Contents

Statement of Directors responsibilities in relation to Quality Account 3
Introduction and Purpose of Quality Account 4

Part 1: Statement on Quality
   About us and a message from our Chief Executive 6

   Our Performance
      Reporting against core indicators 14

Part 2: Priorities for improvement
   Priorities for Improvement 38
      Areas for improvement in the quality of relevant health services that Royal Liverpool
      and Broadgreen University Hospitals Trust intend to provide
Statement of Directors Responsibilities in respect of the Quality Account

The Department of Health has issued guidance on the form and content of annual Quality Accounts, (which incorporates the legal requirements in the Health Act 2009. Amendments were made in 2012, such as the inclusion of quality indicators according to the Health and Social Care Act 2012 and the National Health Service (Quality Accounts) Regulations 2010, (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

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

• The Quality Account presents a balanced picture of the Trust’s performance over the period covered 2018/19

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

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

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

• The Quality Account has been prepared in accordance with Department of Health guidance. The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

The Board of Directors confirm that to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Chairman

Date:

Chief Executive
Introduction and Purpose of Quality Accounts

Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality and standard of services they provide. They are required by the Government to help NHS Trusts, including providers of hospital acute services, community health services and mental health services, maintain focus and improve the quality of care for patients.

Quality Accounts have become an important tool for strengthening accountability for quality within NHS Trusts and for ensuring effective engagement of Trust Board of directors in the quality improvement agenda. By producing a Quality Account, Trusts are able to demonstrate their commitment to continuous evidence based quality improvement and to explain their progress to patients and their families, the public and those who have an interest in the services that the Trust provides.

Identification of Quality Account Priorities

To ensure that our staff, our external partners and our patient representatives and local communities were able to influence the content of this report, a quality improvement and engagement event took place on 29th March 2019 to hear the views and experiences and consequently propose priority areas for inclusion into the Quality Account. We invited suggestions on what our main quality improvement priorities should be for this year (2018/19) and what information should be included in this year’s Quality Account report in addition to the mandated content as set by the Department of Health.

We have also held a number of listening weeks that have given patients and stakeholders the opportunity to talk to us directly about their experience and about developments that are happening in the future. We have worked with partners such as Healthwatch to gain valuable feedback that has shaped the direction of our areas for quality improvement.
As we celebrated 70 years of the National Health Service this year, the nation proudly reflected on what an amazing, innovative, unique and cherished institution the NHS is. The NHS has faced many challenges and changes over the years. As the nation moves towards transformational times, the NHS will continue to meet its challenges with the same spirit of compassion and care that embodies the very best of the service.

One of our objectives towards achieving this is the development of the new Royal and the Liverpool Health Campus. Whilst the new Royal has been delayed, due to the liquidation of Carillion in January 2018, work has restarted following the appointment of Laing O’Rourke as management contractor in November 2018. At the time of writing, Laing O’Rourke are working on a new timetable for completing construction.

In the meantime we continue to invest in and carry out essential maintenance to the current Royal to ensure we have a safe environment for our patients, visitors and staff. This year we have invested over £1m into the maintenance of the current Royal. We have carried out detailed assessments on the current estate to ensure that we are aware of the potential issues. From this, we have developed robust contingency plans, purchased equipment and spare parts and are tackling potential maintenance issues proactively, to reduce the risk of them occurring.

The challenges the Trust faced following the liquidation of Carillion and in managing numerous issues with the infrastructure of the current Royal were featured in the excellent BBC Two Hospital documentary series. But as well as the problems, the documentary also featured the amazing dedication and hard work of our staff and those who work in facilities management in ensuring patient safety. The positive response of viewers towards those that work here, praising their diligence and compassion was truly touching.

Despite the set-back with the new Royal, we have been using this additional time positively, to ensure we are as prepared as possible for when we move. We have begun to use the new stock of beds and mattresses...
and various items of equipment for the new Royal in our current hospital, replacing equipment that was nearing the end of its life.

In February, we opened our new state of the art Clinical Sterile Services Department in purpose built premises at Broadgreen Hospital and moved the service from their deteriorating environment in the lower ground floor of the current Royal.

Another of our major objectives is the proposed merger with Aintree University Hospitals NHS Foundation Trust. Clinicians across both organisations believe this will help to deliver better services and greater outcomes for our patients.

Huge progress has been made on examining opportunities for teams to come together to share best practice and consider how they can work differently to deliver improvements. This has enabled us to identify what the benefits to patients could be and develop our clinical recommendation. We remain on track to merge in 2019/20. Throughout the year we have been engaging with staff across both trusts to understand the benefits integrating services will bring for patients. We have established a programme to understand the culture of both organisations, identifying where the similarities and differences are so that the two organisations can come together as seamlessly as possible. The Trauma and Orthopaedic teams whose proposals to deliver emergency and urgent services at Aintree Hospital and planned procedures at Broadgreen Hospital, will be the first such integration.

Further work this year has included the development of a patients’ benefits case and a draft business case to be presented to NHS Improvement. We have also been preparing for public engagement activities to begin in May 2019. This will be an opportunity for patients, the public and wider health partners to hear more about our merger proposal and what our trusts could achieve by working together. We will ask people to share their views on how we improve the services we have and make them work better for all our patients. The outputs from this engagement will inform future proposals for how we integrate our services.
Like most of the NHS, the Trust continues to face significant increases in demands for its services that pose tough challenges for both our financial and operational performance.

Our staff continue to find innovative ways to improve quality, efficiency and productivity, saving around £20m this year, whilst maintaining patient safety. We continue to work closely with our colleagues in neighbouring trusts and local authorities across Liverpool, Sefton and Knowsley as part of the North Mersey A&E Delivery Board. The aim of the Delivery Board is to ensure that organisations support one another effectively when spikes in demand create challenges to the delivery of emergency and urgent care. The Delivery Board has initiated a number of joint workstreams to improve emergency services, facilitate patient flow and reduce delays to discharging patients. It has been encouraging to see staff across each organisation focusing on the common goal of improving the lives of patients in delivering changes to their services.

Our Global Digital Exemplar (GDE) programme continues to develop innovative technologies to support patient care across Liverpool. This year we launched the first digital testing space of its kind in the NHS to test this latest digital technology. The ‘Livernerds Lab’, located in the Life Sciences Accelerator consists of two specialised areas a ‘Smart Room’, which simulates a hospital bedroom, and a ‘Smart House’, which simulates a patient’s home. Both spaces are specifically adapted and fitted with the latest digital equipment including sensor technology, virtual reality, telehealth and health care. This technology is all enabled by high speed 5G connectivity as part of the £3.5 million Liverpool 5G Health and Social Care pilot. Some of this technology is already being tested by the Trust, with telehealth being used to support appropriate respiratory and cardiology patients at home. This technology allows health care staff to monitor key daily observations, records ad hoc episodes that may be of concern, and triggers support within the patient’s home. It also empowers patients to manage their conditions better with access videos and advice on their condition. The Trust is also piloting the use of virtual reality as a distraction technique for pain management in palliative care and critical care.

Towards the end of the year, the Trust was inspected by the Care Quality Commission as part of its routine programme and their findings will be published after April 2019. In their initial feedback, inspectors acknowledged the period of change for the Trust and observed that morale was good across the organisation and staff were passionate about patient care. These positive comments were reflective of the overwhelmingly positive feedback that we have received regarding our staff during the NHS 70 celebrations and throughout the broadcast of BBC Two’s Hospital.

We are all incredibly proud of the spirit of our staff and their dedication to providing patients with the best possible care, despite the many challenges we have faced. I’d like to thank all our staff for their hard work and I’d also like to thank our patients and the people of Liverpool for the inspirational support and praise they have given us this year.

Dr Peter Williams,
Interim Chief Executive
About the Trust

The Trust was established in 1995 and manages three hospitals based on two sites: the Royal Liverpool University Hospital, Liverpool University Dental Hospital and Broadgreen Hospital. It is the major adult university teaching hospitals trust for Merseyside and Cheshire and our hospitals have often been at the forefront of medical breakthroughs.

As one of the largest employers in the city, we employ over 8000 people and our annual budget is over £500 million.

The Trust provides a comprehensive range of specialist services to over 750,000 people each year within a total catchment population of more than two million people in Merseyside, Cheshire, North Wales, the Isle of Man and beyond. In the past year, we provided emergency and urgent care to an estimate of over 255,000 people, over 95,000 of whom attended our emergency department. We cared for an estimated 117,000 day case and inpatients and provided over 600,000 outpatient appointments.

We are a major centre for the diagnosis, treatment, care and research of cancer. We provide a range of cancer services from our renowned Linda McCartney Centre. We are a regional cancer centre for pancreatic, urological, ocular (eye), testicular, anal, and oesophago-gastric cancers, specialist palliative care, specialist radiology, specialist pathology and chemotherapy cancer treatment services, as well as a national centre for ocular oncology. We also have excellent local cancer treatment services, including skin, breast, colorectal, head, neck and thyroid and lung cancer. We host a Macmillan Cancer Information and Support Service, with centres on both of our sites.

We also provide general hospital services to the adult population of Liverpool with one of the busiest emergency departments in the North West, where we provide care and treatment for patients who have life threatening injuries and serious illnesses such as strokes and heart attacks. We also provide care for patients with more routine illnesses and injuries, such as fractures.

The Liverpool University Dental Hospital supports dental teaching and provides specialist dental services and emergency care for the local community.

Global Digital Exemplar

In September 2016, the Trust was named by the Department of Health as one of the first, ‘Global Digital Exemplar’ organisations. This means we are working to become internationally recognised for our use of digital technology and information in the way we provide care.

The aim of the Global Digital Exemplar (GDE) programme is to; join up and digitise health systems, to give clinicians more timely access to accurate information, give patients better access to their records and support improvements between now and May 2020. As a GDE, the Trust will receive up to £10 million of national funding to invest into technology and infrastructure to enhance staff training and digital technology.

The Trust has made a number of significant developments in digital technology over recent years. These include:

- Progress to ensuring patient records are digitised
- Our whiteboard system that provides staff with information on which beds have been allocated to which patients and what assessments they have had to help manage their care more effectively. This was highlighted as outstanding in our 2016 Care Quality Commission report.
- Enhancing electronic observations by using sensor technology to improve the way we monitor patients and reduce length of stay
- Our nationally recognised eSepsis programme for the screening and early recognition of sepsis. As well as saving up to 200 lives a year at the Trust, eSepsis was adopted as one of the GDE Blueprint programmes, included in the NHS Long Term Plan.
Research and development

Our Trust has significant relationships with all the universities in Liverpool, but in particular the University of Liverpool’s medical and clinical schools and Liverpool John Moores University, with regard to nurse training.

As well as being the host organisation for the North West Coast Comprehensive Research Network, we are also a centre for clinical research and lead teaching and training for a variety of health professions.

We have a dedicated Clinical Research Unit that is accredited by the Medicines and Healthcare products Regulatory Agency (MHRA) to perform first in human clinical trials. In collaboration with the University of Liverpool, we also have the only National Institute for Health Research (NIHR) funded Biomedical Research Unit in the UK, which is dedicated to research into pancreatic disease.

In recent years the Trust has been involved in a variety of ground-breaking research projects including:

- Pioneering clinical research studies to develop a Zika virus vaccine
- Numerous studies at the forefront of pancreatic cancer research
- Developing the use of personalised medicine
- Using big health data intelligently, drawing on masses of information, to transform the understanding of and treatment for rare genetic disorders, through involvement in the Rare Diseases Sprint Exemplar Innovation Project

Our future

We are working together with Aintree University Hospital NHS Foundation Trust and with NHS Improvement, to achieve a proposed merger of the two trusts in the next financial year. Clinicians at both trusts believe that by working as one organisation, they can deliver better clinical outcomes for patients. A combined organisation would also make Liverpool an attractive prospect for research funding, helping to ensure that our patients have access to the latest technologies and treatments.

The Trust’s long-term plan is for the new Royal Liverpool University Hospital to provide state of the art emergency and complex care, as part of a health campus with access to some of the latest innovations in Life Sciences. Broadgreen Hospital would focus on providing the best non-emergency care, including specialist services for older people, elective surgical care and dermatology plus a range of outpatient services.

The aim is to create a world leading hub for research and development in the city, creating thousands of jobs in the process.

Three of the key developments within Liverpool’s Knowledge Quarter are based on the Royal Liverpool University Hospital site; the new Royal Liverpool University Hospital, the new Clatterbridge Cancer Centre being built alongside the new Royal and the Liverpool Life Sciences Accelerator, a collaboration between the Trust and Liverpool School of Tropical Medicine. The Accelerator brings together a range life science companies which support our research and development agenda and will allow our patients access to the latest healthcare innovations.

Our strategy and objectives

The Royal Liverpool Hospital and the Trust has been central to providing innovative care to the people of Liverpool for decades. The Trust is acutely aware of the challenging health issues that are a legacy of social deprivation in the city, but also the city’s rich academic and pioneering heritage in healthcare.

We recognise the strong link between this social deprivation and poor health, and the reverse; the opportunity to improve health through economic prosperity.

We therefore are determined to use our role and assets to contribute to the regeneration of Liverpool.

We also recognise that the Liverpool NHS system has a large number of individual organisations none of which alone is big enough to fully compete on the national stage. It also leaves us struggling to collaborate sufficiently to deliver the critical mass to attract the resources we need.
Our strategy puts the people of Liverpool and our patients at the heart of our future plans. That strategy is outlined below:

- See the completion of a state of the art new Royal Liverpool University Hospital, which will provide the world class environment to greatly improve services and make way for the redevelopment of the rest of the site.

- Redevelop the Royal Liverpool site as a health campus which will provide a comprehensive range of healthcare services, bringing together services that are currently fragmented. Its position next to the universities, the Royal College of Physicians’ northern HQ and within the heart of the Knowledge Quarter provides easy access to the academic expertise and research capability needed to develop new treatments and innovations. The economic boost to the city that this will provide, will improve the prosperity and health of its people.

- Reduce local competition in favour of collaboration in the interests of improving clinical services for the benefit of patients. This is the motivation behind our proposals to merge with Aintree University Hospital NHS Foundation Trust, along with our collaborations with Clatterbridge Cancer Centre to create a comprehensive cancer centre beside the new Royal and the Liverpool Women’s NHS Foundation Trust on their proposals to operate from the new Royal site.

- Amidst all this change the Trust is also determined to remain focused on its core purpose - to continue striving to deliver the best possible treatment and care. We believe the key to doing this is to innovate and to find new ways to deliver quality services, in collaboration with local partners where necessary.

- Liverpool has some of the highest incidences of disease in the country. This makes it vital to invest in research to identify new treatments, to provide our patients now with access to clinical trials, and our future patients with new, more effective treatments. The Trust will continue to focus on maximising its use of resources through research, innovation and improvement activities to become more efficient and effective. It will also help us to develop the innovations we need to transform service delivery for the future. A key part of this is our commitment to digital transformation.

Our vision statement summarises what we stand for, believe and strive for. We have a passionate belief that, in the face of an extremely challenging environment, and to some extent because of it, our role is to focus on our patients, and doing all we can to improve their outcomes.

**Our vision:** “Delivering the highest quality of healthcare driven by world class research for the health and wellbeing of the population.”

**Our values**

- Patient centred
- Professional
- Open and engaged
- Collaborative
- Creative

**Our corporate objectives 2018-19 were:**

- Deliver high quality care to all patients by improving the way we admit and discharge our patients
- Deliver our financial plan and ensure we are as efficient as possible
- Complete the proposed merger with Aintree University Hospital and continue to work with our partners to improve care
- Change the way we work to ensure we are ready for a successful move into the new Royal

Enabled by:

- Creating a great place to work for the benefit of staff and patients
- Deliver excellent digital services to improve patient care
During 2018/19, the Trust provided and/or subcontracted for relevant health services (as per below). The income generated from the provision of relevant health services represents 100% of the total income generated from the provision of relevant health services by Royal Liverpool and Broadgreen University Hospitals NHS Trust in 2018/19.

- Acute and Emergency Care
- Allergies
- Blood (Haematology)
- Bones and Joints (Rheumatology)
- Breast Unit
- Cancer services
- Dental
- Diabetes
- Ear Nose and Throat
- Elderly Services
- Eyes
- Gastroenterology
- Hearing
- Heart
- Infection and Immunology
- Inpatients
- Critical Care
- Kidney
- Trauma and Orthopaedics
- Medical therapy and support services
- Nuclear Medicine
- Nutrition and dietetics
- Outpatients
- Radiology
- Respiratory
- Sexual Health
- Skin, arteries and blood vessels
- Vascular surgery
- Urology

Total income for patient care activities is as follows - **£382,941,000**
How we manage our hospitals

The overall day-to-day management of all three of our hospitals and services is the responsibility of the team of executive directors, under the leadership of the chief executive and supported directly by other senior managers in various departments.

