Where we all make a difference

Quality Account 2015 -2016
<table>
<thead>
<tr>
<th>Description</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair and Chief Executive Statement</td>
<td>5 - 8</td>
</tr>
<tr>
<td>Statement of Directors Responsibilities in respect of the Quality Account</td>
<td>9</td>
</tr>
<tr>
<td>Introduction and Purpose of Quality Accounts</td>
<td>10</td>
</tr>
<tr>
<td>Identification of Quality Account Priorities</td>
<td>10</td>
</tr>
<tr>
<td>About Us</td>
<td>11 - 14</td>
</tr>
<tr>
<td>Our mission, vision and values</td>
<td>15</td>
</tr>
<tr>
<td>Our Corporate and Quality Objectives 2015-16</td>
<td>16</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>17 - 20</td>
</tr>
<tr>
<td>Quality &amp; Performance</td>
<td>21</td>
</tr>
<tr>
<td>Our Performance</td>
<td>22 – 24</td>
</tr>
<tr>
<td>Participating in CQUINs</td>
<td>25 – 28</td>
</tr>
<tr>
<td>Data Quality</td>
<td>29 – 30</td>
</tr>
<tr>
<td>Information Governance toolkit attainment Levels</td>
<td>31 - 32</td>
</tr>
<tr>
<td>Benchmarking Data</td>
<td>33 - 47</td>
</tr>
<tr>
<td>▪ Referral to Treatment (18 weeks)</td>
<td></td>
</tr>
<tr>
<td>▪ Emergency access</td>
<td></td>
</tr>
<tr>
<td>▪ Cancelled Operations</td>
<td></td>
</tr>
<tr>
<td>▪ Cancer waiting times</td>
<td></td>
</tr>
<tr>
<td>▪ Readmissions</td>
<td></td>
</tr>
<tr>
<td>▪ VTE (Venous Thromboembolism)</td>
<td></td>
</tr>
<tr>
<td>▪ Infection Prevention and Control</td>
<td></td>
</tr>
<tr>
<td>Patient Safety Incidents</td>
<td>48 - 56</td>
</tr>
<tr>
<td>Patient Reported Outcome Measures (PROMs)</td>
<td>57 - 59</td>
</tr>
<tr>
<td>Mortality</td>
<td>60 - 65</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>66 – 68</td>
</tr>
<tr>
<td>National Inpatient Survey 2015</td>
<td>69 – 72</td>
</tr>
<tr>
<td>National Cancer Survey 2015</td>
<td>73</td>
</tr>
<tr>
<td>Patient Friends and Family Test</td>
<td>74 – 75</td>
</tr>
<tr>
<td>Section</td>
<td>Pages</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>National Staff Friends and Family Test</td>
<td>76</td>
</tr>
<tr>
<td>National Staff Survey 2015</td>
<td>77-78</td>
</tr>
<tr>
<td>Health, Work and Wellbeing</td>
<td>80-81</td>
</tr>
<tr>
<td>How we did against our 2015/16 Quality Account Priorities</td>
<td>82-92</td>
</tr>
<tr>
<td>Review of Quality Performance: Safety</td>
<td>93-107</td>
</tr>
<tr>
<td>Review of Quality Performance: Clinical Effectiveness</td>
<td>108-113</td>
</tr>
<tr>
<td>Review of Quality Performance: Patient Experience</td>
<td>114-124</td>
</tr>
<tr>
<td>Complaints, Concerns and PALS</td>
<td>125-126</td>
</tr>
<tr>
<td>Participation in National Clinical Audits and Confidential Enquires</td>
<td>127-130</td>
</tr>
<tr>
<td>Quality Account Priorities 2016/17</td>
<td>131-141</td>
</tr>
<tr>
<td>▪ Delivery against the Patient Safety Strategy Objectives</td>
<td></td>
</tr>
<tr>
<td>▪ Effective Discharge Planning</td>
<td></td>
</tr>
<tr>
<td>▪ Develop an Education and Research Strategy</td>
<td></td>
</tr>
<tr>
<td>▪ Developing a world class workforce: Nurse Training Programmes</td>
<td></td>
</tr>
<tr>
<td>▪ To empower carers through collaboration and engagement to ensure they can care for loved ones in our hospital</td>
<td></td>
</tr>
<tr>
<td>Care Quality Commission</td>
<td>142-143</td>
</tr>
<tr>
<td>Investing and Engaging in our staff</td>
<td>144-145</td>
</tr>
<tr>
<td>Leading our staff</td>
<td>146-149</td>
</tr>
<tr>
<td>Our new Royal Liverpool University Hospital</td>
<td>150-151</td>
</tr>
<tr>
<td>Working with our partners</td>
<td>152-153</td>
</tr>
<tr>
<td>Future aims</td>
<td>154</td>
</tr>
<tr>
<td>Statements on the Quality Account by Partner Organisations</td>
<td>155-164</td>
</tr>
<tr>
<td>Appendices</td>
<td>165-176</td>
</tr>
</tbody>
</table>
Chair and Chief Executive Statement

Bill Griffiths, Chairman

Since joining the trust in January 2015 I have been extremely impressed by the commitment of staff to providing patients with high quality care.

This year has seen increasing activity and high demands placed on the services we provide. However our highly skilled and hardworking staff have managed these challenging circumstances with great professionalism.

Our application for Foundation Trust status was deferred for 12 months by the health service regulator Monitor. However we will use this deferral period positively to allow us more time to induct new non-executive directors and further develop financial planning.

