences for Patients and their Families – The CCGs note the Patient and Family Experience Plan with Executive oversight and the revised complaints process with a decrease in formal complaints and an increase in local resolution. The commissioners recognise and continue to work with the Trust on the challenging areas of performance, specifically the 18 week referral to treatment (RRT) targets which were not met; the challenges regarding diagnostics which still remain below standard despite Trust work to improve the position; cancer services challenges which have affected overall performance. Commissioners welcome the Trust’s plans to enhance staff experience to ensure staff engagement and motivation which has a direct impact on quality of care.

This is a comprehensive report that clearly demonstrates progress within the Trust. It identifies where the organisation has done well, where further improvement is required and the ambitions moving forward. We understand the Trust’s Quality Strategy has a number of individual workstreams that will take into account patient feedback on progress made.

We have reviewed the information provided within the Quality Account and checked the accuracy of data within the account against the latest nationally published data where possible.

Commissioners are aspiring through strategic objectives to develop an NHS that delivers positive outcomes, now and for future generations. This means reflecting the government’s objectives for the NHS set out in their mandate to us, adding our own stretching ambitions for improving health and delivering better services to go even further to tailor care to the local health economy. Providing high quality care and achieving excellent outcomes for our patients is the central focus of our work and is paramount to our success.

It is felt that the priorities for improvement identified for the coming year are reflective of how the Trust will further improve services to address the current issues across the health economy.

We acknowledge the actions the Trust is taking to improve the quality as detailed in this Quality Account. It is felt that the priorities for improvement identified for the coming year are both challenging and reflective of the current issues across the health economy. We therefore commend the Trust in taking account of new opportunities to further improve the delivery of excellent, compassionate and safe care for every patient, every time.

Signed:
Fiona Taylor, Chief Officer
South Sefton and Southport & Formby CCGs
Date: 20th May 2019

Jan Ledward, Chief Officer
Date: 22nd May 2019

Dianne Johnson, Accountable Officer
Date: 22nd May 2019
Healthwatch Sefton would like to thank the Trust for the opportunity to comment on the draft Quality Account 2017-18 and attended the Quality Account session on the 3rd May 2019 at which the Trust presented and this was very useful. In reviewing previous accounts we can say that it was really great to see that this year’s account has been drafted in a friendlier format, particularly part three which details some great areas of inclusion of a glossary of terms is also welcomed.

We have been encouraged by the recruitment of a lead nurse for workforce. In reviewing the feedback we have gathered over the last 12 months the rates, although it is early days and the overall vacancy rate is 3.15% which is better than both the regional and national average and that this has helped in delivering the QIC improvement plan. We note that the Trust is rated as ‘Requires Improvement’ at this time.

In reviewing performance in the local commissioning framework (CQUIN) targets, we would like to see the improvement on the timely discharge of patients from critical care over the next 12 months but it is also reassuring that during this period this has not had any significant impact on elective care.

In reviewing the local commissioning framework (CQUIN) targets, we would like to see the trust improve on the timely discharge of patients from critical care over the next 12 months but it is also reassuring that during this period this has not had any significant impact on elective care. It was great to see the achievements in the work to improve services for people with mental health needs who present at Accident and Emergency and we would like to find out more about this.

In reviewing the Trust’s work to learn from deaths, we note the 2 cases reviewed (from 1000) that may have been due to problems with care delivery and one of the actions of improving in the delivery of end of life care. Care at the end of life has been an area we have taken an interest in and we are pleased that this year, the trust launched a new strategy for end of life and bereavement care which includes a ‘safe transfer’ checklist.

Work to promote healthy lifestyles and the recognition of ‘Making Every Contact Count’, is encouraging. It would have been good to see some more detail in relation to the numbers of staff trained, who delivered the training and the number of staff and patients screened. The use of percentages without actual figures included is a flaw throughout the account and this is something we ask for year on year to support the reviewing of the document.

In terms of progress with 7 day services, it is good to see the progress made. It would have been good to have seen some information about the merger with The Royal Liverpool & Broadgreen University Hospitals NHS Trust within the account.