Our operational structure combines some of our clinical departments into care groups based on closely linked patient pathways. Each clinically led care group has a management team comprising a clinical director, general manager and matron. These in turn are managed by a director of operations who reports to the chief operating officer.

Care groups are supported by corporate services, which include communications, estates, finance, governance, human resources, information, organisational development, quality, new Royal redevelopment, research, development and innovation and service excellence and improvement.

We operate a board committee structure to ensure that we are well governed, managed effectively and scrutinised appropriately. The board of directors is responsible for formulating strategy, ensuring accountability and shaping a healthy culture. We operate a board committee structure. Key committees include finance and performance, audit and assurance, quality governance and new hospital. We continually refine our governance arrangements, ensuring that they are suitable for the effective running of our hospitals. A formal escalation framework is in operation to ensure that key issues and concerns are escalated through the committee structure for board attention where appropriate.

### Our Performance

<table>
<thead>
<tr>
<th>National Targets and Minimum Standards</th>
<th>Performance Indicator</th>
<th>2017-2018 Actual Year</th>
<th>2018/19 Target</th>
<th>2018/19 Actual Year</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control</td>
<td>Number of Clostridium difficile cases</td>
<td>37</td>
<td>43</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of MRSA blood stream infection cases</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Cancelled Operations</td>
<td>Cancelled operations (on day of surgery for non-clinical reasons)</td>
<td>0.89%</td>
<td>0.6% (local target)</td>
<td>0.90%</td>
<td></td>
</tr>
<tr>
<td>Access to treatment</td>
<td>Referral to treatment Percentage of patients waiting no more than 18 weeks from Referral to treatment</td>
<td>85.20%</td>
<td>92%</td>
<td>81.81%</td>
<td></td>
</tr>
<tr>
<td>Access to cancer services</td>
<td>Cancer: 31 day wait from diagnosis to first treatment</td>
<td>95.06%</td>
<td>96%</td>
<td>92.74%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cancer: 31 day wait for second or subsequent treatment: (surgery)</td>
<td>96.21%</td>
<td>94%</td>
<td>86.69%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cancer: 62 day wait for first definitive treatment for cancer from urgent GP referral</td>
<td>85.69%</td>
<td>85%</td>
<td>74.01%</td>
<td></td>
</tr>
<tr>
<td>Access to A&amp;E services</td>
<td>A &amp; E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department</td>
<td>89.20%</td>
<td>95%</td>
<td>87.85%</td>
<td></td>
</tr>
<tr>
<td>Stroke Care</td>
<td>Patients admitted with a stroke spending at least 90% of their stay on a stroke unit</td>
<td>72.83%</td>
<td>-</td>
<td>73.44%</td>
<td></td>
</tr>
<tr>
<td>VTE Risk Assessments</td>
<td>All inpatient’s to have a risk assessment for VTE (venous thromboembolism)</td>
<td>88.51%</td>
<td>95%</td>
<td>93.82%</td>
<td></td>
</tr>
<tr>
<td>Readmission rates</td>
<td>Readmission rates within 30 days</td>
<td>6.99%</td>
<td>-</td>
<td>7.36%</td>
<td></td>
</tr>
<tr>
<td>Delayed Transfers of Care</td>
<td>Delayed transfer of care</td>
<td>4.80%</td>
<td>-</td>
<td>12.5%</td>
<td></td>
</tr>
</tbody>
</table>
Infection Prevention and Control

Infection prevention and control remains a high priority for the Trust. We strongly believe that protecting our patients, and staff, against healthcare acquired infections is everyone's responsibility. This is supported by continued monitoring and surveillance of infections, scrutiny and improvement in our use of antibiotics, sustaining high standards of cleanliness in our wards and patient areas and an excellent annual training programme for all our medical and nursing staff including hand hygiene and asepsis protocols.

Our efforts to reduce the number of patients with Healthcare Acquired Infections (HAIs), such as MRSA (Methicillin Resistant Staphylococcus Aureus) and Clostridium difficile (C.diff), across our hospitals and community services continue to be a leading quality improvement priority with the Trust achieving a reduction for C Diff against 18/19 and 16% below trajectory. 8 cases have been successfully appealed to date. Both C. diff infection and MRSA bacteraemia have been a national priority for many years with every hospital acquired case reported to Public Health England as part of a national surveillance programme.

MRSA (Methicillin Resistant Staphylococcus Aureus)

In 2018/19, the national target for all acute hospitals was zero MRSA bacteraemia. We continue to work to prevent bacteraemia (blood stream infections), including MRSA with an extensive programme of screening and decolonisation which is continued for the duration of a patient stay. In addition, we ensure high standards of infection prevention and control practices including hand hygiene and aseptic procedures.

At the end of March 2019, the Trust reported two MRSA bacteraemia, against a trajectory of zero. An investigation is undertaken for each MRSA involving the clinical and nursing team, clinical commissioning group clinical and managerial leads, the community provider and the patient’s general practitioner. The investigation follows the national post infection review (PIR) framework and the actions and lessons learnt are implemented and communicated across the organisation through the weekly safety bulletin and reported to appropriate committees.

Clostridium Difficile (C.Difficile)

Clostridium difficile can cause symptoms including mild to severe diarrhoea and sometimes severe inflammation of the bowel. Patients are more vulnerable to infection when they are in hospital however in a number of cases the infection can be preventable therefore reducing the risk of this is a top priority.
NHS England sets targets to reduce the number of new cases of C.diff infections each year. Whenever a patient becomes infected, the Trust completes a detailed investigation to determine the cause of infection and any actions to be implemented.

Last year, NHS England issued the Trust with a target of no more than 43 hospital acquired cases of C.diff for 18/19. The Trust total cases for the year was, 36, below the prescribed target.

Each case is subject to a review process internally and externally. Although there were 37 cases this year several of these were successfully appealed to the CCG, as ‘no lapses in care’ were identified on local review.

Health Care associated Gram Negative Blood Stream Infections (HCAI GNBSI)

From April 2017, there was an NHS ambition to halve the numbers of healthcare associated Gram-negative BSIs by 2021. The top three Gram-negative BSI causative organisms are Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa) and Klebsiella species (Klebsiella spp.). 70% of these infections originate within the community and 30% within hospitals with an increased incidence seen within the elderly population.

The Trust is working with partners across health and social care to collaboratively deliver the ambition led by Liverpool clinical commissioning group (Liverpool CCG). The group meets regularly to coordinate the reduction strategy. The Trust has not been set an individual reduction target; this remains a local healthcare economy target. Preventing these infections requires that a range of actions are met (including prevention of sepsis), good surveillance systems and antimicrobial stewardship are in place and preventing urinary tract and skin or soft tissue infections.

The number of these infections has been steadily rising in recent years. The Trust reported 92 cases in 2018/19 compared to 91 in 2017/18. Not all cases are preventable; many are symptomatic to the patient’s condition. All cases of infection are subject to an infection control review to identify any lessons learnt.
Benchmarking Data

The Department of Health specifies that the Quality Account includes information on a core set of indicators. All trusts are required to report against these indicators using a standard format. The following data is made available to NHS trusts by the Health and Social Care Information Centre. The Trust has more up-to-date information for some measures. However, only data with specified national benchmarks from the central data sources can be reported. Therefore, some information included in this report must out of necessity be from the previous year or earlier.

Referral to Treatment (18 weeks)

Recent figures suggest that we were below target of patients being treated within 18 weeks of referral, against the target of 92%.

Trying to reach this target has proved difficult throughout the NHS in England. In response to the pressures on emergency departments last winter, NHS England advised hospital Trusts to cancel non-urgent elective procedures; this action has created a backlog of routine procedures and has therefore increased waiting times. In the summer of 2018 a bulletin was issued that mandated that providers must ensure, by the end of March 2019, that the number of open pathway’s (patients who haven’t had treatment) was less than the number of patients who had open pathways at the end of March 2018, we have achieved this target.

Our patient waiting lists continue to be closely monitored with a view to achieving the 92 % target by the end of 2019. Additional work is underway around improving performance such as demand and capacity modelling work, remedial action plans and weekly performance meetings.

Emergency access

The national target for Emergency Department is for 95% of patients to be admitted, discharged or transferred as appropriate within four hours of arrival at hospital. The trust has unfortunately missed the 95% monthly target.
The Emergency Department has been under increased pressures which has had a direct effect on the National 4 hour Trust Access Target, along with stretching the ability to deliver a quality service that meets patient expectations and satisfactions.

The main reasons for failures to meet the target this target within the department were a number of issues including:

- Operational impact of patient flow
- High attendances
- Patient who have complex clinical conditions

The Trust is striving to deliver the national 4 hour Trust Access Target to ensure that patients are seen in a timely manner and to have a positive patient experience providing safe, quality and effective care.

The ED Improvement programme had key priority projects to improve performance against the 4 Hour Access Target and successfully implemented:

- Senior Triage system to ensure patients are seen by the most experienced staff at the time they book into the Emergency department.
- Expansion of Ambulatory Care Unit: Ambulatory care is a service which offers same day emergency care to patients at the hospital. This means that patients are assessed, diagnosed, treated and are able to go home the same day, without being admitted into a hospital bed overnight wherever possible.
- Quality Matron roles 7 days per week to ensure senior support Leadership within the Emergency Department.
- Medical workforce review resulting in additional 3 Consultants and 8 trust grade to support clinical care delivery.

**Patient flow: Supporting patients in the emergency department**

Patients in the emergency department are triaged according to how urgent their illness or injury is. Those in the most urgent need of care are seen first.

The Trust continues to work as part of the wider health system to redirect those patients in the emergency department whose needs are not urgent to more appropriate services in the community. For some patients, following triage, they may be directed to the appropriate primary care services co-located within the emergency department or in the community.

In addition the ambulatory care service has been expanded. This service is supporting patients in the emergency department to be seen quicker and in a more appropriate setting. Often these patients can be seen without the need for them to be admitted to hospital, with any necessary follow ups in a clinic or even over the phone at
home. Up to 30 patients a day are benefiting from this advanced service with an additional 25 patients a day being supported at home. This service has been enabled through enhancements to our Patient Dashboard tracking technology allowing clinicians in ambulatory care to access test results and patient details more efficiently. These clinicians can then contact the patient to inform them over the phone without them needing to come back into the hospital and a letter detailing the outcome is sent to their GP.

The Frailty Unit located beside the emergency department provides rapid assessment and treatment for frail elderly patients. This is aimed at enabling these patients to be medically fit as soon as possible to avoid staying in hospital any longer than necessary. These patients are then discharged with the support of an integrated frailty team, consisting of staff from the Trust, Liverpool Local Authority and Mersey Care NHS Trust.

**Patient flow: Supporting patients’ discharge**

The numbers of patients who remain in a hospital bed, yet are ready to be discharged remains high. Patients who are ‘ready to be discharged’ are defined as patients who are well enough to leave the hospital but have not yet been discharged. These delays may be due to awaiting a care placement or package of care to be agreed or become available. The daily average number of patients who are ready to be discharged has been steadily increasing in recent years. Between April and January this year the average number of patients ready for discharge was 162 a day, which represents a significant portion of inpatient beds.

During the year the Trust produced a comprehensive communications campaign for the North Mersey Delivery Board. The aims of the campaign were to make patients and carers aware of the importance of not delaying discharge and how they can support swifter discharges. It was also aimed at changing the behaviour and attitude of some staff to ensure they understand that prioritising discharges is acting in the patients’ best interests. These aims were informed through detailed research with patients and staff across the three adult acute Trusts within the delivery board. The campaign messages were delivered through comprehensive social media marketing, working proactively with local media outlets, a patient information booklet about the discharge process and through consistent internal communications to staff.

**Cancelled Operations**

When high levels of pressure require the Trust to cancel procedures, the decision is made to cancel any non-urgent planned procedures first so that it can prioritise care for emergency and urgent procedures such as cancer cases. During this year we have consistently ensured all cases have gone ahead.
VTE (Venous Thromboembolism)

Venous thromboembolism (VTE) covers both deep vein thrombosis and its possible consequence: pulmonary embolism (PE). A deep vein thrombosis (DVT) is a blood clot that develops in the deep veins of the leg. If the blood clot becomes mobile in the bloodstream it can travel to the lungs and cause a blockage (PE) that could lead to death. The risk of hospital-acquired VTE can be greatly reduced by risk assessing patients on admission to hospital and taking appropriate action. We check to see if the patient has received the appropriate medication.

Preventing VTE is a national and trust priority.

The table below highlights the improved monthly performance of The Royal Liverpool and Broadgreen University Hospitals Trust over a 2 year period of VTE performance.

![VTE Performance Graph](image)

The Trust has taken the following actions to improve the percentage of patients screened by:

- Development and recruitment of a VTE team as of 2017 with a challenging strategy and aim to become a VTE exemplar site
- Implementation of an electronic, intuitive VTE risk assessment tool
- Undertaken a root cause analysis investigation of all cases of Hospital Acquired Thrombosis in order to prevent it happening again
- Provide immediate feedback/education to ward staff, disseminate learning points and implement any actions for improvement
- On-going VTE training for all clinical staff.

Patient Safety Incidents

This section reports the number and, where available, rate of patient safety incidents within the Trust. It also includes the number and percentage of patient safety incidents that result in severe harm or death. The Trust’s performance is compared against other acute teaching hospitals.
Why is it important?

The Trust believes that an open reporting and learning culture is important to identify trends in incidents and implement preventative action. It also understands that high reporting of incidents indicates an open and transparent culture and therefore encourages staff to report all incidents and near misses to further improve patient safety. Staff should have confidence in the investigation process and understand the value of reporting and learning from incidents.

Research shows that trusts with higher levels of incident reporting are more likely to demonstrate other features of a stronger safety culture and commitment to patients to inform them when incidents have occurred. Incident reporting is important at a local level as it supports clinicians to learn about why patient safety incidents happen within their own service, and what they can do to keep their patients safe from avoidable harm.

The ‘degree of harm’ for patient safety incidents is defined by:

- **No harm:** any patient safety incident that had the potential to cause harm but was prevented.
- **Low harm:** any patient safety incident that required extra observation or minor treatment and caused minimal harm
- **Moderate harm:** any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm
- **Severe harm:** the patient has been permanently harmed as a result of the patient safety incident
- **Death:** the patient safety incident has resulted in the death of the patient. Following a serious incident, a thorough Root Cause Analysis (RCA) investigation is undertaken.

The Trust reviews all patient safety incidents at a weekly patient safety meeting. Incidents of moderate harm, severe harm and death will result in a formal Root Cause Analysis Investigation (RCA).

The Trust will apply the Serious Incident and Never Event Framework and report more serious incidents or incidents were there is greater learning to the Clinical Commissioning Group (CCG).

All incidents at these levels will more importantly being shared with the patient and/or family in accordance with the Trusts Duty of Candour Policy.

The Trust embraces its Duty of Candour and considers it vitally important when standards of care are not fully met.

The number of patients treated at the hospital varies from day to day, so rather than simply measuring the number of incidents reported, the Trust compares this figure with the proportion of patients treated to arrive at a comparable incident reporting rate.

Duty of Candour

This is a legal requirement to act in an open and transparent way with service users. The Trust has a policy in place that has been disseminated to all staff and audit activity is in place to understand progress against the national standard.
Duty of candour reporting requirements state that as soon as reasonably practicable, after becoming aware of a notifiable patient safety incident the health professional [or Trust] must:

- Notify the patient [*or someone lawfully acting on their behalf] that the incident has occurred.
- Provide reasonable support to the patient* following the incident

The notification must:

- Be conducted verbally; by a representative of the Trust, typically the senior doctor or senior nurse responsible for the patient at the time of the incident; with the patient* If the patient is still an inpatient this should occur in the clinical environment, if the patient is no longer an inpatient then a telephone conversation should be made.
- Provide a truthful account of all the facts that the Trust knows about the incident at the time of the notification.
- Advise and, if appropriate, agree with the patient* what further enquiries into the incident are appropriate, from both the patients* and Trust perspective (informing the terms of reference for the investigation).
- Include an apology.

Incidents can relate to moderate, severe harm or death.

The Trust has a policy in place that specifies the process by which the Trust must adhere to national requirements.

The Trust reporting requirements and compliance are monitored through the Trust governance process, and various audits have been carried out to understand our compliance with this.

The tables below provide data on the number and rate of incidents resulting in severe harm. These incidents occurred between 1st October 2017 and 30th September 2018 and were reported to the National Reporting and Learning System (NRLS).

The comparative reporting rate summary shown below provides an overview of incidents reported by NHS organisations to the National Reporting and Learning System (NRLS) occurring between 01 April 2018 to 30 September 2018.

Our hospital reported 7098 incidents (rate of 56.58) per 1,000 bed days, during this period.