As an organisation we continue to play an important role in shaping the future of healthcare in the city and remain at the forefront of providing world-class care to patients. We are working closely with commissioners, neighbouring hospital trusts and our partners in community care to transform how healthcare will be provided, as part of the Healthy Liverpool programme.

We are also helping to drive forward the city’s future as a major force in the world of life sciences with the construction of the Liverpool Life Sciences Accelerator in partnership with the Liverpool School of Tropical Medicine. This state of the art laboratory facility will enable Liverpool to provide innovative research into antibiotic resistance and develop as a world leader in life sciences. This development is the first part of our future plans for the Liverpool Health Campus and will help boost regeneration of the Knowledge Quarter area of the city.

Our new Royal Liverpool University Hospital will open in 2017 and we are finalising our plans for moving into the new hospital and how we will transform the care we provide with single rooms. In addition to planning for this in the future we are continuing to invest in delivering the latest innovations in healthcare. Our multi-million pound vascular hybrid theatre at the Royal is providing ground-breaking, life-saving vascular surgery, using some of the most advanced and technologically innovative equipment and procedures available. We’ve also opened a new academic
palliative care unit to provide compassionate clinical care for those patients with complex, high dependency health care needs at the end of their life.

On behalf of the board of directors I would like to take this opportunity to thank our patients, partners, the public and all our staff for their support and commitment throughout the past year.
This year’s Quality Account assesses the quality of our services and assures our patients, the public, our commissioners and other partners that we rigorously assess and monitor the quality of the care and treatment we provide.

It has been another busy, challenging and exciting year for our hospitals.

We have seen our future plans for the new Royal and Liverpool Health Campus take huge steps forward. Work has started on the Liverpool Life Sciences Accelerator, a partnership with Liverpool School of Tropical Medicine, which represents an exciting development for the life sciences sector in the city.

In addition, the new Royal now takes its place as part of Liverpool’s iconic skyline. We celebrated the topping out of our new building in December and work is progressing on fitting out the interiors of the new hospital. Many members of staff have already had the opportunity to visit a number of ‘mock up’ rooms to see what their new working environment will be like and how they will be able to deliver single room patient care. Our teams are currently busy finalising plans for moving into the new Royal in 2017.

This year we also had our scheduled inspection by the Care Quality Commission. We viewed this as a great opportunity to showcase our services and the compassionate care we provide to our patients. Their initial feedback was
encouraging, highlighting how well our staff worked during an exceptionally busy time and how well motivated friendly and engaging they were.

Like many NHS organisations we have seen a further increase in emergency attendances and hospital admissions in the last year. We are seeing more patients who are acutely unwell with very complex needs. These patients often require support in the community for complex care needs when discharged, which can have an impact on how soon they can be discharged once they are medically fit to leave our care. This has at times caused problems with our ability to discharge patients who no longer require care in an acute setting and how soon we are able to admit sick patients into a hospital bed. We have been collaborating ever closer with our local partners in the community to find better ways of working to ensure that patients are provided the right care in the right place.

As well as working towards building a better future for the people of Liverpool, our staff have worked hard to provide our patients with a high standard of care, despite challenging times. I would like to thank them for their dedication and hard work.
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 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 2015/16
- 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: 28.04.16

Chief Executive
Date: 28.06.16
**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 10th March 2016 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 (2016-17) 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.
About Us

We are one of the busiest university teaching hospital trusts in North West England. We manage three hospitals based on two sites: the Royal Liverpool University Hospital, Liverpool University Dental Hospital and Broadgreen Hospital. Our hospitals have often been at the forefront of medical breakthroughs during our long history at the heart of the city.

We became an NHS trust in 1995 and we are currently applying to become a foundation trust.

We are the major adult university teaching hospitals for Merseyside and Cheshire; we provide general hospital services to the adult population of Liverpool. We also provide a range of specialist health services, including cancer services for Merseyside, Cheshire and beyond. We are also a centre for clinical research and lead teaching and training in a variety of health professions.

We are the major acute university teaching hospital for Merseyside and Cheshire and we have four main roles:

1. to provide general hospital services to the adult population of Liverpool
2. to provide specialist health services including cancer services for Merseyside, Cheshire and beyond
3. to be a centre for biomedical, clinical and health services research
4. to support teaching and training in the health professions

Our three hospitals provide general hospital services, emergency care and specialist dental hospital teaching services, specialist dental services and emergency care to our local community.

Specialist treatments

We offer high quality treatment and diagnosis and host several nationally and internationally regarded services such as ophthalmology, hepatobiliary, surgery, gastroenterology, pathology, vascular surgery and interventional radiology. In addition, we provide regional services for nephrology and renal transplantation,
nuclear medicine, haematology, lithotripsy, dermatology, urology and dental services. We are part of the Major Trauma Centre Collaborative for Merseyside and Cheshire.

Regional cancer centre

We are a regional cancer centre for pancreatic, urology, haematology, ocular oncology, testicular, anal, oesophago-gastric, specialist palliative care, specialist radiology, specialist pathology, and chemotherapy. In addition we have excellent local cancer treatment services, including skin, breast, colorectal, head, neck and thyroid and lung cancer. We also host a Macmillan Cancer Information and Support Service with centres on both sites.

As a major teaching hospital, we have significant relationships with all the universities in Liverpool, in particular the University of Liverpool and its medical and clinical schools. We have an impressive record in research and development, as well as a Biomedical Research Unit in Pancreatic Disease in collaboration with the University of Liverpool.