In our review of last year’s account, we reviewed the use of the MUST screening tool for nutrition and hydration and were keen for its use to be improved. There was no mention of this in this account.

The Trust has continued to work in partnership with Healthwatch Sefton. We regularly attend the Patient Experience Executive Led Group and have attended a meeting of the Patient Experience Operational Group to see if this is something we should attend on a regular basis. We continue to hold monthly engagement events to gather both patient and visitor feedback. There is no reference to our work with the Trust in the account but one of the areas in which the Trust has listened to Healthwatch and worked to improve experience is in the area of car parking. The Standard Operating procedure was updated to include the financial impact on patients when clinics overrun. It is however unclear how patients are being informed about this.

The account does not include any information on the work the trust has undertaken on equality. We had asked the Trust to consider the Navajo Merseyside & Cheshire LGBT Charter Mark but this has yet to be achieved.

Healthwatch Sefton will continue to work in partnership with the Trust to support the on-going work to improve the overall care and services provided to both patients and their visitors, particularly those areas of work/ strategies which are ongoing in the next 12 months.

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Statement of directors’ responsibilities for the quality report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board
Date: 22 May 2019
Chairman

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

• the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and detailed guidance for quality reports 2018/19

• the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes for the period April 2018 to April 2019
  - Papers relating to quality report reported to the board over the period April 2018 to April 2019
  - Feedback from Commissioners; joint response from South Sefton CCG dated 17 May 2019, Liverpool CCG dated 20 May 2019 and Knowsley CCG dated 22 May 2019
  - Feedback from Governors dated 14 April 2019
  - Feedback from local Healthwatch organisations; Healthwatch Sefton dated 16 May 2019 and Liverpool dated 14 May 2019

• The Trust’s complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, published April 2018 to March 2019

• The 2018 national patient survey published January 2019

• The 2018 national staff survey published March 2019

• Care Quality Commission inspection published 08/04/2019

• The Head of Internal Audit’s annual opinion of the Trust’s control environment dated 14/05/2019

• The Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered

• The performance information reported in the Quality Report is reliable and accurate

• There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

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

• The Quality Report has been prepared in accordance with NHS improvement’s annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

Governors have a key role in ensuring that the voice of our patients, members and local community is at the heart of the Trust’s decision-making. This provides an opportunity for Governors to get involved where appropriate in the quality initiatives and improvement work undertaken by the Trust during the course of the year.

One of the responsibilities of the Council of Governors is to approve the local quality indicator for the purpose of external audit (as detailed on page 120). Governors discussed this at a session in February 2019 and subsequently ratified their decision at the formal Council of Governors’ meeting in March 2019 for the external auditors to review the Summary Hospital-level Mortality Indicator (SHMI).

In 2018/19, Governors continued to support and contribute to improving the quality of care that the Trust provides through, for example, the Patient-Led Assessments of the Care Environment and the ever evolving work on discharge planning including the Multi-Disciplinary Accelerated Discharge Event. We were also involved in the promotion of the Bowel Cancer Screening Programme with two Governors attending local Prisons to support specialist practitioners and they met with health mentors who are a network of offenders tasked with providing all offenders with a voice on health matters and health promotion. Governors are also involved in other collaborative initiatives - for example, the Catering Food Standards Group where excellent progress has been made in improving the standard and content of food available to patients as well as working towards the removal of all single plastic cups. Governors also participated in Nutrition & Hydration week, during March 2019, in the distribution of Afternoon Tea to all inpatients. We also took the opportunity to review the content of the Quality Account at two sessions in April and May 2019. There has also been an opportunity for Governors to be part of the revised Aintree Assessment & Accreditation Framework, which provides a more in-depth analysis of the quality standards on wards over the course of 3 days and includes an opportunity to visit the areas and assess them against these standards. We have also been provided with bespoke training sessions from executive directors and senior managers on Patient Experience, the Corporate Performance Report and Mortality which have provided Governors with further insight into the systems and processes within the Trust. This training is an important part of the Governor development programme as it deepens our knowledge and gives us the opportunity to challenge the quality agenda.