Degree of Harm 01.4.18 – 30.9.18

<table>
<thead>
<tr>
<th>None</th>
<th>Low</th>
<th>Moderate</th>
<th>Severe</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>6185</td>
<td>734</td>
<td>171</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>87.1</td>
<td>10.3</td>
<td>2.4</td>
<td>0.1</td>
<td>0</td>
</tr>
</tbody>
</table>

The comparative reporting rate summary shown below provides an overview of incidents reported by NHS organisations to the NRLS occurring between 01 October 2017 to 31 March 2018.

The Trust reported 5335 incidents (rate of 41.09) incidents per 1,000 bed days during this period.
Degree of Harm 01.10.17 – 31.3.18

<table>
<thead>
<tr>
<th>None</th>
<th>Low</th>
<th>Moderate</th>
<th>Severe</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>4440</td>
<td>730</td>
<td>152</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>83.2</td>
<td>13.7</td>
<td>2.9</td>
<td>0.2</td>
<td>0</td>
</tr>
</tbody>
</table>

The Trust has taken the following actions to improve the rates of reporting and improve the quality of the investigation.

- Undertaking comprehensive investigations following moderate and severe incidents in order to learn lessons and improve practice
- Providing staff training in relation to risk and incident management, root cause analysis and Duty of Candour
- Ensuring rigorous reporting of key performance indicators in relation to incidents at the monthly Patient Safety sub-committee and Perfect Ward meetings with ward managers to ensure lessons are learned, learning is shared across the organisation and appropriate actions are implemented.
- A human factors training programme has been implemented to enhance team working in clinical areas.

The human factors course raises awareness with staff of how the way in which they react to different situations, may contribute to improving quality and safety of patient care. This reinforces the importance of leadership, communication and an open culture of learning

- Monitor and audit compliance against the Duty of Candour and report to appropriate committees.

**Never Events**

Never Events are described by NHS England as serious incidents that are wholly preventable. Guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Each Never Event has a potential to cause serious harm or death. However, serious harm or death is not required for the incident to be categorised as a Never Event. Never Events include incidents such as: wrong site surgery, retained foreign object post procedure and chest or neck entrapment in bedrails.

For the period 2018/19, The Royal Liverpool and Broadgreen University Hospitals NHS Trust reported 3 Never Events.

The Trust has taken the following actions to mitigate the risk of reoccurrence of Never Events.

- Improved surgery safety checklists
- Human factors training course and rolled out for theatre staff alongside the introduction of LocSSIPs (Local Safety Standards for Invasive Procedures)
- Staff empowered to challenge areas of concern
- Regular communication to staff through the Safety Bulletin to share lessons learnt and trend analysis and share areas of good practice.

The Trust is committed to using Root Cause Analysis (RCA) to investigate adverse events, including Never Events.
This approach is underpinned by the Trust’s commitment to ensuring an open and honest culture in which staff are encouraged to report any errors or incidents and encourage feedback in the knowledge that the issues will be fairly investigated and any learning and improvement opportunities implemented.

### National Safety Standards for Invasive Procedures (NatSSIPs)

NHS England published NatSSIPs in September 2015 with an original mandate for all healthcare providers undertaking invasive procedures to be fully compliant within the following 12 month period. During April 2016 NHS England corrected the initial implementation schedule to read that providers must have plans in place to ‘Commence implementation of procedures and practice compliant with LocSSIPs within cycles of continuous Improvement including consideration of teamwork and training, human factors and cultural aspects of compliance’. No further guidance re final completion date has been issued at the time of writing.

### Local Safety Standards for Invasive Procedures (LocSSIPs) Development

The Trust undertakes in excess of 570 individual invasive procedures. The NatSSIP standard is that a LocSSIP must be applied to all invasive procedures with the exception of a peripheral cannula or a urethral catheter. All LocSSIPs have been designed, piloted and refined in our Patient Electronic Noting Systems (PENS)

#### LocSSIP Human Factors Training:

The Trust continues to provide bespoke training to staff from areas within which invasive procedures are carried out. It is anticipated that the training program will continue indefinitely to ensure that new staff entering the organisation are fully supported in providing the safest possible clinical care.

#### LocSSIPs Assurance model:

The most frequently utilised LocSSIPs have been mapped into a digital audit solution within the Trust’s Business intelligence reporting system LIGHT. The audit profile ensures that every invasive procedure undertaken is automatically checked at midnight for a corresponding and completed LocSSIP protocol in PENS. This provides a 100% sample size and the highest level of assurance that each and every patient has the safety protocol applied.

### Theatre LocSSIP performance

<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>Activity</th>
<th>Anaesthetic Room Sign</th>
<th>Operating Room Care</th>
<th>Operating Room Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>October</td>
<td>1187</td>
<td>1187</td>
<td>100%</td>
<td>1186</td>
</tr>
<tr>
<td>2018</td>
<td>November</td>
<td>1242</td>
<td>1235</td>
<td>99.40%</td>
<td>1235</td>
</tr>
<tr>
<td>2018</td>
<td>December</td>
<td>940</td>
<td>938</td>
<td>99.80%</td>
<td>936</td>
</tr>
<tr>
<td>2019</td>
<td>January</td>
<td>1179</td>
<td>1176</td>
<td>99.70%</td>
<td>1176</td>
</tr>
<tr>
<td>2019</td>
<td>February</td>
<td>1128</td>
<td>1127</td>
<td>99.90%</td>
<td>1127</td>
</tr>
<tr>
<td>2019</td>
<td>March</td>
<td>820</td>
<td>815</td>
<td>99.40%</td>
<td>820</td>
</tr>
</tbody>
</table>

### Ophthalmology LocSSIP performance

<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>Activity</th>
<th>Operating Room Care</th>
<th>Operating Room Care</th>
<th>Operating Room Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>October</td>
<td>560</td>
<td>553</td>
<td>98.80%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>November</td>
<td>508</td>
<td>504</td>
<td>99.20%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>December</td>
<td>401</td>
<td>400</td>
<td>99.80%</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>January</td>
<td>534</td>
<td>533</td>
<td>99.80%</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>February</td>
<td>529</td>
<td>528</td>
<td>99.80%</td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>March</td>
<td>423</td>
<td>418</td>
<td>99.80%</td>
<td></td>
</tr>
</tbody>
</table>
Anaesthetic led pain reduction invasive procedures

<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
<th>Activity</th>
<th>Operating Room Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>November</td>
<td>65</td>
<td>65</td>
</tr>
<tr>
<td>2018</td>
<td>December</td>
<td>68</td>
<td>68</td>
</tr>
<tr>
<td>2019</td>
<td>January</td>
<td>88</td>
<td>88</td>
</tr>
<tr>
<td>2019</td>
<td>February</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>2019</td>
<td>March</td>
<td>49</td>
<td>49</td>
</tr>
</tbody>
</table>

Interventional Radiology LocSSIP performance

<table>
<thead>
<tr>
<th>Month</th>
<th>Activity</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>October</td>
<td>205</td>
<td>199</td>
</tr>
<tr>
<td>November</td>
<td>195</td>
<td>192</td>
</tr>
<tr>
<td>December</td>
<td>163</td>
<td>158</td>
</tr>
<tr>
<td>January</td>
<td>189</td>
<td>180</td>
</tr>
<tr>
<td>February</td>
<td>170</td>
<td>166</td>
</tr>
<tr>
<td>March</td>
<td>106</td>
<td>106</td>
</tr>
</tbody>
</table>

Mortality

NHS England uses two different measures called hospital standardised mortality rate (HSMR) and summary of hospital level mortality indicator (SHMI) to measure mortality rates across NHS providers. Each is a subjective measure which needs to be interpreted with caution. Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) are risk adjusted indicators which measure whether mortality associated with hospitalisation and post discharge are in line with expectations.

This provides greater clarity in the understanding and monitoring of mortality. The HSMR is available monthly while the SHMI is published on a quarterly basis and includes deaths 30 days after discharge. Hospitals need to monitor their data and understand variation. A statistically higher than expected mortality may indicate problems with quality of care provided and should be investigated further using a robust and reliable method of evaluation and analysis.

Summary Hospital-level Mortality Indicator (SHMI)

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of patients treated. It covers all deaths reported of patients who were admitted and either die while in hospital or within 30 days of discharge.

The SHMI methodology does not make any adjustment for patients who are recorded as receiving palliative care. This is because there is considerable variation between trusts in the way that palliative care codes are used. As an interim solution pending the adoption of new national coding guidelines the HSCIC publish contextual indicators relating to palliative care that are published alongside the SHMI. The percentage of deaths with palliative care coding is one of these contextual indicators.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Total number of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>299</td>
</tr>
<tr>
<td>Q2</td>
<td>264</td>
</tr>
<tr>
<td>Q3</td>
<td>316</td>
</tr>
<tr>
<td>Q4</td>
<td>104*(up to Jan 2019 only)</td>
</tr>
<tr>
<td>Total</td>
<td>TBC</td>
</tr>
</tbody>
</table>
Summary Hospital-level Mortality Indicator (SHMI)

- Indicator Developed by the NHS Information Centre
- Counts deaths for ALL 213 diagnostic groups.
- Counts all Hospital deaths AND deaths within 30 days of Discharge.
- Does not Adjust for Palliative Care Coding
- Data is Published Quarterly

SHMI Benchmarking

The Trust SHMI score for 2018/19 was 105.40, within expected parameters.

This year we have made excellent progress in relation to ensuring we reduce mortality but work continues. The current rate of mortality for both SHMI and HSMR for the Trust are within expected number of deaths against the number reported.

Particular areas of focus for 2019/20 will include ongoing work to reduce mortality from Sepsis and Pneumonia.

Learning from deaths

Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Independent peer review of deaths occurring within the Trust is required to ensure we have provided the highest quality of patient care or that lessons are learned and disseminated across the organization if we have not.

The Trust has investigated deaths since 2012 through the use of a 2 stage independent peer review process.

In February 2017 the CQC set out new requirements for the investigation of deaths to run alongside the existing local processes. The National Quality Board has subsequently provided further guidance and recommendations for learning from deaths entitled ‘National Guidance for Learning from Deaths - A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care’.

In January 2018 the Trust updated its Mortality Peer Review process and in doing so, ensured compliance with all national guidance requirements. The Trust has an assurance target of 90% for deaths having an independent peer review.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Deaths</th>
<th>Number reviewed</th>
<th>Compliance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qtr1</td>
<td>391</td>
<td>373</td>
<td>95.40</td>
</tr>
<tr>
<td>Apr</td>
<td>153</td>
<td>148</td>
<td>96.73</td>
</tr>
<tr>
<td>May</td>
<td>122</td>
<td>116</td>
<td>95.08</td>
</tr>
<tr>
<td>Jun</td>
<td>116</td>
<td>109</td>
<td>93.97</td>
</tr>
<tr>
<td>Qtr2</td>
<td>359</td>
<td>352</td>
<td>98.05</td>
</tr>
<tr>
<td>Jul</td>
<td>122</td>
<td>117</td>
<td>95.90</td>
</tr>
<tr>
<td>Aug</td>
<td>119</td>
<td>119</td>
<td>100.00</td>
</tr>
<tr>
<td>Sep</td>
<td>118</td>
<td>116</td>
<td>98.31</td>
</tr>
<tr>
<td>Qtr3</td>
<td>441</td>
<td>415</td>
<td>94.10</td>
</tr>
<tr>
<td>Oct</td>
<td>127</td>
<td>122</td>
<td>96.06</td>
</tr>
<tr>
<td>Nov</td>
<td>134</td>
<td>131</td>
<td>97.76</td>
</tr>
<tr>
<td>Dec</td>
<td>180</td>
<td>162</td>
<td>90.00</td>
</tr>
<tr>
<td>2019</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qtr4</td>
<td>433</td>
<td>344</td>
<td>79.45</td>
</tr>
<tr>
<td>Jan</td>
<td>163</td>
<td>151</td>
<td>92.64</td>
</tr>
<tr>
<td>Feb</td>
<td>125</td>
<td>90</td>
<td>72.00</td>
</tr>
<tr>
<td>Mar</td>
<td>145</td>
<td>103</td>
<td>71.03</td>
</tr>
<tr>
<td>Total</td>
<td>1624</td>
<td>1484</td>
<td>91.38</td>
</tr>
</tbody>
</table>

A further 364 deaths were reviewed during 2018/9 for the reporting year 2017/8.

There were 4 deaths following review by the Mortality QA group with an avoidability score of greater than 4.

Further investigation of the deaths where harm may have been caused has led to the following lessons being identified:
- The need for a review of the anticoagulation policy for patients who have had a PEG inserted
- Suspended medications need to be regularly reviewed and re-commenced if appropriate
- Patients should continue to be regularly reviewed and the review documented if there is a delay in stepping them down from a high dependency area to a ward
- The NEWS escalation policy should be followed for all patients including when they have recently been stepped down from a critical care area.

An action plan has been developed for each investigation which incorporates the lessons learned
The Trust’s Mortality Peer Review process asks the initial independent peer reviewer to rate deaths as being either unavoidable or potentially avoidable. All deaths rated as potentially avoidable subsequently undergo secondary multidisciplinary review by the Mortality Quality Assurance Group.

Learning Disabilities Mortality Review

The Learning Disabilities Mortality Review (LeDeR) Programme aims to make improvements to the lives of people with learning disabilities. It identifies any potentially modifiable factors associated with a person’s death, and works to ensure that these are not repeated elsewhere.

All LeDeR deaths are reviewed by the Mortality QA group, irrespective of rated avoidability or the presence/absence of problems with the patients care. The Trust participates actively in the National LeDeR program and submits all deaths of people with learning disabilities for LeDeR review. The regional LeDer program has recognised the Trust as a centre of good practice.

Learning from deaths programme

- The Trust’s methodology for Learning from Deaths changed to the RCP Structured Judgement Review model on the 1st of January 2018 - This is a 2 stage independent peer review process:
  - Stage 1 - Initial independent speciality consultant peer review focusing on quality of care and identifying problems with care
  - Stage 2 - A defined group of deaths will proceed to independent secondary review by the Mortality Quality Assurance Group which will focus on avoidability and lessons learnt
- The Trust’s new policy has introduced a new model for sharing and implementing the output from Learning from Deaths peer reviews to ensure lessons learnt are rapidly disseminated amongst clinical staff and provide additional assurance with regards to actions from the Mortality Quality Assurance Group
- The Trust’s new policy also increases the involvement of bereaved relatives in the Learning from Deaths process and increases transparency through the publication of the Learning from Deaths Policy and Quarterly Learning from Deaths Board reports on the Trust’s external website.

Participating in CQUINs

NHS Trusts (providers of services) are required to make a proportion of their income conditional on quality and innovation. This is carried out and monitored through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The CQUIN framework forms one part of the overall approach on quality, which includes: defining and measuring quality, publishing information, recognising and rewarding quality, improving quality, safeguarding quality and staying ahead. It is intended to support and reinforce other elements of the approach on quality and existing work in the NHS by embedding the focus on improved quality of care in commissioning and contract discussions. CQUINs encourage and reward organisations that focus on quality improvement and innovation in commissioning discussions to improve quality for patients and innovate.

For 2017/18, there were acute contract CQUIN and specialist commissioning indicators made up of 8 nationally agreed indicators (acute) and 5 national defined indicators (specialist commissioning). As a result of participation in the CQUIN framework, the Trust continues to make significant improvements to both patient experience and outcomes. The Trust has agreed a number of national and local CQUIN indicators with its Commissioners for 2017 – 2019 as part of a two year programme. Further details of the agreed goals are available on request via anthony.duffy@rlbuht.nhs.uk

Acute Services CQUIN Schemes 2018/19 (awaiting results from Q4)

National Health and wellbeing CQUIN

This CQUIN is made up of three work streams which involve improving the health and wellbeing of staff, and collaborating with suppliers of food and drink across the Trust. The first CQUIN relates to achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health
and wellbeing, MSK and stress. The two questions do not have to be pre-selected before the staff survey results, with 50% of the value of this indicator relating to performance in one question and the remaining 50% of the value relating to performance in a second question. Various schemes, initiatives and services will be introduced to improve the health and wellbeing of our staff.

**Annual submission at Q4**
Firstly, maintaining the four changes that were required in the 2016/17 CQUIN in both 2017/18 & 2018/19 and Secondly, introducing three new changes to food and drink provision,

- **a.)** Outlets will be eligible for the CQUIN where they have signed up to the national SSB reduction scheme, and totals litres of SSBs sold account for 10% or less of all litres of drinks sold in 2018/19.
- **b.)** 80% of confectionery and sweets do not exceed 250 kcal.
- **c.)** At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g

**Annual submission at Q4**
The final workstream relates to flu vaccinations and compliance against the 75% target.

**Annual submission at Q4 – full compliance**

**National Sepsis CQUIN**
The sepsis CQUIN is split into the following.

**Timely identification and treatment of sepsis – Emergency department – screening, treatment and 3 day review**

**Timely identification and treatment of sepsis – inpatients – screening, treatment and 3 day review**

Given the pressure on the ground floor, although there has been compliance with screening, there was difficulty in achieving the treatment to antibiotics element. Within this specific CQUIN, there has also been a difficulty with identifying inpatients on a specific sepsis pathway, despite the impact of e-sepsis. Antibiotic treatment will be measured from diagnosis NOT treatment, and e-Sepsis should be able to identify inpatients with sepsis and will allow the sepsis nurse team to conduct clinical duties instead of data collection.
Antimicrobial consumption
Reduction in antibiotic consumption per 1,000 admissions.