We provide a comprehensive range of specialist services to 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 cared for over 90,000 people in our emergency department, around 95,000 day case and inpatients and over 587,000 outpatient appointments.

As one of the largest employers in the city, we employ over 5,500 staff as well as staff in outsourced services. The total amount of revenue from patient care activities in 15/16 was £389,016k and £120,399k for other operating revenue. Many of our services are highly regarded both nationally and internationally. These include ophthalmology, pancreatic surgery, gastroenterology, pathology, vascular surgery and interventional radiology. We are a specialist centre for nephrology, renal transplantation, nuclear medicine, haematology, lithotripsy, dermatology, urology and dental services.
We are building a new Royal Liverpool University Hospital on the same site as the existing Royal and Dental hospitals. Clatterbridge Cancer Centre will also be relocating to the site and work has begun on the Liverpool Life Sciences Accelerator, cutting-edge research space for the city. The new Royal will transform healthcare in the city and is currently the single biggest regeneration project in Liverpool.

We have the largest emergency department providing 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 simple fractures.

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, urology, haematology, ocular oncology, testicular, anal, oesophago-gastric, specialist palliative care, specialist radiology, and specialist pathology and chemotherapy cancer treatment services. We are a national centre for ocular oncology (eye cancer). We also have excellent local cancer treatment services, including skin, breast and colorectal, head, neck and thyroid and lung cancer. We host a Macmillan Cancer Information and Support Service, with centres on both of our sites.

The trust’s long-term plan is for the Royal Liverpool University Hospital to focus on emergency and complex care and Broadgreen Hospital on non-emergency care, including specialist services for older people, elective surgical care and dermatology plus a range of outpatient services.

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

As a major teaching hospital trust we have 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, for the training of nurses.
We have the only National Institute for Health Research funded Biomedical Research Unit in the UK, which is dedicated to pancreatic disease, in collaboration with the University of Liverpool. We have a dedicated Clinical Research Facility and we are the host organisation for the North West Coast Comprehensive Research Network. We continue to look at ways to enhance our research and development programme to identify improved treatment and care for our patients and patients across the world.

We continue to monitor our work against national performance indicators as set by the Care Quality Commission and Department of Health. This enables us to benchmark our services against other providers around the country and ensure that we provide a consistently high level of service for our patients.
Our mission, vision and values

Our mission, vision, values and strategic themes reflect our approach to providing excellent care for our patients, improving health for our population and investing in our staff.

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 strategic themes

- To deliver an exceptional patient experience, making the trust one of the most sought after places to be treated anywhere in the world
- To improve the quality of life for our patients by providing excellent, safe and accessible healthcare, which puts patient’s wellbeing at the heart of all we do
- To develop a world-class workforce, recognised for its skills and level of engagement and founded on a culture of achievement, education, training and development
- To achieve international recognition for our research and innovation, bringing new therapies from the bench to the bedside
- To play a lead role in the development of a sustainable health system for the communities we serve.
Our corporate and quality objectives 2015-16

- Implement evidence-based pathways for patients
- Implement 2018 programme/develop strategy to 2025
- Implement coaching leadership
- Establish an accredited nurse training programme
- Establish the BioMedical Research Centre (Stratified Medicines and Personalised Health)

Our quality plan is a framework, designed to monitor the quality of care and services that we provide to our patients. By using information from a range of quality improvement activities, we aim to deliver improvements in patient care, creating a culture that is safe and committed to learning and continuous organisational development.
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.

In addition the Trust participates in the NHS Equality Delivery System (EDS2) and the new national workforce race equality standard (WRES) that was introduced in 2015 and is working toward implementation of the new Accessible information standard in 2016.

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) this is due to be reviewed in September 2016.

The equality performance in all of the above is used to identify areas for improvement and to develop Equality Objectives. The equality objectives for 2012 to 2016 have now expired and objectives for 2016 to 2020 are being developed in readiness for consultation and agreement with stakeholders. The E & D Sub-
Committee forward plan is developed annually to support meeting the equality objectives, the WRES and to improve outcomes in EDS2.

Statutory equality objectives were set in 2012 for the period 2012 to 2016; Progress against each of the objectives is overseen through the work programme of the Equality and Diversity Sub-Committee. The status of achievement of the objectives is as follows:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Extend patient profiling (equality monitoring) data collection to all protected characteristics by April 2013</td>
</tr>
<tr>
<td>2.</td>
<td>Introduce robust equality performance reporting and monitoring on all protected characteristics by April 2013</td>
</tr>
<tr>
<td>3.</td>
<td>Develop readily available accessible patient information including patient information leaflets, corporate reports and appointment letters by April 2013</td>
</tr>
<tr>
<td>4.</td>
<td>Conduct an equal pay audit in 2012</td>
</tr>
<tr>
<td>5.</td>
<td>Set workforce diversity targets to develop a more representative workforce by April 2013</td>
</tr>
<tr>
<td>6.</td>
<td>Develop ED competency in the workforce</td>
</tr>
</tbody>
</table>

**Achievement of Previous 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. Ongoing awareness raising continues around the importance of equality monitoring through a video campaign played in waiting areas. We monitor patient equality data annually to understand the demographics of patients accessing services in comparison to the population served, and analyse survey results from an equality perspective. This allows us 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. We have introduced an equality dashboard for patient equality data that services can use to access equality data. We use equality monitoring to flag when a patient with a learning disability or visual impairments 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. It has been agreed that workforce diversity monitoring will in future be 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 has developed a working group to oversee the implementation of the new Accessible information standard in 2016.