At the Governor-led Quality of Care Committee, executive directors and senior managers are asked to provide information to assist Governors in understanding, supporting and engaging with the three key elements of the Trust’s Quality Strategy (i.e. care that is safe, care that is clinically effective and provides a positive experience for patients and their families). The Committee has received reports on the Trust’s progress with its Safeguarding agenda and Quality Strategy Delivery Plan as well as some insightful presentations on Safe Nurse Staffing, Quality Improvements and development of the Safety First programme. At formal Council of Governors’ meetings, Governors have the opportunity to challenge the Non-Executive Directors and seek assurance on quality, performance and system issues. We also take part in the Director Walk Rounds which provide an opportunity for Governors to observe how the Trust is working and how the Quality Strategy and its Quality Priorities are being delivered.

Governors keep themselves abreast of local and national developments by attending local and regional externally facilitated workshops and seminars, where appropriate, enabling them to be more informed when reviewing Aintree’s Quality Account which they do at the beginning of each financial year. Governors also comment on the accessibility of the Quality Account for members and wider stakeholder groups.

Signed on behalf of Aintree’s Council of Governors

Pamela Peel-Reade
Lead Governor

Statement from Trust Governors
We have been engaged by the Council of Governors of Aintree University Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of the Annual Quality Report for the year ended 31 March 2019 (the “Quality Report”) and specified performance indicators contained therein.

Specified Indicators

The indicators for the year ended 31 March 2019 subject to limited assurance (the “specified indicators”) marked with the symbol ☉ in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement) (“NHSI”):

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.
- The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the ‘Detailed requirements for external assurance for quality reports 2018/19’.

The Directors are responsible for the conformity of the specified indicators criteria with the assessment criteria set out in the FT ARM and the ‘Detailed requirements for external assurance for quality reports 2018/19’, and consider whether it addresses the specified above.

We conducted this limited assurance engagement in accordance with the International Standard on Assurance Engagements 3000 (Revised) ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘IAASB’). Our limited assurance procedures included:

- reading the documents.
- reviewing the contents of the Quality Report against the requirements of the FT ARM and the ‘Detailed requirements for quality reports 2018/19’.
- reviewing the Quality Report for consistency against the documents specified above.
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and personnel and processes through to confirm our understanding:
  - based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
  - making enquiries of relevant management, personnel and, where relevant, third parties;
  - considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
  - performing limited testing, on a selective basis, of evidence supporting the reported performance indicators, and assessing the related disclosures; and
  - reviewing the content of the Quality Report against the requirements set out in the FT ARM and the ‘Detailed requirements for external assurance for quality reports 2018/19’.

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

Our Independence and Quality Control

We complied with the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of Aintree University Hospital NHS Foundation Trust as a body, to assist the Council of Governors of Aintree University Hospital NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Aintree University Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed with and our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3003 (Revised) ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘IAASB’). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the ‘Detailed requirements for quality reports 2018/19’;
- considering significant judgements made by the NHS Foundation Trust in preparing the specified indicators;
- performing limited testing, on a selective basis, of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reviewing the documents.

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3003 (Revised) ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘IAASB’). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the ‘Detailed requirements for quality reports 2018/19’;
- reviewing the Quality Report for consistency against the documents specified above.
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and personnel and processes through to confirm our understanding:
  - based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
  - making enquiries of relevant management, personnel and, where relevant, third parties;
  - considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
  - performing limited testing, on a selective basis, of evidence supporting the reported performance indicators, and assessing the related disclosures; and
  - reviewing the documents.

A limited assurance engagement is less 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

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Aintree University Hospital NHS Foundation 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 2019:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the ‘Detailed requirements for quality reports 2018/19’;
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the ‘Detailed requirements for external assurance for quality reports 2018/19’.

We are required to express an opinion over the Trust’s control environment dated 14/05/2019.