Improving services for people with mental health needs who present to A&E.
20% reduction in A&E attendances of those within the selected cohort of frequent attenders in 2016/17 who would benefit from mental health and psychosocial interventions. Trust has worked closely with Merseycare and other external bodies to improve triage and care plans for patients who present to A&E with mental health needs. To date, there was a 45% reduction in the number of attendances for the specific cohort.

Chart highlighting reduction in mental health attendances

Offering advice and Guidance (A&G)
The scheme requires providers to set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative. A&G services operational for specialties covering at least 35% of total GP referrals by start of Q4 and sustained across the quarter. For Q3, the Trust identified further areas to pilot this work, which should reduce the number of non-urgent 1st O/P referrals that the Trust currently receive. Collaborative working has taken place internally and externally with Liverpool CCG and local GPs. To date, the Trust had received over 600 requests with only 4.7%
of the requests turning into a referral. The Trust only gained partial compliance as a result of the response time, which was slightly below the 48 hour turnaround time.

Chart highlighting increase in the number of Advice and Guidance requests

![Graph showing increase in Advice and Guidance requests]

**Preventing ill health by risky behaviours - alcohol and tobacco:**
The scheme requires providers to submit information relating to the number of patients who have been screened for alcohol and tobacco usage and either in receipt of or referred to appropriate advice and guidance.

The Trust has continued to struggle to meet the requirements of the CQUIN. The project team continue to engage with IT to ensure system upgrades are in place to ensure that patients can be screened and referred as appropriate. The Trust was recently successful in a bid to Cancer Alliance to fund work relating to smoking cessation. The CURE (Ottawa) model is outlined in the NHS ten year plan, and the team hope that securing the funding will assist with the delivery of the CQUIN.

**Specialist Commissioning Services CQUIN Scheme 2018/19**
The Trust is compliant against the following CQUINs which are subject to continuous external review and validation by North of England Specialist Commissioning team.

- **Clinical Utilisation Review**
- **Haemoglobinopathy**
- **Haemtrak**
- **Hepatitis C**
- **Medicines Optimisation**

**Public Health England Screening CQUINs**
The Trust has participated in screening CQUINs which relate to improving the provision of patient information to patients and visitors as regards the specific screening programmes we offer to patient. The Trust has satisfied all the criteria relating to the monthly requirements. The CQUIN related to the following services:

- **Bowel Screening**
- **Diabetic Eye Screening**
- **Breast Screening**
- **AAA Screening**
- **Cervical screening**

The Trust has continuously been compliant against the Public Health screening CQUIN.
<table>
<thead>
<tr>
<th>National</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Introduction of health and wellbeing initiatives</td>
<td></td>
<td></td>
<td></td>
<td>Full year submission</td>
</tr>
<tr>
<td>1.2 Healthy food for NHS staff, visitors and patients</td>
<td></td>
<td></td>
<td></td>
<td>Full year submission</td>
</tr>
<tr>
<td>1.3 Improving the uptake of flu vaccinations for front line staff with Providers</td>
<td></td>
<td></td>
<td></td>
<td>75.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sepsis</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Reduction in antibiotic consumption per 1,000 admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2 Empiric review of antibiotic prescriptions and 3 day review</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1a A&amp;E Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1b Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2a Inpatient Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2b Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other national CQUINs</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving services for people with mental health needs who present to A&amp;E</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offering Advice and Guidance (A&amp;G)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Awaiting findings from local commissioners*

**Key:**  
- NR – not required for that quarter  
- Fully achieved  
- Partially achieved  
- Failed
Working with the CQC for continual improvement

The Trust continues to maintain an active registration with CQC and in the 2018/19 we added six locations following the addition of some community services and satellite dialysis units.

The Trust was inspected by CQC in July 2016 and this resulted in an overall ‘Good Rating’ with ‘Outstanding’ for End of Life care. Since the inspection, we have continued to monitor and test the actions we put in place to address the areas for improvement identified by CQC.

In 2018/19, the Trust were inspected as part of the new methodology introduced by CQC. This included the new well-led assessment and a use of resources assessment undertaken by NHS Improvement. At the time of writing the Quality Account, we are awaiting the outcome from this process.
How we did against our 18/19 Quality Account Priorities

Each year in the Quality Account, the Trust sets key targets aimed at delivering high quality care to patients. In this section, the priorities for last year are reviewed and progress against them described.

<table>
<thead>
<tr>
<th>Quality Account Priority</th>
<th>2018/19</th>
<th>Current Status</th>
<th>Supporting Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient safety</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25% reduction in falls leading to moderate harm or greater per 100 bed days</td>
<td></td>
<td>Various initiatives have ensured that the Trust remain on target to achieve this specific reduction in falls that cause moderate to severe harm. Referrals to the falls team have increased significantly which ensures that patients who are at risk of falling receive appropriate interventions to reduce the risk of falling.</td>
<td></td>
</tr>
<tr>
<td>10% reduction in the number of hospital acquired pressure ulcers per 1000 bed days</td>
<td></td>
<td>There has been an improvement in the number of reported hospital acquired pressure ulcers for grades 2, 3 and 4 despite non-compliance against the 10% reduction</td>
<td></td>
</tr>
<tr>
<td>Compliance against 95% target of VTE assessment target</td>
<td></td>
<td>Continued improvement in the VTE assessment compliance, despite being marginally below the national target. The Trust have recently introduced a new assessment process</td>
<td></td>
</tr>
<tr>
<td><strong>Patient experience</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of MECC (Making Every Contact Count)</td>
<td></td>
<td>Trust compliant against target.</td>
<td></td>
</tr>
<tr>
<td>Improvement in FFT compliance and response rates</td>
<td></td>
<td>Trust marginally below target rate, specifically for response rates. The patient Experience sub committee is monitoring the specific KPI on a monthly basis.</td>
<td></td>
</tr>
<tr>
<td>Zero tolerance on 12 hour trolley waits</td>
<td></td>
<td>Trust compliant against target</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical effectiveness</strong></td>
<td></td>
<td>The Trust remains within the expected parameters, despite being slightly over the threshold of 100.</td>
<td></td>
</tr>
<tr>
<td>Level 1, 2, and 3 complaints responded to in a timely manner</td>
<td></td>
<td>The Trust marginally missed our internal target for response time. Despite this, the Trust have maintained an improved performance in the latter part of the year.</td>
<td></td>
</tr>
<tr>
<td>Compliance against targets relating to mandatory training</td>
<td></td>
<td>Trust compliant against internal target.</td>
<td></td>
</tr>
</tbody>
</table>
Falls performance 18/19

The Trust set out an ambitious 25% reduction target for inpatient falls that led to harm graded moderate or above in 18/19. Following significant improvements in falls prevention strategies and the addition of technological prevention measures, the Trust has achieved a 55% reduction in falls resulting in moderate harm or above during 18/19.

This has included:

- Introduction of pressure sensing falls alarms
- Introduction of bay tagging to align staff supervision to the highest risk patients
- Introduction of close observation protocol
- Re-design of falls risk assessment tools to include
  - Visual assessment
  - Delirium assessment
  - Bed rail assessment

Pressure Ulcers

The Trust’s 18/19 target of a further 10% reduction in Hospital Acquired pressure ulcers has not been achieved; however, the Trust continues to achieve one of the lowest rates of hospital Acquired pressure ulcers in the NHS and remains the highest performing Trust within its peer group.
We have established numerous priorities through management with key stakeholders, and based upon on the CQC methodology domains of Safe, Caring, Responsive, Effective and Well-led, which also highlights how quality is defined within the NHS as defined below.

**Patient safety**
This means protecting people who use services from harm and injury and providing treatment in a safe environment.

**Patient experience**
This means ensuring that people who use services have a positive experience of their care and providing treatment with compassion, dignity and respect.

**Clinical effectiveness**
This means providing care and treatment to people who use services that improves their quality of life.

**Identification of Quality Account Priorities**
To ensure that our staff, our external partners and our patient representatives and local communities were able to influence the content of this report, a quality improvement and engagement event took place on 29th March 2019 to hear the views and experiences and consequently propose priority areas for inclusion into the Quality Account. We invited suggestions on what our main quality improvement priorities should be for this year (2018/19) and what information should be included in this year’s Quality Account report in addition to the mandated content as set by the Department of Health.

We have also held a number of listening weeks that have given patients and stakeholders the opportunity to talk to us directly about their experience and about developments that are happening in the future. We have worked with partners such as Healthwatch to gain valuable feedback that has shaped the direction of our areas for quality improvement.
Rationale for inclusion

The vision of the Trust is to deliver the highest quality healthcare driven by world class research for the health and wellbeing of the population over our hospital sites. In order to protect our patients from avoidable harm, these three distinct objectives will contribute to ensuring out patients are safe. Our patient safety improvement programmes continue to improve outcomes including AKI, Falls, Pressure Ulcers and VTE. New areas of focus include timely observations in line with the rollout of eNEWS2, 100% compliance with sepsis screening, zero tolerance of MRSA and to remain within trajectory against CDT.

Monitoring of compliance against the deteriorating patient and the appropriate assessment of patients for sepsis has been included as objectives for 19/20 as this has been stepped down as a CQUIN for 19/20. Keeping patients safe from infection as a patient within the Trust is of paramount importance. The trajectory has increased significantly for CDT and by including within objectives of the Quality Account, this adds greater scrutiny to performance against this specific target.

How progress to achieve the priority will be monitored

Compliance against deteriorating patient and sepsis screening will be captured and monitored on the Trust IT whiteboard and e-Sepsis systems. Monthly data will be presented to Quality Governance Committee as part of the Integrated Quality and Performance dashboard. Performance on this will also be monitored through the Trust Patient Safety Committee and reported to Board on a quarterly basis. Infection rates are also monitored via the monthly Infection Prevention and Control meetings and in collaboration with our commissioning colleagues.
Patient Experience

Compliance with complaints response times across all levels

Improvement in Friends and Family Test (FFT) compliance and response times

Rationale for inclusion

To ensure that we are measured against the care that we provide for our patients by using patient feedback to drive improvements to services and care.

By ensuring that we measure ourselves against the national Friends and Family Test (FFT), and Inpatient Survey targets, to understand compliance and areas of potential improvement. The Trust continue to perform comparatively well against national surveys, but there are still areas that the Trust can improve upon. In order to improve the quality and response to our patient complaints, this has been included as an objective as part of this years Quality Account.

How progress to achieve the priority will be monitored

Monthly data is presented to the Quality Governance Committee as part of the Integrated Quality and Performance dashboard. Performance on this will also be monitored monthly through the Trust Patient Experience Committee and reported to Board on a quarterly basis.
Clinical Effectiveness

Rationale for inclusion
To ensure that patients receive appropriate care and treatment in a timely manner, improving patient outcomes by greater use of key clinical systems and care pathways. To date, the Trust has made good progress against specific mortality targets by implementing various pathways aligned to national best practice, and improving outcomes for patients. Mortality reduction is a specific strategic aim of the Trust which measures that our patients are receiving appropriate care and treatment. In line with the safety standards published by NHS England and to promote and provide safer surgical care, compliance with the Trust 500+ LocSSIPs have also been included.

How progress to achieve the priority will be monitored
Monthly data will be presented to the Quality Governance Committee as part of the Integrated Quality and Performance dashboard. Performance on this will also be monitored through divisional operational meetings and reported to Board on a quarterly basis.

Remain within expected range for SHMI (Summary Hospital-level Mortality Indicator)

Screen >90% of in-hospital deaths in line with local policy

100% compliance with Local Safety Standards for Invasive Procedures (LocSSIPs)
Patient Experience

Experience of care, clinical effectiveness and patient safety together make the three key components of quality in the NHS. Good care is linked to positive outcomes for the patient and is also associated with high levels of staff satisfaction. Patients tell us that they care about their experience of care as much as clinical effectiveness and safety. They want to feel informed, supported and listened to so that they can make meaningful decisions and choices about their care. They want to be treated as a person not a number and they value efficient processes.

The Government has made it clear that the patient experience is a crucial part of quality healthcare provision. The NHS Constitution, the Outcomes Framework and the NICE Quality Standards for Experience reinforce the need for patient centred care. The trust monitors the experience of patients by asking a series of questions from the national in-patient survey to continually monitor and identify areas for further improvement and attention.

Providing the very best patient experience is essential and we want to ensure effective treatment is delivered in a comfortable, caring and safe environment by staff who demonstrates our trust values.

The trust has taken the following actions to drive the improvements in responses and addressing the areas highlighted as requiring improvement.

- Development of a comprehensive forward plan and strategy to address the areas for improvement across the organisation

- The implementation plan, dashboard and progress report is presented to the monthly patient experience committee were colleagues from the patient council and health watch challenge the trust position and actions taken to drive the improvements required.

- Continue to ensure that the board receives regular and meaningful reports on patient experience including instances where the patient experience has been poor through patient stories.

- Continue to hold “Listening events” which have proven to be very successful in gathering feedback from patients, relatives, carers and visitors to the Trust to inform service development and improvements which will be shared with the divisions and departments. A “you said we did” poster will be published to share with patients, relatives, visitors and staff in the main entrances of both hospital sites.

- Continue to publish “Listening” newsletters to provide an update on activities and events held within our hospitals to promote patient engagement and experience.

Improving patient and family care is paramount to the trust development and through the involvement of patients and families we utilised this to develop a patient and Carer Experience Strategy in conjunction with Aintree University Hospitals Trust which will support our journey from 2019. This draft strategy sets our direction of travel, focusing on delivering high quality patient care and will take us right up to the move into our new hospital.
Patient Friends and Family Test

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use our services should have the opportunity to provide feedback on their experience.

It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming NHS services and supporting patient choice. Patient comments also identify areas where improvements can be made so that the trust can make care and treatment better for everyone.

Since it was initially launched in April 2013, the FFT has been rolled out in phases across the trust in all in-patient areas, accident and emergency, day cases and outpatients departments, giving all patients the opportunity to leave feedback on their care and treatment.

The feedback gathered through the FFT is being used in the trust to stimulate local improvements and empower staff to carry out the sorts of changes that make a real difference to patients and their care. FFT will continue to provide a broad measure of patient experience that can also be used alongside other patient experience feedback to inform service improvement and patient choice.

Results for the year have been extremely positive, with the majority of patients stating they would recommend Royal Liverpool and Broadgreen Hospital to their friends and family, with an overall improvement on last year.

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>93.70%</td>
<td>94.70%</td>
<td>94.15%</td>
<td>75%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>91.90%</td>
<td>91.50%</td>
<td>92.02%</td>
<td>75%</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>81%</td>
<td>81%</td>
<td>79.59%</td>
<td>75%</td>
</tr>
</tbody>
</table>

Complaints, Concerns and PALS

The NHS Complaints system is a powerful and useful mechanism for improving the quality of care and the patient experience, both for individual complainants and for the wider NHS, thus creating a culture of learning from mistakes and putting things right.

Complaints about the NHS are a valuable way of identifying issues in the service where change is needed. Acknowledging these issues and taking steps to rectify any problems identified is vital to create an open and honest NHS. Complaints are welcomed with a positive attitude by the Trust Board and are valued as feedback on service performance in the search for improvement.

Patient safety is our priority and we are committed to ensuring all of our patients have a positive experience. However, we recognise that we do not always get it right first time. If our service has not been as good as it should be we will make sure we learn lessons and share them across the organisation.

During the year, we have worked to improve the way we respond to and learn from complaints.
Informal complaints

These are complaints or concerns that are raised at ward or departmental level. In the last 12 months we received 2,082 informal complaints. This compares to 1,742 the previous year, an increase of 16%. All of these informal complaints were dealt with by PALS within the response target of five working days. The increase has occurred due to our referral system through online media applications and due to our goal to attempt to address as many complaints or concerns as possible at source.

Formal complaints

In 2018/19, we addressed 331 formal complaints in line with our target of 25/35/ or 60 working days with a similar number in 2017/18. We met our response time in, 76% at the time of reporting (28 remain in time).