• The Trust completed an equal pay audit in 2012.

• Targets were set to increase disclosure of equality data in the workforce, this has resulted in an overall increase in disclosure, the next step is to set recruitment targets to change the workforce profile over time and decrease differences in experience identified in equality monitoring reports and the staff survey. We continue 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.

Proposed Equality Objectives 2016-2020

The aim of the equality objectives is to improve patient and employee experience from an equality perspective, improve analysis and use equality information to inform changes to practice, inclusion of Equality and human rights into Trust strategy, service developments and equality analysis to ensure that equality and human rights are at the heart of the Trust internal processes to ensure they continue to be fundamental to its work. The trust proposes the following new equality objectives for the period 2016 to 2020 subject to consultation and agreement with stakeholders:

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 final objectives will be published on the Trust website with an action plan to support achievement.
Quality & Performance

The Trust has reviewed all the data available on the quality of care in all of these NHS services as part of a review of quality performance.

This includes:

- Participation in relevant national audit programmes (see section on participation in clinical audit)
- Local audit plans
- CQUIN development schemes as agreed with commissioners
- National / Contractual / Local Key and Quality Performance Indicators aligned to quality (outcomes)
- Ongoing assurance monitoring, via internal governance processes and external quality meeting with Commissioners on a bi-monthly basis.

Our vision is delivered in partnership with our partner agencies and particularly our local commissioners (Clinical Commissioning Groups) who purchase our services from us and with whom we agree each year areas of quality improvement under the contracting for quality process. These areas of quality improvement payments are known as Commissioning for Quality and Innovation or CQUINs.

We continuously and routinely review data related to the quality of our services to ensure we are meeting high standards for our patients. We use our Quality Performance dashboard to demonstrate this which is reported at Quality Governance Committee on a monthly basis.

Progress against last year’s priorities for quality improvements as set out in our Quality Account Report 2015/16 have been monitored and reported through our Quality Governance Committee on a quarterly basis.
Our Performance

Measuring how we are performing enables us to provide necessary assurance to our patients, staff, local clinical commissioning groups, the Department of Health and other regulatory bodies, such as the NHS Trust Development Authority and Monitor. It allows us to monitor whether we are delivering our key corporate objectives and providing a consistently high level of care and service for our patients.

The Trust continues to be measured against a wide range of performance indicators.

The Trust’s performance against key national priorities for 2014/15 is detailed in the table below:

<table>
<thead>
<tr>
<th>National Targets and Minimum Standards</th>
<th>Performance Indicator</th>
<th>2014/15 Performance</th>
<th>2015-2016 Target</th>
<th>2015-2016 Actual Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control</td>
<td>Number of Clostridium difficile cases</td>
<td>43</td>
<td>44</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Number of MRSA blood stream infection cases</td>
<td>7</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Cancelled Operations</td>
<td>Cancelled operations (on day of surgery for non-clinical reasons)</td>
<td>365</td>
<td>0.6% (local target)</td>
<td>376 (0.46%)</td>
</tr>
<tr>
<td></td>
<td>Cancelled operations (patients not treated within 28 days following cancellation)</td>
<td>3</td>
<td>0</td>
<td>5</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>92.59%</td>
<td>92%</td>
<td>85.72%</td>
</tr>
<tr>
<td>Access to cancer services</td>
<td>Cancer: 31 day wait from diagnosis to first treatment</td>
<td>96.75%</td>
<td>96%</td>
<td>97.17%</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Target 1</td>
<td>Target 2</td>
<td>Target 3</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Cancer: 31 day wait for second or subsequent treatment: (surgery)</td>
<td>96.52%</td>
<td>94%</td>
<td>96.99%</td>
<td></td>
</tr>
<tr>
<td>Cancer: 31 day wait for second or subsequent treatment: (anti-cancer drug regimen)</td>
<td>99.71%</td>
<td>98%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Cancer: 62 day wait for first definitive treatment for cancer from urgent GP referral</td>
<td>86.80%</td>
<td>85%</td>
<td>86.35%</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>93.52%</td>
<td>95%</td>
<td>93.07%</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>77.13%</td>
<td>90%</td>
<td>76.37%</td>
</tr>
<tr>
<td>VTE Risk Assessments</td>
<td>All inpatient’s to have a risk assessment for VTE (venous thromboembolism)</td>
<td>94.78%</td>
<td>95%</td>
<td>95.18%</td>
</tr>
<tr>
<td>Delayed Transfers of Care</td>
<td>Delayed transfer of care</td>
<td>Average 1.8</td>
<td>Local target 2.1%</td>
<td>Average 2.0</td>
</tr>
</tbody>
</table>
National Variation to amend Operational Standards in relation to RTT waiting times for non-urgent consultant-led treatment.

The Trust has previously reported against the three national standards in relation to RTT waiting times (Referral to Treatment) within the Quality Account. Following consultation NHS England issued a letter (4th June 2015) to all Chief Executives and CCG Accountable Officers announcing that the two RTT measures relating to completed pathways are to be abolished as soon as possible, with the performance focus in the future being solely on the incomplete pathway measure. A national variation was complete and the following was included within the operational standards of the NHS standard contract.