We express the opinion over the Trust’s control environment dated 14/05/2019.

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

PricewaterhouseCoopers LLP
Manchester
28 May 2019

The maintenance and integrity of Aintree University Hospital NHS Foundation Trust’s website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the website, its contents or indicators or criteria since they were initially presented on the website.

Annex iv

Independent Auditor’s Limited Assurance Report to the Council of Governors of Aintree NHS Foundation Trust on the Annual Quality Report

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3003 (Revised) ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘IAASB’). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the ‘Detailed requirements for quality reports 2018/19’;
- reviewing the Quality Report for consistency against the documents specified above.
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and personnel and processes through to confirm our understanding:
  - based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
  - making enquiries of relevant management, personnel and, where relevant, third parties;
  - considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
  - performing limited testing, on a selective basis, of evidence supporting the reported performance indicators, and assessing the related disclosures; and
  - reviewing the documents.

A limited assurance engagement is less 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
Annex v

Glossary of Terms

AAA  Aintree Assessment and Accreditation
AAGA  Accidental Awareness under General Anaesthesia
aBl  Aintree Business Intelligence
A&E  Accident & Emergency Department
AKI  Acute Kidney Injury
AwaRe  Access, Watch, Reserve Antibiotic Groups
BAUS  British Association of Urological Surgeons
BOAST  British Orthopaedic Association Standards for Trauma
CAP  Community Acquired Pneumonia
CMP  Case Mix Programme
CCG  Clinical Commissioning Group
CDifficile  Clostridium Difficile infection
COPD  Chronic Obstructive Pulmonary Disease
CQC  Care Quality Commission
COQUIN  Commissioning for Quality and Innovation (payment framework)
CRM  Cardiac Rhythm Management
DNA  Did Not Attend
DNAACPR  Do Not Attempt Cardiopulmonary Resuscitation
EPMA  Electronic Prescribing and Medicines Administration
FFAP  Falls and Fragility Fractures Audit programme
HbA1c  A blood test to determine how well diabetes is being controlled
HSMR  Hospital Standardised Mortality Rate
IBD  Inflammatory Bowel Disease
IPC  Infection Prevention & Control
LeDeR  Learning Disabilities Mortality Review
Medway SIGMA  Trust patient administration system
MINAP  Myocardial Ischaemia National Audit Project
MRSa  Methicillin-Resistant Staphylococcus Aureus
NABCOP  National Audit of Breast Cancer in Older People
NACEL  National Audit of Care at the End of Life
NaDia  National Diabetes Inpatient Audit
NCRA  National Cardiac Arrest Audit
NCAP  National Cardiac Audit Programme
NATSSIPs  National Safety Standards for Invasive Procedures
NBOCa  National Gastrointestinal Cancer Programme - National Bowel Cancer Audit
NCEPOD  National Confidential Enquiry into Patient Outcome and Death
NECAA  National Early Inflammatory Arthritis Audit
NELA  National Early Lung Cancer Audit
NHS  National Health Service
NICE  National Institute of Clinical Effectiveness
NIV  Non-Invasive Ventilation
NJR  National Joint Registry
NLCA  National Lung Cancer Audit
NOD  National Ophthalmology Audit
NOGCa  National Gastrointestinal Cancer Programme - National Osophaso-gastric Cancer
PainAd  Pain Assessment in Advanced Dementia
PCNL  Percutaneous Nephrolithotomy
PMO  Patient Reported Outcomes
QuEST  Quality Excellence Support Team
RLBUHT  Royal Liverpool and Broadgreen University Hospitals NHS Trust
RTT  Referral to Treatment
SACT  Systemic Anti-cancer Therapy
SAFER  S (senior review), A (all patients), F (flow), E (early discharge), R (review)
SHMI  Summary Hospital Level Mortality Indicator
SSNAP  Sentinel Stroke National Audit Programme
SHOT  Serious Stroke Audit Programme
VTE  Venous-Thromboembolism
WTE  Working Time Equivalent