National Cancer Survey 2017

The National Cancer Patient Experience Survey is for adult patients (16+) with a confirmed diagnosis of Cancer from the trust after an inpatient stay or day case attendance for a cancer related treatment. It is the 7th iteration of the survey and is designed to monitor national progress on cancer care, to provide information to drive local quality improvements as well as other quality measures. The survey is overseen by a national Cancer Patient Experience Advisory Group who set the principles and objectives of the survey programme.

Patients were asked their opinion on every aspect of the cancer care they had received. This ranged from their first visit to the GP to them receiving their treatment, and included questions on communication, compassion and support. Patients were also given the opportunity to add any additional information they felt was important.

The sample of patients are drawn from all adult patients (aged 16 and over), with a primary diagnosis of cancer, who have been admitted to hospital as inpatients for a cancer related treatment, or who were seen as day case patients for cancer related treatment, and have been discharged between 1st April 2017 and 30th June 2017. This year saw a significant decrease in numbers of patients which was expected as the Haemato-oncology service was transferred away from the trust resulting in a reduction in recorded activity.

The purpose of collecting and analysing data via this survey is to:

- Enable local providers to assess their performance improvement with other providers over time
- Enable commissioners to assess local improvements in cancer patient experience
- Provide NHS England with an up to date overview of cancer patient experience across England
- Enable patients to make informed choices about where to go for cancer treatment

The overall trust rating was 9.1% which is up from last year (9.0%) and above the national average of 8.8%.
Key for tables below: - □ Below National Average, □ Same as National Average, □ Above National Average

<table>
<thead>
<tr>
<th></th>
<th>RLBUHT 2015</th>
<th>RLBUHT 2017</th>
<th>Nat Av 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely involved as much as they wanted to be in decisions about their care and treatment</td>
<td>82%</td>
<td>80%</td>
<td>78%</td>
</tr>
<tr>
<td>Given the name of a Clinical Nurse Specialist</td>
<td>92%</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td>It was quite or very easy to contact their Clinical Nurse Specialist</td>
<td>90%</td>
<td>88%</td>
<td>86%</td>
</tr>
<tr>
<td>Overall, they were always treated with dignity and respect</td>
<td>91%</td>
<td>88%</td>
<td>88%</td>
</tr>
<tr>
<td>Hospital staff told them who to contact if they were worried after they left hospital</td>
<td>96%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment.</td>
<td>60%</td>
<td>62%</td>
<td>62%</td>
</tr>
</tbody>
</table>

**Staff survey 2018**

The annual staff survey achieved a response rate of 41.7% which is below the 48% achieved in the previous year. The Trust chose to use a new survey provider this year (Clever Together), which was the same provider chosen by Aintree University Hospitals NHS Foundation Trust. The aim of this was to facilitate faster turnaround of feedback reports and enable the two Trusts to work in a more joined up way with a view to preparing effectively for merger. The survey was a full census (i.e. all staff were asked to participate) and a small number of additional questions were included about the Freedom to Speak Up Guardian and how staff feel about the proposed merger.

The main change in the format of the survey this year is a reduced number of summary indicators – instead the questions have been presented in the form of ten main themes:

- equality, diversity & inclusion
- health and wellbeing
- immediate managers (which includes providing support and feedback)
- morale (a new area for 2018)
- quality of appraisals
- quality of care
- safe environment - bullying and harassment
- safe environment – violence
- safety culture
- staff engagement

Key Themes and National Comparisons
The graph below shows the Trust's performance in each of the themes compared to the best, worst and average across benchmarked organisations:

The NHS Staff Survey Coordination Centre has provided significance testing for each of the themes:
Freedom to Speak Up

Following on from the Public Inquiry into Mid Staffordshire NHS Foundation Trust in February 2013, Sir Robert Francis QC undertook the Freedom to Speak Up Review (2015); in order to ascertain the failings in the ability for staff within the NHS to be able to speak up safely about any concerns into patient safety. It was identified that a defensive culture within the NHS had begun to grow, discouraging staff from raising concerns and not treating those who did in a fair way.

Sir Robert Francis identified some overarching goals in promoting an honest and open culture that is able to face the truth about the services provided within the NHS. One of those goals was to appoint a Freedom to Speak Up (FTSU) Guardian within every NHS Trust and a National Independent Guardian to oversee the NHS as a whole. The CQC requires Trusts to evidence that they have robust arrangements in place to handle concerns including the appointment of a FTSU Guardian, as part of their ‘well-led’ domain. The Trust appointed the Assistant Director of Patient Safety and Human Factors to the role of FTSU Guardian in June 2017, and also appointed five FTSU champions from various professional and ethnic backgrounds to enhance the approachability and accessibility of the FTSU team.

The Trust has seen significant improvements in both the awareness and confidence of staff to raise concerns via the FTSU guardian as depicted in the below graph.

<table>
<thead>
<tr>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff recommended for care</td>
<td>83.03%</td>
<td>Staff recommended for care</td>
</tr>
<tr>
<td>Staff recommended for work</td>
<td>66.07%</td>
<td>Staff recommended for care</td>
</tr>
<tr>
<td>Staff recommended for work</td>
<td>79.10%</td>
<td>Staff recommended for care</td>
</tr>
<tr>
<td>Staff recommended for work</td>
<td>61.64%</td>
<td>Staff recommended for care</td>
</tr>
<tr>
<td>Staff recommended for work</td>
<td>80.74%</td>
<td>Staff recommended for care</td>
</tr>
<tr>
<td>Staff recommended for work</td>
<td>65.50%</td>
<td>Staff recommended for care</td>
</tr>
</tbody>
</table>

(Q3 forms part of the annual staff survey)

For Staff FFT –

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Staff recommended for care</th>
<th>Staff recommended for work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>83.03%</td>
<td>66.07%</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>79.10%</td>
<td>61.64%</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>80.74%</td>
<td>65.50%</td>
</tr>
</tbody>
</table>

Each concern is held on the guardian’s database and remains open until such a time as the trust has provided adequate assurance to the concern raiser that their issues have been adequately addressed. Since the start of this process a total of fifty concerns have been raised of which thirty one have been addressed in full and closed.
Data Quality

Good quality information underpins sound decision making within the Trust and contributes to the improvement of healthcare services. The Trust is committed to improving data quality and has a Data Quality Strategy and Information Quality Assurance Policy in place, together with an Information Quality Department who have a range of processes to support the Trust. Work includes monitoring a range of national and internal indicators, and carrying out audits. These cover a range of data quality dimensions, with a large annual accuracy audit and regular completeness and validity checks. We maintain a suite of data validation reports and processes against our Patient Administration System (iPM), and our clerical officers review and update systems as necessary in close liaison with Directorate staff.

We recognise the need to have regular dialogue with our local commissioners (CCGs) and data quality is discussed within monthly Information Sub Group meetings where the Trust and CCG review topics including data quality validations and the Data Quality Improvement Plan (DQIP).

We monitor a wide range of indicators via the published Data Quality Dashboards, which are based on our SUS data for Admitted Patient Care (APC), Outpatients (OP) and Accident & Emergency (A&E). Two of the key fields monitored are:

- **NHS Number.** The NHS Number is a unique number that identifies an individual patient and is used to support direct patient care. It can identify patients in systems locally and nationally and is also used for ensuring patients are treated safely and correctly. Using the NHS Number is generally acknowledged as an indicator of good data quality and underpins world class care whilst improving patient safety. NHS Number coverage published in the Data Quality Dashboards (based on SUS data) was as follows for April 18– March 19:

<table>
<thead>
<tr>
<th>Indicator number</th>
<th>Apr 18</th>
<th>May 18</th>
<th>Jun 18</th>
<th>Jul 18</th>
<th>Aug 18</th>
<th>Sep 18</th>
<th>Oct 18</th>
<th>Nov 18</th>
<th>Dec 18</th>
<th>Jan 19</th>
<th>Feb 19</th>
<th>Mar 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>% NHS Number Coverage: Inpatients</td>
<td>99.65%</td>
<td>99.50%</td>
<td>99.77%</td>
<td>99.77%</td>
<td>99.65%</td>
<td>99.77%</td>
<td>99.73%</td>
<td>99.61%</td>
<td>99.24%</td>
<td>99.33%</td>
<td>99.18%</td>
<td>98.97%</td>
</tr>
<tr>
<td>% NHS Number Coverage: Outpatients</td>
<td>99.95%</td>
<td>99.98%</td>
<td>99.90%</td>
<td>99.94%</td>
<td>99.97%</td>
<td>99.98%</td>
<td>99.98%</td>
<td>99.94%</td>
<td>99.88%</td>
<td>99.93%</td>
<td>99.92%</td>
<td>99.93%</td>
</tr>
</tbody>
</table>

- **General Medical Practice Code.** The inclusion of a valid General Medical Practice Code is also vital to ensure both patient care (ensuring that letters go to the correct GP) and for commissioning purposes. The percentage of records in the published data which included a valid General Medical Practice Code was 100% for Admitted Patient Care, Outpatients and Emergency care.

Information Quality

Clinical coding Auditors have worked closely with infection disease Clinicians and Advancing Quality Specialist Nurses throughout the year, this collaborative work ensures all data provided to clinical coders is robust which allows correct assignment of clinical coding, this supports quality data and revenue.

NHS Improvement have also identified coding as an area for support and we are currently working with them looking at our processes and procedures. Their feedback to date is positive, they are very happy with working practises in place.
Information Governance toolkit attainment Levels

Information Governance (IG) and Information Security (IS) is about how NHS and social care organisations and individuals manage information.

25th May 2018 saw the implementation of the new General Data Protection Regulations followed closely by the UK’s Data Protection Act 2018.

The Trust used the (beta) first of type new Data Security and Protection Toolkit (DSPT) this year, and continued to maintain high standards for IG/IS. The 10 assertions are based on the National Data Guardian’s data security standards, and there are 100 mandatory and 49 non-mandatory sub-assertions. The Trust has been focused on completing just the mandatory (sub) assertions although a couple of the non-mandatory ones have been completed. The Trust submitted its assessment on time.

The Trust has consistently achieved compliance and the DSPT score for the year 2018/19 was assured as substantial by MIAA (Mersey Internal Audit Agency) for the 4 assertions audited.

<table>
<thead>
<tr>
<th>National Data Guardian’s data security assertions</th>
<th>Mandatory sub-assertions</th>
<th>Non-mandatory sub-assertions</th>
<th>Externally audited</th>
<th>Level of achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Confidential Data</td>
<td>41</td>
<td>9 (3 met)</td>
<td>Yes</td>
<td>Substantial</td>
</tr>
<tr>
<td>Staff Responsibilities</td>
<td>4</td>
<td>7</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>10</td>
<td>2</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Managing Data Access</td>
<td>6</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Process Reviews</td>
<td>1</td>
<td>3 (1 met)</td>
<td>Yes</td>
<td>Substantial</td>
</tr>
<tr>
<td>Responding to Incidents</td>
<td>11</td>
<td>7 (1 met)</td>
<td>Yes</td>
<td>Substantial</td>
</tr>
<tr>
<td>Continuity Planning</td>
<td>6</td>
<td>8</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Unsupported Systems</td>
<td>9</td>
<td>0</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>IT Protection</td>
<td>9</td>
<td>3 (2 met)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Accountable Suppliers</td>
<td>3</td>
<td>6 (4 met)</td>
<td>Yes</td>
<td>Substantial</td>
</tr>
<tr>
<td>TOTALS</td>
<td>100</td>
<td>49 (11 met)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Equality and Diversity

The Trust is committed to meeting the public sector general equality duty (PSED) under the Equality Act 2010 to collect and publish workforce and patient equality monitoring information, conduct equality impact analysis and set equality objectives every four years.

To demonstrate how it meets its PSED, the Trust participates in the NHS Equality Delivery System (EDS2). EDS2 is a national tool for reviewing and assessing equality performance with stakeholders, bringing equality into core business and identifying future priorities and actions.
We aim to improve the way people from different groups are treated so that there is no unjustified difference in outcomes or experience based on protected characteristics (age, gender, race, disability, religion or belief, marital or civil partnership status, sexual orientation, gender reassignment, pregnancy and maternity). The four goals of the EDS are:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and well supported staff
- Inclusive leadership at all levels.

The Trust’s performance under EDS2 was last assessed with Healthwatch in March 2015 (11 outcomes assessed as achieving, 6 as excelling and 1 developing). In addition to the above the Trust participates in the national workforce race equality standard (WRES) and is working toward full implementation of the Accessible Information Standard. From August 2019 it will participate in the new workforce disability equality standard.

The Trust agreed its equality objectives for 2016 to 2020 following consultation and agreement with stakeholders. These were developed as a result of an analysis of equality performance to identify areas for improvement. The objectives are:

1. Embed analysis of patient and employee experience by protected characteristics in to core business
2. All service changes to explicitly take account of the needs of those with protected characteristics
3. Redesign policy and process to improve reasonable adjustments for disabled staff
4. Set workforce diversity targets (disclosure, recruitment and staff survey targets) to reduce differences in experience and improve workforce diversity
5. Improve disabled access

The overarching aims of the equality objectives is to improve patient and employee experience from an equality perspective and; to ensure that equality and human rights are at the forefront of all Trust decisions relating to internal processes, strategies and service developments. The E & D Sub-Committee forward plan is developed annually to support meeting the equality objectives, and to improve outcomes in EDS2

**Achievement of Equality Objectives**

- The Trust extended equality monitoring data collection to all protected characteristics for both staff and patients and developed the processes to collect the data and systems to record this information. Patient equality data is monitored to understand the demographics of patients accessing services in comparison to the population served, and analyse survey results from an equality perspective. This allows the Trust to identify if all areas of the community are accessing services and monitor performance outcomes to identify any differences in experience and outcomes between people from different groups.

- An equality dashboard has been introduced that services can use to access equality data. Equality monitoring information is used to flag when a patient with a declared learning disability, visual impairment, hearing impairment or physical disability is recorded on the system so that they can be contacted and supported appropriately when they are in the hospital.

- The Trust has developed a comprehensive equality monitoring performance framework to monitor the patient and workforce profile and outcomes from an equality perspective across all protected characteristics. The equality monitoring reports are produced and published annually on the trust website. The monitoring information is
analysed and reported to E & D Sub-committee and actions are agreed to investigate and address any identified issues. Workforce profile monitoring is included in regular performance reports for each service. We have also delivered equality monitoring training to all of our booking staff so that they can encourage patients to respond to the equality monitoring questionnaire and answer questions.

- The Trust agreed an Accessible Publications policy that sets out how the Trust will provide information in a range of accessible formats, the policy is applicable to all forms of information including patient information leaflets, corporate reports and appointment letters and arrangements are in place to enable the production of accessible information. In addition the Trust collects and records information from patients to meet the communication support requirements through the Accessible information standard.

- Targets were set to increase disclosure of equality data in the workforce, which has resulted in an overall increase in disclosure. To change the workforce profile over time and decrease differences in experience identified in equality monitoring reports and the staff survey, recruitment targets have been set and a number of initiatives have been undertaken. These include targeting unconscious bias training at managers involved in recruitment panels; targeting recruitment training to BME and disabled staff and; the future recruitment of Cultural Ambassadors who will be tasked with overseeing investigation, grievance, disciplinary and recruitment processes to ensure the elimination and/or mitigation of bias within those processes. The Trust continues to take action to encourage staff to update and disclose their equal opportunities monitoring.

- The Trust has invested significantly in developing the competence of the workforce through mandatory equality and diversity training, equality and human rights training for managers, race equality awareness, deaf and visual impairment awareness, LGBT awareness, unconscious bias testing and training, managing cancer in the workplace and physical disability and learning disability awareness training; basic SSL training and practical visual impairment training; and this year Reasonable Adjustment Training for managers was introduced.

What is going well?

- To improve the quality and experience of accessing Trust provision by deaf and hearing impaired patients, the Trust is working towards its Louder than Words Accreditation and is currently implementing the recommendations of an Hearing Loss audit.

- Trust member of Merseyside EDS2 Provider Collaborative and contributes to the development of processes and systems to improve patient experience and access. The Trust has contributed to the development local language and interpretation quality standards and is currently contributing to the development of reasonable adjustments guidance and regional staff networks

- AccessAble (Disablego) accessibility guides available on Trust Website

- Engagement with BME Staff Focus Group (virtual and via attendance at meetings) has improved as a direct consequence of targeted communication improved opportunities to engage

- Mandatory E & D training levels are stable and additional training has been rolled out including LGBT awareness, equality monitoring training, deaf and visual impairment awareness, physical disability and learning disability awareness sessions and unconscious bias testing and training.

- A short film, is played in waiting areas on screens explaining the importance of providing equality monitoring data and how it is used to improve services.