(a) With effect from 1 April 2015, Operational Standards (90% of admitted Service Users starting treatment within a maximum of 18 weeks from Referral and 95% of non-admitted Service Users starting treatment within a maximum of 18 weeks from Referral) are deleted; and

(b) With effect from 1 October 2015, Operational Standard (92% of service users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral) is varied by the deletion of the existing consequence of breach £150 and its replacement by the following: “Where the number of breaches at the end of the month exceeds the tolerance permitted by the threshold, £300 in respect of each excess breach above that threshold”
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. A proportion of The Royal Liverpool and Broadgreen Acute NHS Trust’s income for 2015/16 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body we entered into a contract, agreement or arrangement with for the provision of NHS services. Further details of the agreed goals for 2015-16 and the following 12 month period are available on request from the Trust.

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 2015/16 there were acute contract CQUIN and specialist commissioning indicators made up of 4 nationally defined indicators and 4 locally agreed indicators (acute) and 8 national defined indicators (specialist commissioning), with an associated value of approximately £7 million for both contracts. The percentage weighting assigned to each and the approximate financial value associated is detailed in the appendices section of the quality account. 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 2016/17. Further details of the agreed goals for 2016/17 are available on request via kellie.connor@rlbuhut.nhs.uk
Acute Services CQUIN Schemes 2015/2016

National Dementia CQUIN
The trust failed to achieve 90% for identifying, assessing and referring patients during the first quarter of this financial year 15/16 (April – June). Improvements have been noted on a monthly basis and the trust has continued to achieve these targets from July 2015. As a consequence a reduction in payment of £60,193 will be made by Liverpool Clinical Commissioning Group as lead commissioner of the trust contract.

National Sepsis CQUIN
The trust failed to achieve the 90% target in Quarter 4 for Sepsis Screening achieved 80%. The trust also failed to achieve the 70% target in quarter 4 for antibiotic administration within the national timeframe. A reduction in payment of approximately £47,000 will be made by Liverpool CCG in line with contractual arrangements. The trust is committed to deliver the National CQUIN targets for 16/17 for Sepsis and has developed a robust plan to support and monitor progress against the expected outcomes of this CQUIN.

Local Advancing Quality CQUIN
Due to the reporting schedule and availability of data the year end performance of the trust against all AQ measures will be available in July 2016. The year-end position is estimated based on current performance and analysis over the last 12 months. Financial evaluation is unable to be determined until July 2016 when April 15 – March 16 data is available due to the information being two months behind. The data is provided to advancing quality were analysis and evaluation is undertaken to determine actual performance.

Each identified worsktream has a clinical lead and the trust AQ steering group is responsible for overseeing and monitoring the development and performance of Advancing Quality pathways. Each clinical pathway is expected to develop a robust action plan which supports the trust in achieving the required targets. The clinical lead is expected to present progress to date and update the AQ steering group on all
actions taken to improve performance. The AQ steering group will challenge and support the programme leads and the following information is required for each AQ pathway in order to support continuous improvement and ultimately demonstrate improved outcomes for patients

- To develop action plans to meet the AQ measures and milestones
- To produce monthly compliance reports for each indicator
- Demonstrate compliance against the 95% target for data completeness.
- Highlight missed opportunities, to be reviewed and challenged
- To report performance to the Trust Board on a monthly basis
- To ensure compliance with external audit for the AQ programme
- To ensure staff are trained appropriately in the AQ pathways
- To benchmark Trust performance against other similar Trusts
- To review clinical coding reports where appropriate
- To drive continuous improvement across all indicators
- To improve usage of the electronic data collection forms which supports compliance against each AQ pathway.
- To ensure and monitor collaborative working of all clinical teams involved in the pathway.
- To liaise with medical records, and prioritise where necessary, the retrieval of casenotes and highlight shortfalls to enable the Trust to achieve targets outlined within the NHS standard contract 16/17.

Specialist Commissioning Services CQUIN Scheme 2015/2016

The achievement included in the appendix (2) is therefore subject to external review and validation by North of England Specialist Commissioning team. The trust partially achieved the following CQUIN indicators – Clinical Utilisation Review and Increasing Home Renal Dialysis.
Clinical Utilisation Review

There were a number of requirements for this CQUIN with one of the elements being the installation and implementation of a clinical utilisation system across a number of specialities within the trust. The “go live” dates for these areas were not completed by 31\textsuperscript{st} March 2016. This has resulted in an under achievement of this element of the CQUIN with a financial deduction of 20\% of the overall CQUIN value which equates to approximately £54,663. The trust has demonstrated compliance against the remaining elements of the CQUIN such as: - evidence a project team with relevant stakeholders to manage CUR installation and implementation is in place, agreed and documented operational /mobilisation plan is in place and evidence of appropriate information flows have been established, along with datasets and a schedule of regular reports have been agreed and shared with commissioners on a quarterly/monthly basis.

Increasing Home Renal Dialysis.

The expected outcome of this CQUIN was to achieve an increase in the percentage of dialysis patients who receive their dialysis at home, either by peritoneal dialysis or home haemodialysis. For providers with a baseline below 30\%, the minimum target for quarter 4 was 30\%. The trust achieved a 22.25\% which constitutes 50\% payment. The overall financial deduction equates to approximately £27,332.
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 Assurance Group in place to review related reports and provide assessment and assurance on data quality. We recognise the need to have regular dialogue with our local commissioners (CCGs) and data quality is discussed on a regular basis.

Our hospital was not subject to an external Payment by Results clinical coding audit during the reporting period but completed the audit locally and the results are detailed below:

<table>
<thead>
<tr>
<th>Coding Field</th>
<th>Internal audit results</th>
<th>Comparison with 2014/15 Results (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015/16 Results (%)</td>
<td></td>
</tr>
<tr>
<td>Primary Diagnosis</td>
<td>90%</td>
<td>-2%</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>91%</td>
<td>-2%</td>
</tr>
<tr>
<td>Primary Procedure</td>
<td>92%</td>
<td>-1%</td>
</tr>
<tr>
<td>Secondary Procedure</td>
<td>87%</td>
<td>-1%</td>
</tr>
</tbody>
</table>

Improving data quality will therefore improve patient care and improve value for money. High quality information means better patient care and patient safety.

NHS number and general medical practice code validity

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.

The Royal Liverpool and Broadgreen University Hospitals will be taking the following actions to improve data quality:
• We have commissioned a comprehensive piece of work to assure performance data
• Both internal and external audits assist in assuring us of the quality of data held about the care we have provided to patients
• We meet with and work closely with our commissioners to provide assurances that the quality of data submitted to the Secondary Uses Service (SUS) is high.

The Royal Liverpool and Broadgreen University Hospitals NHS Trust submitted records during April 2015 to March 2016 the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data which included the patient’s valid NHS number was:

99.9% for admitted patient care (APC)
100% for outpatient care (OP)
99.3% for emergency care (A&E)

High NHS Number coverage has been maintained over recent years and meets a high standard when compared with the national average, as per the table below (data taken from the Secondary Uses Service (SUS) published Data Quality dashboards).

<table>
<thead>
<tr>
<th>Activity Type</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>APC</td>
<td>99.7%</td>
<td>99.8%</td>
<td>100.0%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>99.9%</td>
<td></td>
</tr>
<tr>
<td>OP</td>
<td>99.9%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>A&amp;E</td>
<td>98.1%</td>
<td>98.7%</td>
<td>99.6%</td>
<td>99.4%</td>
<td>99.0%</td>
<td>99.3%</td>
<td></td>
</tr>
</tbody>
</table>

The percentage of records in the published data which included a valid General Medical Practice Code was:

100% for admitted patient care
100% for outpatient care and
100% for emergency care
Information Governance toolkit attainment Levels

Information Governance is about how NHS and social care organisations and individuals handle information.

The trust reported an 82% compliance level for its IG toolkit submission for the end of the last financial year with an overall rating of Green.

There are six initiatives with 45 standards within this national toolkit. The initiatives include information governance management, confidentiality and data protection assurance, information security assurance, clinical information assurance, secondary use assurance and corporate information assurance. All of these standards are rated as satisfactory by Mersey Internal Audit Agency.
Final year position

The standards provide a framework for the Trust to measure its Information Governance compliance. As in previous years each standard is self-assessed and weighted between 0 and 3. Any standard that does not achieve a level 2 is classified as unsatisfactory which effects the whole of the toolkit, not just the specific standard.

The tables below details the position at 31st March 2016

<table>
<thead>
<tr>
<th>INITIATIVE DESCRIPTION</th>
<th>Total Standards</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance Management</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Confidentiality &amp; Data Protection Assurance</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Information Security Assurance</td>
<td>15</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Clinical Information Assurance</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Secondary Use Assurance</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Corporate Information Assurance</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>45</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>24</strong></td>
<td><strong>21</strong></td>
</tr>
</tbody>
</table>
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)

In previous years we have consistently delivered against the 18 weeks maximum wait target (from GP referral to treatment, if needed). However our figures up to the end of January 2016 showed that we were below target from November 2015 of patients being treated within 18 weeks of referral, against the target of 90%.

Our patient waiting lists continue to be monitored in weekly meetings to ensure the targets are met.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted Treated Within 18 Weeks</td>
<td>1557</td>
<td>1433</td>
<td>1408</td>
<td>1491</td>
<td>1231</td>
<td>1520</td>
<td>1512</td>
<td>1386</td>
<td>1246</td>
<td>1405</td>
<td>1391</td>
<td>1340</td>
</tr>
<tr>
<td>Admitted Referrals Total</td>
<td>1721</td>
<td>1578</td>
<td>1530</td>
<td>1618</td>
<td>1328</td>
<td>1666</td>
<td>1666</td>
<td>1523</td>
<td>1338</td>
<td>1536</td>
<td>1536</td>
<td>1544</td>
</tr>
<tr>
<td>Admitted % Treated</td>
<td>90.47%</td>
<td>90.81%</td>
<td>92.03%</td>
<td>92.15%</td>
<td>92.70%</td>
<td>91.24%</td>
<td>90.76%</td>
<td>91.00%</td>
<td>93.12%</td>
<td>91.47%</td>
<td>90.09%</td>
<td>90.05%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted Treated Within 18 Weeks</td>
<td>1292</td>
<td>1240</td>
<td>1429</td>
<td>1423</td>
<td>1131</td>
<td>1330</td>
<td>1407</td>
<td>1485</td>
<td>1061</td>
<td>1262</td>
<td>1265</td>
<td>1290</td>
</tr>
<tr>
<td>Admitted Referrals Total</td>
<td>1433</td>
<td>1363</td>
<td>1570</td>
<td>1566</td>
<td>1249</td>
<td>1463</td>
<td>1556</td>
<td>1859</td>
<td>1320</td>
<td>1587</td>
<td>1613</td>
<td>1635</td>
</tr>
<tr>
<td>Admitted % Treated</td>
<td>90.16%</td>
<td>90.98%</td>
<td>91.02%</td>
<td>90.87%</td>
<td>90.55%</td>
<td>90.91%</td>
<td>90.42%</td>
<td>79.88%</td>
<td>80.38%</td>
<td>79.52%</td>
<td>78.43%</td>
<td>78.90%</td>
</tr>
</tbody>
</table>
Emergency access

The national target for emergency department waiting times is for 95% of patients to be admitted, discharged or transferred as appropriate within four hours of their arrival at hospital. The trust has failed to achieve the 95% monthly target from November 2015. The total number of admissions to emergency department from April 15 – March 16 is stated below which equates to an overall performance of 93.22% of patients, seen, admitted, discharged or transferred within four hours.