- Corporate information have developed a dashboard that will allow services to understand the diversity profile of patients and to understand equality performance

- Workforce Reasonable Adjustment Policy and Budget is in place. This is supported by a toolkit introduced to
support managers and staff in meeting the needs of disabled people. A Reasonable Adjustments task and finish group has been established to identify areas for improvement relating to reasonable adjustments using advice and guidance from the Business Disability Forum

- Unconscious bias testing and training undertaken by recruiting managers
- The Trust is a hate crime 3rd party reporting centre and works closely with Merseyside police and Stophate UK to increase awareness of hate crime and hate crime reporting.
- The Workforce Executive Director and Chief Nurse support for E & D initiatives including 3rd party hate crime reporting; say something about bullying, Reciprocal Mentoring and Cultural Ambassadors Programmes, BME targeted Chief Nurse Scholarships, Stepping up and Ready Now programmes. These initiatives are aimed at improving the diversity of the Trust’s workforce by eliminating/mitigating barriers to BME staff recruitment, retention and progression; and reducing the gap in experiences between BME and white staff.
- 2 recruitment workshops targeted at BME staff were delivered to help improve understanding of recruitment processes and improve quality of job applications.
- The Trust was an associate partner of the RCN 2018 Black History Month Event hosted in Manchester and BME Staff award winner.
- Winner of Liverpool Chambers of Commerce Workforce Health and Wellbeing Award 2018 for the range of support available to staff in the Trust
- Access to virtual interpreters for patients (Interpreter on Wheels)

**Safeguarding**

Our Safeguarding Team provides specialist advice, support, supervision and training to staff on all matters relating to the protection of adults and children at risk. The team develop and update policy, practice guidelines and procedures and ensure that the Trust’s obligations under legislation and national and local standards are met. The Trust is represented on all of the Local Safeguarding Children’s and Adult Boards within its footprint by the Designate Professionals of Liverpool Clinical commissioning Group and is actively engaged in Serious Case Review (SCR), Serious Adult Reviews (SAR) and Domestic Homicide Review activity.

A review of the integrated strategy incorporating safeguarding Adults, Children and young people, Domestic Abuse and associated agenda’s will support the Trust in meeting it’s regulatory, statutory and legislative responsibilities for safeguarding.

Safeguarding vulnerable people is a Trust priority and in giving equal status to each of the safeguarding themes will demonstrate our commitment to this and the interrelated nature of the safeguarding agenda. Staff safeguarding training remains mandatory for all staff and the trust is currently achieving the local targets as included within the Quality Schedule of the NHS Standard Contract. Monitoring of information sharing/safeguarding referrals to other disciplines and agencies shows a year on year increase providing an indication of the level of awareness and knowledge among staff. Trust policies and procedures have been aligned to the strategy in order to give them greater meaning within the Trust supported by a robust training, education, policy and procedure.

**Safeguarding Strategy**

Our safeguarding strategy sets out our priorities for the 2018 - 2021 and remains the journey to plan and provide locally delivered services that drive up quality and ensure our population receives effective, safe and personalised care. We work in partnership to safeguard children and adults, enhancing health and well-being and protecting the rights of those in the most vulnerable situations.
Key Strategic Objectives

- Senior leadership responsibility and lines of accountability for the safeguarding arrangements are clearly outlined to employees and members of the Trust as well as to external partners.

- To contribute to the work of the LSCB and LSAB and their Safeguarding Strategic Plan and provide support to ensure that the boards meet their statutory responsibilities. This would include engagement with specific work streams such as Child Exploitation (CE), the PREVENT Agenda, and the Trust including preparation for inspections across health and local authority.

- To continue support designated individuals to contribute to the work of the LSCB and LSAB subgroups, recognising the changing landscape relating to the Safeguarding Boards.

- To continue support designated individuals to contribute to national and local safeguarding implementation networks.

- Integrate safeguarding within other Trust functions, such as quality and safety, patient experience, healthcare acquired infections, management of serious incidents.

- Secure, where possible, the expertise of designated professionals, this includes the expertise of a designated doctor for children, to strengthen the specialist knowledge within the Trust. Work with other designated and named professionals within other provider and commissioning organisations to enable stronger working partnerships.

- Safeguarding professionals have appropriate amount of time and support to complete individual management reviews for DHR’s, SCR’s, SAR’s and all other safeguarding reports required to be completed. This will include Root Cause Analysis (RCA) Investigations.

- All relevant actions identified through Serious Case Reviews (SCRs), serious Adult Reviews (SARs), Domestic Homicide Reviews (DHRs), Management Reviews etc. are carried out according to the timescales set out by the LSCB, LSAB and the Community Safety Partnerships (for Domestic Homicide Reviews) Panels scoping and Terms of Reference.

- Ensuring key priorities such as Child Sexual Exploitation, Child Exploitation, PREVENT, Modern Slavery and self-harm is delivered effectively within the Trust.

- Staff, including Non-Executive Directors are trained to embed safeguarding within the organisation, and are able to recognise and report safeguarding concerns through the appropriate channels. The Trust, through its own named professionals, will actively work to raise awareness of, and ensure robust arrangements are developed and in place, to address the risk and harm associated with both national and local issues.

- The Trust publicise on its website contact details for staff with specific safeguarding responsibilities, disseminate key learning and themes from local and national inquiries and provide links to signpost Trust staff and members of the public to organisations and support to safeguard adults and children at risk of or who have suffered significant harm.

- To ensure that the Trust continues to engage with the Independent Inquiry Child Sexual Abuse (IICSA) reflecting upon the interim report and actions and the final report being issued in 2019.

- To engage and support the new Child Protection Information System (CPIS), introduced to ensure that appropriate information pertaining to children across the country.
Continuous Improvement

Evidence of continuous improvement and compliance in quality and safety outcomes for our services will be achieved through the use of data collection for the population of a safeguarding dashboard, as well as audit and monitoring of compliance to policies and procedures. Included in the wider quality assurance there will be in place: Key Performance Indicators (KPI) agreed by both the Trust and our commissioners, CQUIN targets, quality schedules, systems to embed learning from Safeguarding Adult reviews (SAR), Serious Case Reviews (SCR), Domestic Homicide reviews (DHR) incidents and complaints, comprehensive single and multiagency safeguarding policies and procedures and a safeguarding training strategy and framework.

On-going collaboration with Children’s services are contained within the Safeguarding Forward Plan as Transitioning young people into adult services is a focus for the coming year.

Learning Disability (LD)

The LD team were nominated and recognised for the work they are doing by the RCNi awards, whilst not winning the RCNi recognised the positive work that is being undertaken within this area.

LD training is now established within the Trust intranet page with staff data currently being added to new data base. RLBUHT training now adopted by entire LD CCG Network and developed further with MENCAP. The Trust intranet site contains LD contact details introduction to LD and Autism spectrum, with definitions and characteristics highlighted. This also contains information and direction as to what happens when you come into hospital and describes reasonable adjustments including the Health Passports. Additional information identifying safeguarding issues and epilepsy management also covered. The flagging of LD patients is now contained on Whiteboards which auto populates on further admissions. All ward and clinical areas have updated Resource files and LD policy folders. LD support packs have been developed and are now in place to support patients, carers and staff while in hospital will provide passports, LD service information including reasonable adjustments, flexible visiting, bedside activities and signposting to community services. LD audit continues to demonstrate performance monthly and driving continuous improvements, now contained in our Safeguarding Dashboard.

Continued investigation and reporting into LD mortality under the LeDeR process is on-going with 3 staff members now LeDeR reviewers. This will support evidence re potential avoidable mortality.
Dementia

The Trust have a dementia steering group and champions network all supported with the dementia forward plan 2018 - 2019. Dementia training delivered in line with national dementia education standards (SCIE dementia programme). All trust staff and allied health professionals access this training. Universities and local Trusts are supported to deliver our training format. Dementia information packs provided to all confirmed dementia patients/carers that include the team contact details flagging “Tree” symbols for ID bands, ward name boards, nursing and medical notes. The pack also contains “This is me” dementia passport to compliment the clinical care plans. A carer experience questionnaire is also included, this is followed up by a telephone survey and immediate issues reported to Matrons and governance teams.

The pack also has additional eating and drinking preference assessments. The correct use of these packs are audited via our WQI and NQI. Dementia patients are now flagged electronically under VP (vulnerable patient) status on the ward whiteboards, this will auto populate on further admissions. “This is me” passport provides non clinical preferences, anxieties and relaxation information that the carer or person who knows the patient best can enhance care and support the patient in an unfamiliar place. Trust staff and agency staff can familiarise themselves with the patient who may be unable to express themselves. Copies are kept in medical records in case of re admission. The pack also includes information as to what our service is and includes information re early diagnosis, accessing community services and our range of bedside activities. Bedside activities are available to patients who benefit from, diversion, distraction and reminiscence therapies. We use memory boxes with tactile objects and activities, Digital reminiscence therapy that provides music, local history, sport and classic TV clips.

Restrictive Intervention

The Trust’s policy around restrictive interventions given the increasing patient population with conditions such as dementia, and alcohol and drug misuse. Restrictive interventions are defined as:

- ‘deliberate acts on the part of other person(s) that restrict an individual’s movement, liberty and/or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken;
- end or reduce significantly the danger to the person or others; contain or limit the person’s freedom for no longer than is necessary’

Whilst the aim is always to reduce the need for the use of restrictive interventions, it is recognised that where a person’s behaviour places themselves or others at imminent risk of significant harm and were de-escalation strategies have not prevented a crisis, a restrictive practice may be necessary as a proportionate and reasonable response to the risk posed. The choice of intervention will be informed by the service user’s preference (if known), any particular risks associated with their general health (again if known) and an appraisal of the immediate environment. Alongside the MHA, the Mental Capacity Act 2005 provides a framework for protecting the interests of people who lack the capacity to make their own decisions. It strengthens the concept of ‘best interests’ decision making, and the requirement to search for the least restrictive option in any decision made for, or about, the person.

The Deprivation of Liberty Safeguards (DoLS) were put in place to reflect incidents of restrictive practice where patients lacked the capacity to make decisions. The Trust has policy in place which outlines and highlights all of the key interventions. Providers are required to publish a public annual report on their increased behaviour support planning and restrictive intervention reduction, which outlines the training strategy, techniques used and reason why and whether any significant injuries results and details of on-going strategies for bringing about reductions in the use of restrictive interventions.
7 Day Services (7DS)
The increased focus on the provision of services 7 days is necessary because demand for urgent and emergency care doesn’t follow a pattern; acute illness happens 24 hours a day, 7 days a week and there is increasing evidence to suggest poor provision at weekends being associated with increased variation in mortality, patient experience, length of stay and readmission.

Of the ten clinical standards identified by NHSEngland, four are considered to be priority standards:

- review by a consultant within 14 hours of admission
- 7 day access to diagnostics such as radiology
- 24 hour access to consultant-directed interventions, and
- on-going consultant review, twice daily for patients with high dependency needs.

Priority 7DS Clinical Standards

Clinical Standard 2 – Time to first consultant review

Performance
Weekday results have seen an improvement, between March 2017 (68%) to April 2018 (83%) results, a 15% increase of patients seen with 14 hours of admission to hospital.

Weekend results have seen similar improvements over the same period, March 2017 (50%) to April 2018 (68%), and an 18% increase of patients seen with 14 hours of admission to hospital.

Actions
The Trust has recently undertaken a full review of Consultant Job plans; all consultants within the Trust now have an electronic job plan. These job plan reviews have ensured Medical Director level review of Job Plans for acute specialities ensuring that there is sufficient time job planned to ensure review of acute patients within the required timeframe. Consultant recruitment in MAU remains a challenge in terms of delivering this standard; recruitment to vacant MAU posts is underway.

Clinical Standard 5 - Diagnostics

Performance
24/7 critical and urgent ultrasound scanning is available via the on call radiologist.

Actions
As part of the proposed upcoming merger of the Royal Liverpool and Aintree Hospitals a 7 day routine ultrasound scanning service will be delivered at the Royal Liverpool site as it already is at the Aintree site.

Clinical Standard 6 – Intervention / key services

Performance
The Trust continues to achieve against this standard.

Clinical Standard 8 – Ongoing consultant directed review

Performance
March 2017 and April 2018 results indicate the trust achieves twice daily reviews consistently 7 days a week, (100%), where indicated. Once daily reviews saw the Trust improve by 3% for weekday (96.2% - 99.2%) and 16.5% for the weekend (88.2% - 99%).

Actions
Whilst achieving the standard, the Trust continues to drive improvements and uses a standardised SAFER* board-round for consultants to prioritise patients for review and delegate review as appropriate.

The board round is used to make an multi-disciplinary decision regarding which patients do not require a daily consultant review and agree who these non-consultant reviews should be delegated to.

As part of the Trust’s digital improvement program 2019 will see the development of a dedicated electronic consultant review form which will allow real time reporting of performance against this standard.

Clinical Standard 6 – Intervention / key services

Performance
The Trust continues to achieve against this standard.

Clinical Standard 8 – Ongoing consultant directed review

Performance
March 2017 and April 2018 results indicate the trust achieves twice daily reviews consistently 7 days a week, (100%), where indicated. Once daily reviews saw the Trust improve by 3% for weekday (96.2% - 99.2%) and 16.5% for the weekend (88.2% - 99%).

Actions
Whilst achieving the standard, the Trust continues to drive improvements and uses a standardised SAFER* board-round for consultants to prioritise patients for review and delegate review as appropriate.

As part of the Global Digital Exemplar (GDE) program the Trust has introduced eNEWS2 which in conjunction with its electronic patient dashboard and eSepsis module allow the early identification of deteriorating patients for consultant review.
**SAFER:**

**S** Senior review: all patients will have a senior review before midday by a clinician able to make management and discharge decisions.

**A** All patients will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.

**F** Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

**E** Early discharge: 33% of patients will be discharged from base inpatient wards before midday.

**R** Review: a systematic Multi-disciplinary Team (MDT) review of patients with extended lengths of stay (7 days or greater – ‘stranded patients’) with a clear ‘home first’ mind set.

At weekends, MDT meetings take place at 9am on Saturday and Sunday – they are attended by health and social care professionals who provide a comprehensive assessment of a patient’s health and social care needs and his or her desired outcomes and highlight any patients RFD (Ready For Discharge) that require intervention to progress discharge.

The Multi-disciplinary Team (MDT) may involve the following professional groups in addition to the medical team and nursing staff:

- Hospital Case Managers
- Social Workers / Social Care Assessors
- Occupational Therapists
- Physiotherapists
- Mental Health Team
- Palliative care Team
- Speech and Language Therapists
- Dieticians
- Podiatrists
- Community Assessment Teams
- Specialist Nurses
- Community base care teams’

---

**Global Digital Exemplar (GDE)**

In FY2018/19 the Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT) recognised the key role digital has to play in the delivery of quality patient care by formalising the delivery of digital excellence as a corporate objective. This builds on significant progress made at RLBUHT to digitise patient records with the transition from paper to electronic records across the whole organisation.

The leading role RLBUHT has in the delivery of digital excellence in health and care was externally recognised in September 2016 when RLBUHT was selected as an acute care provider for the Global Digital Exemplar (GDE) programme. The GDE programme is the flagship digital programme for NHS England with an objective to accelerate development of world-class digital NHS providers and enable others to learn and adopt the technologies they have in use.

RLBUHT is hosting the award-winning “Digital Liverpool” GDE programme which focuses on four principal themes and is due to complete in 2020:

1. Digital Innovation
2. Digital First Hospital
3. Digital Patient Records
4. Clinical Transformation

The Digital Liverpool programme is comprised of digital innovations in each work stream that will enable RLBUHT to achieve GDE accreditation from NHS England and international recognition through realisation of the HIMSS Electronic Medical Record Adoption Model (EMRAM) Stage 7 status.

Our international reputation for digital innovation continues to grow as we head towards accreditation. We forged a partnership with a series of healthcare and academic institutions in Boston which led to an exchange visit with national representatives in November 2018. The scope of this partnership is to share best practice between the UK and US for the delivery of exceptional care enabled through technology.
Digital Liverpool has had a significant impact on care delivery to date as follows:

**Clinical outcomes:**

- Consistent 100% screening of patients’ for sepsis using e-Sepsis, saving up to 200 lives per year.
- Consistent identification of escalating patients more quickly through e-Observations.
- Electronic Local Safety Standards for Invasive Procedures (LocSSIPS) moving from a manual ad hoc process to a digital mandated process has resulted in compliance with NatSSIPS and helps ensure there continue to be no further theatre never events.
- Clerking and VTE; since the introduction of The Falls Risk Assessment and Decision (FRAD) tool with an electronic referral to the Falls Team we are able to intervene appropriately and create a specific package to prevent the patient from falling and further harm being caused.
- E-Handover provides a reduction in manual completion of hand-over documentation through access to an electronic medical record on all wards within the Trust. Improving the “handover” of patients’ care ensuring consistent information to be readily accessible throughout the patient healthcare journey.