Like other hospitals, we have seen an increase in emergency attendances and patients who need admitting to a hospital bed from the emergency department. Among these have been an increase in sicker patients who required more complex care and treatment. In addition we have seen a significant increase and consistently high numbers of patients in hospital beds who although medically fit and ready for discharge, have been unable to be discharged due to challenges in providing the appropriate support outside of hospital. This has a huge impact on the flow of patients through the hospital resulting in increased pressure on the emergency department.
We implemented a range of measures to help manage these pressures, including opening additional beds and working with partners in the community to improve access to healthcare in the community and directing patients to alternative options rather than attending our emergency department.

In addition the trust volunteered to be part of a national Multi-Disciplinary Accelerated Discharge (MADE) initiative. This aimed to identify inpatients who were ready for discharge or would benefit from early discharge planning to prevent a longer than needed stay in hospital. This involved utilising senior clinicians and managers from across the trust and also from partner organisations including commissioners, community services, social care and mental health services. At the start of every day, the MADE team met to identify and resolve any blockages preventing our inpatients from being safely discharged to either their own home or an alternative placement. We have continued to conduct this initiative on a smaller scale on several further occasions. This has helped resolve issues preventing discharge for many patients who had been ready for discharge in our hospital beds for long
periods of time and also helped further strengthen good working practices with our community based partners.

**Cancelled Operations**

During the year, we have worked to minimise the number of cancelled operations on the day of surgery for non-clinical reasons, and to ensure that if an operation has to be cancelled, our patients are given a new date which is within 28 days from their original date. However, an increase in emergency admissions throughout the year means that we have cancelled more operations than we would like (376) which is a slight increase to the number cancelled in 14/15 (365). However the trust has achieved the local target of 0.6% reporting 0.46% for 15/16.

![Cancelled Operations Chart]

**Cancer waiting times**

To ensure delivery of cancer waiting times targets, patients are tracked continuously by multi-disciplinary team coordinators from their initial referral or suspected cancer diagnosis. Our figures up to the end of February 2016 are showing that we have consistently achieved the national target of 85% on a month by month basis.
Readmissions

The Trust Board continues to monitor re-admission rates for patients recently discharged from hospital (within 30 days of discharge).

Whilst some emergency re-admissions following discharge from hospital are an unavoidable consequence of the original treatment, others could potentially be avoided through ensuring the delivery of optimal treatment according to each patient’s needs, careful planning, support for self-care, and availability of appropriate community support services. Our figures show that there has been a slight improvement in the overall rate of readmissions in 2015/16 (6.51%) to 2014/15 (6.67%).

The table below reports the percentage of patients aged 0 to 15 and 16 and over, readmitted within 30 days of being discharged from our hospital.
The Trust has taken the following actions to improve readmission rates by:

- Working to improve discharge as a patient experience priority
- Implementation of 7 day working across a number of speciality areas
- Improving the discharge process to ensure that early and effective planning is undertaken
- Ensuring appropriate liaison with local authority, clinical commissioning groups and community providers
- Utilising data to identify reasons for re-admissions and implement actions to address these issues to work collaboratively across the health economy

VTE (Venous Thromboembolism)

Venous thromboembolism (VTE) is a term that 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 blood stream 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 to prevent a VTE from occurring. Where clots happen the assessment, prescription and administration of appropriate medication is assessed to see if this has all been done correctly.

Preventing VTE is a national and trust priority. The table below shows the percentage of patients who were admitted to hospital for 2015/16 who received a risk assessment for VTE during that reporting period.

The table below show the national comparison of VTE performance between 2015 and 2016

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Reporting period</th>
<th>Total Number of Patient Eligible</th>
<th>RLBUHT Total</th>
<th>National Performance</th>
<th>National Total</th>
<th>Lowest Total</th>
<th>Highest Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients admitted to hospital who were risk assessed for VTE</td>
<td>Qtr 4 (15/16)</td>
<td>27,833</td>
<td>94.62%</td>
<td>95.53%</td>
<td>78.06%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients admitted to hospital who were risk assessed for VTE</td>
<td>Qtr 3 (15/16)</td>
<td>29,653</td>
<td>94.4%</td>
<td>95.5%</td>
<td>61.5%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients admitted to hospital who were risk assessed for VTE</td>
<td>Qtr 2 (15/16)</td>
<td>29,294</td>
<td>95.4%</td>
<td>95.9%</td>
<td>75%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients admitted to hospital who were risk assessed for VTE</td>
<td>Qtr 1 (15/16)</td>
<td>28,924</td>
<td>96.6%</td>
<td>96.04%</td>
<td>86.1%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients admitted to hospital who were risk assessed for VTE</td>
<td>Qtr 4 (14/15)</td>
<td>28,596</td>
<td>96.79%</td>
<td>96%</td>
<td>79.23%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
The table below shows the monthly performance of the Royal Liverpool Hospital Trust over a 2 year period of VTE performance