**Quality**

- LocSSIPS is now compliant at 98% against a 95% target.
- Clerking and VTE has resulted in a reduction in the Moderate to Severe Harm per thousand bed days to 1.34.
- E-Handover has resulted in a reduction of Datix incidents since implementation of 68%.

**Efficiency**

- Digitisation of clinical pathways and notes allows clinicians to proactively plan patient care. Clinical staff are able to invest more valuable time caring at the patients’ bedside by having information available at the point of care at any time and in any location.
- Use of Whiteboard system provides clinical decision support tools that support the clinical decision-making process.

The success of our GDE programme continues to be celebrated nationally. In 2017 RLBUHT was awarded “GDE of the Year” by Digital Health Media, and in 2018 we saw equivalent successes with e-Sepsis “highly commended” at the HSJ Patient Safety Awards and featuring as a case study in the NHS Long Term Plan. We also become Regional Champions at the NHS Parliamentary Awards 2018 after nomination from our local MP.

**eNEWS2**

The National Early Warning Score (NEWS) is used to help identify patients who are showing signs of clinical deterioration and provide guidance to staff as to the actions required depending on the score. Common patient observations recorded routinely on inpatients such as heart rate, respiratory rate, temperature etc are assigned a score based on the value, the scores from all the observations are added together to calculate a NEWS score. The trust has been recording observations on the electronic ADT Dashboard, which also calculates NEWS and notifies staff when observations are next due for the past 2 years.

NEWS was reviewed by the National NEWS working group and as a result NEWS2 has been developed. The trust implemented NEWS2 in November 2018 and used the opportunity to enhance the features of the electronic system. Recent audits had demonstrated that whilst 100% of observations had a corresponding news score which was calculated correctly only 75% of observations were recorded at the correct frequency. Part of the enhancements included features to help staff achieve better compliance. The graph below demonstrates a significant improvement since the deployment of NEWS2 and associated enhancements. Future work on eNEWS will focus on timely escalation of deteriorating patients to the most appropriate team.
Clerking and VTE

The Falls Risk Assessment and Decision (FRAD) tool onto PENS (Patient Electronic Notes System) is now live within RLBUHT and forms part of the clerking and VTE programme of work. The system automatically calculates a patient's FRAD based on individual observations entered at the bed side. The system via the RLBUHT Whiteboard displays the current FRAD and allows staff to electronically refer patients to the Falls Team allowing the Team to intervene appropriately and create a specific package to prevent the patient from falling and harm being caused. The system provides assurance that each applicable patient is referred to the Falls Team and that early intervention and prevention of falls will result in reduction of moderate to severe harm.

Clerking and VTE has automated the required information by gathering information from a number of systems, in turn ensuring timely referrals and automation of calculations improving overall patient safety. The system also provides a clear action and escalation plan ensuring patients are treated as early as possible.

E-Handover

E-Handover system provides a reduction in manual completion of hand-over documentation through access to an electronic patient record on all live wards within the Trust. This improves the handover of patients’ care ensuring consistent information to be readily accessible throughout the patient healthcare journey. This releases clinical time to care for patients on wards and increased clinical productivity; improves communication and ensures clear digital auditability and legible handover of care; and ensures clinicians able to prioritise patients as they are able to view all handovers jobs in one clear system at any one time.

E-Handover was introduced as an adaptive change. It involved an organisation-wide roll out with the digital team working collaboratively with a team of nurses and healthcare assistants to adopt the innovation.

Using an e-handover system in replacement of a manual process will improve accuracy of patient flow and further enable RLBUHT to reduced length of stay for patient. This innovation was recently shortlisted at the National Patient Safety awards.
Do Not Attempt Cardio Pulmonary resuscitation (DNACPR)

There are times when a patient's medical condition is so severe that should their heart stop and they suffer a cardiac arrest any attempt to revive them would be futile, and unfair, this may be due to their illness being so severe that further treatment is unlikely to be effective or their illness is terminal, in this situation and following discussion with the patient and where appropriate their relatives or those close to them the medical team looking after the patient will complete a DNACPR order which informs all staff that should the patient's heart stop they should not be resuscitated.

DNACPR orders where recorded on paper and stored in the patient's notes; however in March 2018 the trust launched eDNACPR which allowed DNACPR orders to be written via the electronic ADT Dashboard. This development enabled the Resuscitation Status of all inpatients to be easily accessible across the whole organisation, it also ensured all sections of the form were completed correctly and only by medical staff with suitable experience. The transition has made auditing of the form easier and more accurate. 100% of DNACPR orders are now recorded electronically.

Innovation in a wider context

We continue to lead the way locally and regionally with our approach to innovation across Liverpool. RLBUHT is the lead provider in a series of local and regional initiatives including:

- Production of a sensor strategy and hosting of a Sensorthon to innovate around common problems in healthcare such as falls detection and prevention.
- Launch of a pilot blueprint

We are also the lead health partner in the Liverpool 5G Test Bed programme in association with Sensor City and Liverpool City Council. This is a first-of-type innovation in health and care that is exploring the use of next-generation technologies to improve patient outcomes and equality of access. The first phase has completed successfully after delivery of tele-health acute care pathways and advanced clinical mobility solutions. We also saw the launch of the first 5G lab in health and care with the “Livernerds Lab” opening; this will support continued innovation between clinical, academic and subject matter experts and is hosted out of the Liverpool Life Sciences Accelerator. The Liverpool 5G Test Bed was awarded “Most Innovative Use of 5G Technology” at the 5G Realised ceremony in March 2019 for its early successes.

The GDE programme continues to support the delivery of excellent, safe and accessible healthcare for the population health. We are becoming an internationally recognised NHS provider for digital excellence achieved by a strong culture of change across the organisation that is committed to realising the highest quality of healthcare.
Participation in Clinical Audits

During 2018/19, 54 National Clinical Audits (NCAs) and Clinical Outcome Review Programmes and other quality improvement projects covered NHS services that the Royal Liverpool and Broadgreen University Hospitals NHS Trust provides.

During this period, the Trust participated in 96% of NCAs and other quality improvement projects and 100% of Clinical Outcome Review Programmes which it was eligible to participate in.

The reports of 44 National Clinical Audits and Clinical Outcome Review Programmes and other quality improvement projects were reviewed by the Trust in 2018/19 and audit returns for each, in conjunction with the reports, have been independently reviewed by the Associate Medical Director for Clinical Audit. For the following, it was thought the Trust performed comparably or better than nationally:

- National Comparative Audit of Blood Transfusion (NHSBT) - Transfusion in children and adults with Sickle Cell disease
- Bowel Cancer (NBOCAP)
- National Confidential Enquiries into Patient Outcome and Death (NCEPOD) Non-Invasive Ventilation Study
- National Cardiac Arrest Audit (NCAA)
- UK Registry of Endocrine and Thyroid Surgery (UKRETS)
- Patient Reported Outcome Measures (PROMs): Hip Replacement
- National Comparative Audit of Blood Transfusion (NHSBT) - Audit of Patient Blood Management in adults undergoing elective, scheduled surgery
- National Audit of Cardiac Rehabilitation (NACR)
- National Prostate Cancer Audit (NPCA)
- National Hip Fracture Database (NHFD) - Part of FFFAP
- National Audit of Breast Cancer in Older Patients (NABCOP)
- National Diabetes Footcare Audit (NDFA)
- British Association of Urological Surgeons (BAUS); Cystectomy, Nephrectomy, Radical Prostatectomy and Percutaneous Nephrolithotomy (PCNL)
- UK Inflammatory Bowel Disease (IBD) Registry Biologics Audit
- Learning Disability Mortality Review Programme (LeDeR)
- Severe Trauma / Trauma Audit & Research Network (TARN)
- National Oesophago-Gastric Audit (NOGCA)
- Serious Hazards of Transfusion (SHOT) National haemovigilance scheme
- National Diabetes Transition (NDTA).
As a result of, and review of recommendations, the Trust is taking the following actions to improve the quality of healthcare provided:

- **National Audit of Dementia (NAD);** actions include amendment of delirium assessment documentation to allow recording of both full and reduced capacity status for people with dementia, dementia awareness training and dementia champions identified on each ward.

- **National Oesophago-Gastric Audit (NOGCA;** the Trust's action plan places emphasis on case ascertainment and data completeness.

- **National Audit of Inpatient Falls;** the Specialist Fall Nurses have embedded the use of standardised tools and documented care plans within the dementia and delirium policies. In addition, all patients assessed at risk of fall will have a lying and standing blood pressure performed as soon as practicable, and action will be taken if there is a substantial drop in blood pressure on standing. The Trust conducts an annual internal falls audit to inform local service improvement.

- **National Vascular Registry (NVR);** Getting it Right First Time (GIRFT) and peer review recommendations have been adopted to reduce variability and improve access to surgery times for patients undergoing Abdominal Aortic Aneurysm and carotid surgery.

- **National Parkinson’s (PD) Audit;** the clinic proforma on the Patient Electronic Notes (PENs) software was amended to prompt staff to ask patients relevant questions and to offer advice and discussion on end of life care. It will also be amended to sign post patients to support services. Advance care planning skills training will be provided for consultant staff and an education programme developed for ward staff in regards to timely administration of PD drugs when admitted acutely, anywhere within RLBUHT.

- **Procedural Sedation in Adults (College of Emergency Medicine - CEM);** actions include purchasing of monitoring equipment to meet standard 5 Monitoring during procedural sedation must be documented to have included all of the below: a. Non-invasive blood pressure b. Pulse oximetry c. Capnography d. ECG and the introduction of an electronic pathway to monitor administration of oxygen.

- **Intensive Care National Audit & Research Centre (ICNARC) - Case Mix Programme (CMP);** A critical care stepdown policy has been introduced and the ICNARC lead proactively reviews data in conjunction with the national body (ICNARC).

- **National Diabetes Audit (NDA): National Pregnancy in Diabetes Audit (NPiD);** comprehensive actions include; enabling patients to self-refer to the service, advertising the service locally and encouraging GPs to refer early to the service – facilitated via the community diabetes specialist nurses.

- **NHSBT - Audit of the management of patients at risk of Transfusion Associated Circulatory Overload (TACO);** all patients who could develop two or more risk factors leading to a TACO will be risk assed using the Adult Transfusion Pathway and the Transfusion policy.

- **CEM Fractured Neck of Femur (#NOF);** A comprehensive action plan was developed which includes liaison with Radiology to improve appropriate reporting of CT prior to surgery and exploring team, surgeon and anaesthetist of the week to improve preoperative review by a consultant surgeon and anaesthetist when the risk of death is greater or equal to 5%.

- **National Audit of Dementia (NAD) Spotlight Audit - delirium screen and delirium assessment;** actions include but not limited to adding the Single Question in Delirium (SQiD) and Abbreviated Mental Test Score (AMTS), or equivalent cognitive assessment tool, to the new electronic medical assessment tool and provide medical staff with appropriate training.
• National Lung Cancer Audit (NLCA); to focus on MDT meeting to improve recording of performance status and staging.

• National Diabetes Audit (NDA): Core Audit; actions are in relation to non-submission of data to the national audit; the Clinical Effectiveness Team will confirm receipt of data following submission in June 2019.

• National Ophthalmology Database Audit (NOD); actions were in relation to non-submission of data. All clinicians were registered on to the IT system to allow them to submit their data.

The national reports reviewed during 2018/19 are not explicit to the list of National Clinical Audits and Clinical Outcome Review Programmes and other quality improvement projects listed on the NHS England Quality Accounts List 2018/19 but are, however, the reports published/reviewed during 2018/19.

The reports of 214 local clinical audits were reviewed by the provider in 2018/19 and examples of actions to be taken by the Trust to improve the quality of healthcare provided are as follows:

• Complex Fracture Assessment and Management Assessed In Relation to NG37 NICE Guidelines; introduction of a clerking proforma on PENs which will include prompts of photography, British Orthopaedic Association Standards for Trauma (BOAST) 4 guidelines, checklist for nerve and muscle function and a checklist for pulses palpated. Junior doctors to be informed to review BOAST and NICE guidance on induction.

• Management of patients with dysphagia (safe prescribing and transfer of information to primary care on discharge); discharge summaries to be added to the dashboard with a better designed discharge summary template with a mandatory field for information about ‘swallowing’. The To Take Out (TTOs) generated on the electronic prescribing and medicines administration (EPMA) system are to have information on the number of scopes of thickeners required to achieve the designed fluid consistency incorporated in to them. A re-audit is currently in progress.

• An audit of the management of diabetes mellitus in HIV-positive patients in a tertiary health centre; An annual review of HBA1C (glycated haemoglobin) to take place, an alert to be added to a database to ensure appropriate ARVs (antiretrovirals) to minimise renal and cardiac risk and an annual review to ensure patients are referred to their GP for hypertension and statins.

• NICE guidelines: Spondyloarthritis (SpA); cardiovascular risk paragraph in the standard letter amended, improved documentation for NSAIDS (Nonsteroidal anti-inflammatory drugs) and improved distribution of SpA leaflet.

• Audit of screening and management of latent tuberculosis infection in newly diagnosed HIV-positive adults; revision of local latent tuberculosis infection (LTBI) screening guidelines with a view to update, potential introduction of an electronic prompt for clinicians to undertake LTBI screening when appropriate.

• Polypharmacy and medicines management in frailty patients; Pharmacy to have a slot on the morning multidisciplinary team (MDT) meeting for frailty patients, medication review to take place to improve prescribing according to STOPP/START guidelines (STOPP: Screening Tool of Older People’s potentially in appropriate Prescriptions, START: Screening Tool to Alert doctors to Right Treatment).

Engagement in clinical audit

Each speciality area has a designated Speciality Audit Lead (SAL) who is responsible for oversight and approval of their audit plan at a local level, and prioritising mandatory and trust priority audit. Attendance at the Clinical Audit Group, a formal reporting group within the Governance Structure, is good and SALs use the opportunity to review
their activity, audit findings and to escalate key areas for discussion in other forums. Newly appointed SALs are provided with an induction package and all leads have dedicated time within their job plan.

Clinical Audit reporting is well embedded in the Governance Structure, and regularly reported at Divisional Subcommittees with full oversight being maintained by the Clinical and Cost Effectiveness Sub-committee, which reports to the Quality Governance Committee and through that to the Board.

The clinical audit and quality improvement poster competition took place in June 2018. Seventeen posters were entered, the winner being Improving attendance at HIV clinic – a text message reminder service and analysis of a demographic database to tailor interventions

**The National Clinical Audits and Clinical Outcome Review Programmes and other quality improvement projects applicable to the Trust on the 2018/19**

**Quality Account list published 15th January 2018 were:-**

- Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)
- British Thoracic Society (BTS) Adult Community Acquired Pneumonia
- BAUS Cystectomy
- BAUS Nephrectomy
- BAUS Radical Prostatectomy
- BAUS Percutaneous Nephrolithotomy (PCNL)
- BAUS Prostatectomy Audit
- National Bowel Cancer Audit (NBOCAP)
- Cardiac Rhythm Management (CRM)
- Case Mix Programme (CEM) - ICNARC
- Elective surgery (National PROMs Programme):
  - Hip Replacement
  - Knee Replacement
  - Groin Hernia
- Endocrine and Thyroid National Audit (UKREATS)
- Falls and Fragility Fractures programme (FFAP):
  - National Hip Fracture Database (NHFD)
  - National Inpatient Falls
  - Fractured Neck of Femur – College of Emergency Medicine (CEM)
- Head and Neck Cancer (HANA)
- Inflammatory Bowel Disease (IBD) programme: Biologics Audit
- Learning Disability Mortality Review Programme
- Major Trauma: The Trauma Audit & Research Network (TARN)
- NCEPOD Acute Pancreatitis
- NCEPOD Chronic Neurodisability study – Cerebral Palsy
- NCEPOD Heart Failure Study
- NCEPOD Perioperative diabetes
- NCEPOD Cancer in Children, Teens and Young Adults
- NCEPOD Physical and mental health care of mental health patients in acute hospitals
- NCEPOD Non-invasive ventilation
- National Audit of Breast Cancer in Older Patients (NABCOP)
Patient Related Outcome Measures (PROMs)

PROMs measure health gain in patients for specific procedures in England, based on responses to questionnaires before and after surgery. The following relates to hip and knee replacement surgery, including participation and outcome data, as at end March 2019.

Condition-specific measures

Patients receiving hip or knee replacements are asked to complete questions that are specifically tailored to their condition:

- The Oxford Hip Score (OHS)
- The Oxford Knee Score (OKS)
**General health measures**

All patients are also asked to complete two general measures, the EQ-5DTM Index and the EQ VAS, both before and after their surgery:

EQ-5DTM Index is a five item measure that asks patients about their:
- ability to pursue their usual activities;
- current experience of anxiety and/or depression, if any;
- current experience of pain and discomfort, if any;
- mobility, and;
- ability to wash and dress themselves (self-care).

EQ – Visual Analogue Scale (EQ VAS) is a single-item ‘thermometer’-style measure which asks patients to rate their general health at the time of completion on a linear scale from 0 to 100, with 100 representing the best possible state of health.

Within their post-operative questionnaires, all patients are also asked:
- how they would describe the results of their operation (satisfaction), and;
- how their problems are now, compared with before the operation (success).

**Hip Replacement**

<table>
<thead>
<tr>
<th>Participation</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome</th>
<th>2017/18 – Primary Hip replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improved</td>
</tr>
<tr>
<td>EQ-5D Index</td>
<td>RLBUHT</td>
</tr>
<tr>
<td>EQ VAS65</td>
<td>65.9%</td>
</tr>
<tr>
<td>Oxford Hip Score</td>
<td>97.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome</th>
<th>2016/17 – Primary Hip replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improved</td>
</tr>
<tr>
<td>EQ-5D Index</td>
<td>RLBUHT</td>
</tr>
<tr>
<td>EQ VAS65</td>
<td>87.3%</td>
</tr>
<tr>
<td>Oxford Hip Score</td>
<td>94.2%</td>
</tr>
</tbody>
</table>

**PROMs Total Knee Replacement Outcomes**

- 16/17 - Finalised
- 17/18 - Finalised
- EQ 5D
- EQ-VAS
- Oxford Knee

- Improved
- Unchanged
- Worsened
## Knee Replacement

### Participation

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knee</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Outcome

#### 2017/18 – Total Knee replacement

<table>
<thead>
<tr>
<th></th>
<th>Improved</th>
<th>Unchanged</th>
<th>Worsened</th>
</tr>
</thead>
<tbody>
<tr>
<td>EQ-5D Index</td>
<td>88.7%</td>
<td>5.2%</td>
<td>6.1%</td>
</tr>
<tr>
<td>EQ VAS65</td>
<td>58.1%</td>
<td>10.5%</td>
<td>31.5%</td>
</tr>
<tr>
<td>Oxford Hip Score</td>
<td>95.2%</td>
<td>1.6%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

#### 2016/17 – Total Knee replacement

<table>
<thead>
<tr>
<th></th>
<th>Improved</th>
<th>Unchanged</th>
<th>Worsened</th>
</tr>
</thead>
<tbody>
<tr>
<td>EQ-5D Index</td>
<td>84.4%</td>
<td>6.0%</td>
<td>9.6%</td>
</tr>
<tr>
<td>EQ VAS65</td>
<td>66.2%</td>
<td>11.6%</td>
<td>23.2%</td>
</tr>
<tr>
<td>Oxford Hip Score</td>
<td>94.2%</td>
<td>1.2%</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

The Groin Hernia and Varicose Veins surgery PROMs scores have been retired.

### Clinical trials

5841 patients receiving relevant health services provided or sub-contracted by Royal Liverpool and Broadgreen University Hospitals Trust in 2018/19 that were recruited during that period to participate in research and required ethical approval, was approved by a research ethics committee.
Liverpool, South Sefton and Knowsley CCGs welcome the opportunity to jointly comment on Royal Liverpool and Broadgreen University Hospitals NHS Trust Draft Quality Account for 2018/19. In issuing this statement it is noted that in the version reviewed by Commissioners was draft and some areas of the Quality Account are outstanding and require completion in line with national guidance. Commissioners look forward to receiving the final version of the Quality Account.

Commissioners 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 supports their strategy to deliver high quality, harm free care.

The account reflects some progress in some areas and the challenges the Trust has faced and continues to face in others. Commissioners note the objective to merge with Aintree University Hospitals NHS Foundation Trust in 2019/20. It is noted however that the Account is not reflective of any joint plans in relation to quality priorities for the merged organisations. It is noted that work will continue in the planning of the merger the aim to deliver better services and greater outcomes for patients and will monitor progress against these objectives.

This Account indicates the Trust’s commitment to improving the quality of the services it provides. Commissioners note the priorities identified could be considered as priorities from previous years and as being part of current and historic KLOE and performance monitoring metrics. It is felt that the priorities identified may not stretch the Trust further to improve quality and should be reviewed. Commissioners note the priorities for 2019/20 as being:

Priority 1: Patient Safety
- 90% of observations completed on time in conjunction with rollout of eNEWS2
- 100% sepsis screening of patients with >80% of patients receiving antibiotics within the hour
- Zero tolerance of MRSA and to remain within trajectory against Clostridium Difficile Toxin (CDT)

Priority 2: Patient Experience
- Compliance with complaints response times across all levels
- Improvement in Friends and Family Test (FFT) compliance and response times

Priority 3: Clinical Effectiveness
- Remain within expected range SHMI (Summary Hospital-level Mortality Index)
- Screen >90% of in-hospital deaths in line with local policy
- 100% compliance with Local Safety Standards for Invasive Procedures (LocSSIPs)
The Quality Account identifies where the organisation has done well, where further improvement is required and what actions are needed to achieve these goals. The account details progress against the 2018/19 priorities set.

Through this Quality Account and on-going quality assurance process, the Trust demonstrates their commitment to improving the quality of care and services delivered. The CCGs note the areas where the Trust has not achieved compliance with the targets set and will continue to work closely with the Trust to develop plans to improve and monitor performance.

Of note is the work the Trust has undertaken to improve outcomes on the following work streams:

- The Trust achieving a reduction of Clostridium Difficile cases against the 2017/18 figure which was 16% below the 2018/19 trajectory.
- The ambition to see a 25% reduction target for inpatient falls that led to harm graded moderate or above in 2018/19 with the delivery of a 55% reduction.
- The continued improvements in clinical outcomes related to the Global Digital Exemplar work undertaken in the Trust.

Commissioners are aspiring through strategic objectives to develop an NHS that delivers great 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 not 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.

Liverpool CCG

Jan Ledward  
Chief Officer  
Date: 20th May 2019
South Sefton CCG
Southport and Formby CCG

Fiona Taylor
Chief Officer
Date: 17 May 2019

Knowsley CCG

Dianne Johnson
Chief Executive
Date: 17 May 2019
Dear Dr. Williams,

Royal Liverpool and Broadgreen University Hospitals NHS Trust – Quality Account 2018/19

As Chair of Sefton Council’s Overview and Scrutiny Committee (Adult Social Care and Health), I write to submit a commentary on your Quality Account for 2018/19.

Members of the Committee met informally on 10 May 2019 to consider your draft Quality Account, together with representatives from Healthwatch Sefton and from the local Sefton CCGs. We welcomed the opportunity to comment on your Quality Account and I have outlined the main comments raised in the paragraphs below.

Anthony Duffy, Senior Practitioner, Service Improvement and Excellence Team, attended from your Trust to provide a presentation on the Quality Account and to respond to our questions.

We had chosen to comment on the Trust’s draft Quality Account as we were aware of various forthcoming changes at the Trust and we have not met with Trust representatives for some time.

We received a presentation from the Trust representative outlining the following:-

- Overview of the Trust;
- Vision, Value and Strategic Themes;
- Corporate & Quality Objectives 2018/19;
- Trust Board Changes;
- Embedding Quality;
- CQuin 2018/19;
- Patient Safety;
- Patient Experience;

www.sefton.gov.uk
• Clinical Effectiveness;
• What’s Actually Happened?;
• Clinical Effectiveness - Through Global Digital Exemplars;
• Staff Survey Improvements;
• Quality Priorities 2018/19;
• Quality Priorities 2019/20;
• Seven Day Services;
• Freedom to Speak Up.

We were reminded that Laing O’Rourke has been appointed as the management contractor to oversee the delivery of the remaining construction work of the new-build Royal. It was hoped that completion would be reached by 2020, although the work may remain on-going until 2021. The current site is reaching the end of its life and the Trust is trying to mitigate any associated risks. We asked about the old site, once the new-build is completed, and saw a picture of the planned landscaping.

We asked about the proposed number of beds for the new build and were advised that there will be about 650, which represents a reduction of beds. So far as your Trust representative was aware, they will all be NHS beds. There will also be en-suite facilities. We asked if the reduction in beds will impact on the proposed merger with Aintree University Hospital NHS Foundation Trust and heard that the build was first commissioned 8 or 9 years’ ago and the reductions that have occurred in social care were not anticipated at that time. However, single rooms will contribute positively towards infection control. Measures will also be taken to ensure patient safety. We did question whether the changes will lead to isolation for patients and if single rooms will create additional work for staff and we heard that the Trust is putting measures in place to offer as much support for staff as possible. We also asked about the high dependency unit and intensive care unit in the new build and were assured that, despite single rooms, the Trust will be able to manage patients who require such care.

The Trust representative also reported on changes to the Trust Board; influenza vaccinations targets for staff; and infection control.

We heard that the Trust provides advice to primary care practitioners regarding patients with mental health issues. This is carried out via a text conversation and not in “real time”, rather the Trust has 40 hours to respond.

We asked about the big reduction in patient falls and heard that the Trust appears in the top performing quartile for this area, comparing well to peer Trusts. We heard that patients are now assessed and scored as part of a risk assessment, patients over 65 being most at risk.

Regarding infection control, we were advised that the Trust has a good performance from an infection perspective and is a Global Digital Exemplar, in that patients who have, or are likely to develop, sepsis are screened as part of a digital care pathway.

Our Healthwatch representatives asked about patients vacating Hospital premises, particularly at night, to smoke and drink alcohol outside. We heard that the Trust has processes in place to monitor what is brought in to Hospital premises. The Trust has agreements in place with local retailers not to sell alcohol to patients.

We asked about the process and procedure in relation to staff raising concerns and heard about the Freedom to Speak Up Guardian scheme. We learned that the Guardian will raise the matter with the Chief Executive and that any issues are investigated.
We referred to the Staff Survey Improvements, which suggests that staff feel able to raise issues, with a view to making improvements happen, although we did wonder why the response rate is not higher. We heard that such information is perceived as “good intelligence”. We also pointed out that staff appear to be extremely busy and asked whether staff feel valued. We were advised that exit interviews are undertaken when staff leave to ascertain any issues. We were also advised that no posts will be lost post-merger and that all staff will be TUPE’d across, in due course. We questioned whether the Trust is facing a shortage of nursing staff and were advised that numbers currently provide adequate patient safety, although retention can sometimes be problematic.

The Trust representative mentioned the amount of change facing the Trust, including financial, the merger with Aintree Hospital, and the new build, and offered to share some information with our Scrutiny Officer. I look forward to receiving additional information in due course.

We very much appreciated the opportunity to scrutinise your draft Quality Account for 2018/19 and were grateful for the attendance at our meeting of the Trust representative. I hope you find these comments, together with the suggestions raised at the meeting, useful.

Please accept this letter as Sefton OSC’s formal response to your Quality Account.

Yours sincerely,

[Signature]

Councillor Mhairi Doyle, M.B.E.
Chair of Sefton Council’s Overview and Scrutiny Committee (Adult Social Care and Health)
Healthwatch Liverpool
Royal and Broadgreen Quality Account 2018-19 commentary

Healthwatch Liverpool welcomes this opportunity to comment on the Quality Account of the Royal Liverpool and Broadgreen University Hospitals NHS Trust. We base these comments on the contents of a draft Quality Account which was provided to us prior to publication, as well as our ongoing engagement with the Trust and feedback received from patients and families.

This year has undoubtedly presented a number of challenges for the Trust, not least due to the delayed new build and needing to remain in the old hospital building for much longer than originally planned.

As with all Trusts in Liverpool, we hold an annual Listening Event where a team of staff and volunteers from Healthwatch Liverpool visits the hospital to speak to patients and visitors about their experiences. These events are intended to provide a snapshot of what patients and visitors think about the service. The Trust can then use this feedback in conjunction with other patient experience measures to provide valuable insight. This year we visited the Royal site on 24th July 2018 and spoke to a total of 79 people. We also visited the Broadgreen site on 27th November 2018 and spoke to 58 people.

At both locations the people we spoke to gave positive feedback about the staff, often describing them as kind and caring. Some people also felt that the environment of both sites was clean, this is despite some negative comments about the environment of the Royal site appearing dated and worn. With this in mind we are pleased to read that the Trust has continued to invest in essential maintenance of the old Royal building and we would encourage the Trust to continue to work proactively to ensure the environment does not have a detrimental impact on patient experience.

Whilst we acknowledge there are pressures across the health system, and many Trusts are missing their referral to treatment targets, it is clear from this Quality Account that access to services has been a particular challenge for the Trust this year. It is disappointing to see that referral to treatment targets have been missed by a considerable margin and that the figures are worse than last year. It is also disappointing to see that performance against the 4 hour A&E target has also slipped compared to last year. Missing these targets is likely to have had a negative impact on patient experience so we encourage the Trust to continue their work in these areas as a priority for the forthcoming year.

Despite the challenges it is positive to see a significant reduction in falls resulting in moderate harm or above. The Trust set a target of a 25% reduction and achieved an impressive 55% reduction.
The Trust has also achieved a 45% reduction in A&E attendances for a cohort of patients with mental health needs. This piece of work was first reported in the Quality Account last year but it is positive to see that the reduction in attendances has been sustained. Given the evident pressures on A&E, we encourage the Trust to use the learning from this scheme to benefit other patient groups.

The work around equality and diversity is particularly noteworthy and it is encouraging to see the progress in this area for the benefit of patients. However, there is still much work to be done to ensure that the needs of all communities in Liverpool are accommodated.

The forthcoming year is likely to be even more busy as, in addition to day to day pressures, the Trust will be merging with Aintree University Hospital NHS Foundation Trust. Whilst it offers the opportunity to improve services across the city the merger does hold many potential risks. We therefore encourage the Trust to carry out robust public engagement before decisions are made about service changes to ensure that improvements are realised.

In relation to the priorities for the forthcoming year, we are unsure whether these will capture the positive work which the Trust will be doing to improve and maintain the experience of patients. We are also unsure whether these priorities match with what patients themselves would prioritise.

Despite these reservations we are hopeful that the Trust will continue to address areas of concern and that this will result in improved experiences for patients and visitors. We look forward to continuing to work closely with the Trust over the forthcoming year.
Independent Practitioner's Limited Assurance Report to the Board of Directors of The Royal Liverpool and Broadgreen University Hospitals NHS Trust on the Quality Account

We have been engaged by the Board of Directors of The Royal Liverpool and Broadgreen University Hospitals NHS Trust to perform an independent assurance engagement in respect of The Royal Liverpool and Broadgreen University Hospitals NHS Trust's Quality Account for the year ended 31 March 2019 ('the Quality Account') and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and as subsequently amended in 2011, 2012, 2017 and 2018 ('the Regulations').

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the following indicators:

- Percentage of patient safety incidents resulting in severe harm or death.
- Rate of clostridiun difficile infections.

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

Respective responsibilities of the directors and Practitioner

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

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

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

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.
Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 (‘the Guidance’); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period 1 April 2018 to 28 June 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 28 June 2019;
- feedback from commissioners dated 20 May 2019;
- feedback from local Healthwatch organisations dated 21 May 2019;
- feedback from the Overview and Scrutiny Committee dated 20 May 2019;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account dated 15 June 2019;
- the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated June 2019;
- the national patient survey dated September 2018;
- the national staff survey dated 1 January 2018;
- the Head of Internal Audit’s annual opinion over the Trust’s control environment dated March 2019;
- the annual governance statement dated 11 June 2019; and
- the Care Quality Commission’s inspection report dated 29 July 2016.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Directors of The Royal Liverpool and Broadgreen University Hospitals NHS Trust. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and The Royal Liverpool and Broadgreen University Hospitals NHS Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.
Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

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

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques that can result in materially different measurements and can affect 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 of those criteria, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

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

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Royal Liverpool and Broadgreen University Hospitals NHS Trust.

Our audit work on the financial statements of The Royal Liverpool and Broadgreen University Hospitals NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as The Royal Liverpool and Broadgreen University Hospitals NHS Trust’s external auditors. Our audit reports on the financial statements are made solely to The Royal Liverpool and Broadgreen University Hospitals NHS Trust’s directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to The Royal Liverpool and Broadgreen University Hospitals NHS Trust’s directors those matters we are required to state to them in an auditor’s report and for no other purpose. Our audits of The Royal Liverpool and Broadgreen University Hospitals NHS Trust’s financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than The Royal Liverpool and Broadgreen University Hospitals NHS Trust and The Royal Liverpool and Broadgreen University Hospitals NHS Trust’s directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.
Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

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

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Manchester

1 July 2019
The Royal Liverpool and Broadgreen University Hospitals NHS Trust
Prescot Street
Liverpool
L7 8XP

Tel: 0151 706 2000

www.ribuht.nhs.uk

- www.facebook.com/royalliverpoolhospitals
- www.twitter.com/royallpoolhosps
- www.youtube.com/royallpoolhosps
- www.instagram.com/rlbuht

Please recycle this document