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6783</td>
<td>7027</td>
<td>8839</td>
<td>9394</td>
<td>7932</td>
<td>9430</td>
<td>9918</td>
<td>9175</td>
<td>8989</td>
<td>9473</td>
<td>8831</td>
<td>9375</td>
</tr>
<tr>
<td></td>
<td>7446</td>
<td>7596</td>
<td>9515</td>
<td>9927</td>
<td>8597</td>
<td>10027</td>
<td>10396</td>
<td>9549</td>
<td>9309</td>
<td>9784</td>
<td>9118</td>
<td>9694</td>
</tr>
<tr>
<td>91.10%</td>
<td>92.51%</td>
<td>92.90%</td>
<td>94.63%</td>
<td>92.26%</td>
<td>94.05%</td>
<td>95.40%</td>
<td>96.08%</td>
<td>96.56%</td>
<td>96.82%</td>
<td>96.85%</td>
<td>96.71%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9346</td>
<td>9099</td>
<td>9494</td>
<td>9769</td>
<td>8719</td>
<td>9339</td>
<td>9739</td>
<td>9428</td>
<td>8868</td>
<td>9343</td>
<td>8693</td>
<td>9033</td>
</tr>
<tr>
<td></td>
<td>9652</td>
<td>9452</td>
<td>9815</td>
<td>10129</td>
<td>9146</td>
<td>9797</td>
<td>10304</td>
<td>9992</td>
<td>9478</td>
<td>9873</td>
<td>9242</td>
<td>9609</td>
</tr>
<tr>
<td>96.83%</td>
<td>96.27%</td>
<td>96.73%</td>
<td>96.45%</td>
<td>95.33%</td>
<td>95.33%</td>
<td>94.52%</td>
<td>94.36%</td>
<td>93.56%</td>
<td>94.63%</td>
<td>94.06%</td>
<td>94.01%</td>
<td></td>
</tr>
</tbody>
</table>

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

- Development of VTE work programme to facilitate and support the VTE programme of work across the organisation.
- Continuing to complete VTE risk assessments for adult patients on admission to hospital, with the aim of achieving a target of above 95%
- Ensuring that all patients are appropriately risk assessed to identify if treatment to prevent thrombosis is required
- Development of an electronic system (electronic white board) to identify and track patients across the organisation requiring a VTE risk assessment.
- Performing monthly audits on each adult ward to ensure patients at risk of VTE receive appropriate medicines and/or compression stockings to help prevent blood clots developing during hospital admission.
Continuing to identify patients who developed a Hospital Acquired Thrombosis (HAT) during or within three months of admission

Undertaken a root cause analysis process to review all cases of HAT 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

**Infection Prevention and Control**

Infection prevention and control remains a high priority for the Trust. We strongly believe that protecting our patients and our staff against healthcare acquired infections is the responsibility of all our staff. This is supported by continued 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. Difficile), across our hospitals and community services continue to be a top quality improvement priority. Both Clostridium Difficile and MRSA bacteraemia have been a national priority for many years with every hospital acquired case reported to the Health Protection Agency (HPA) as part of a national surveillance programme.

**MRSA (Methicillin Resistant Staphylococcus Aureus)**

In 2015/16 the national target for all acute hospitals was zero MRSA Bacteraemias. We reported seven cases. We continue to work to prevent bacteraemia (blood stream infections), including MRSA with an extensive programme of screening and decolonisation which we continue for the duration of a patient stay. In addition, we ensure high standards for infection prevention and control practices including hand hygiene and aseptic procedures.
At the end of March 2016 the Trust reported two MRSA bacteraemia against a trajectory of zero. The second bacteraemia was a contaminant. A clinical skills facilitator working within the Infection Prevention and control team is working with the Team on the Emergency floor to embed a robust training and peer review process to address this issue.

<table>
<thead>
<tr>
<th>MRSA</th>
<th>Trust Attributable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-14</td>
<td>0</td>
</tr>
<tr>
<td>May-14</td>
<td>1</td>
</tr>
<tr>
<td>Jun-14</td>
<td>2</td>
</tr>
<tr>
<td>Jul-14</td>
<td>1</td>
</tr>
<tr>
<td>Aug-14</td>
<td>1</td>
</tr>
<tr>
<td>Sep-14</td>
<td>1</td>
</tr>
<tr>
<td>Oct-14</td>
<td>0</td>
</tr>
<tr>
<td>Nov-14</td>
<td>0</td>
</tr>
<tr>
<td>Dec-14</td>
<td>1</td>
</tr>
<tr>
<td>Jan-15</td>
<td>0</td>
</tr>
<tr>
<td>Feb-15</td>
<td>0</td>
</tr>
<tr>
<td>Mar-15</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total 2014/15 YTD</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MRSA</th>
<th>Trust Attributable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-15</td>
<td>1</td>
</tr>
<tr>
<td>May-15</td>
<td>0</td>
</tr>
<tr>
<td>Jun-15</td>
<td>0</td>
</tr>
<tr>
<td>Jul-15</td>
<td>0</td>
</tr>
<tr>
<td>Aug-15</td>
<td>0</td>
</tr>
<tr>
<td>Sep-15</td>
<td>0</td>
</tr>
<tr>
<td>Oct-15</td>
<td>0</td>
</tr>
<tr>
<td>Nov-15</td>
<td>0</td>
</tr>
<tr>
<td>Dec-15</td>
<td>0</td>
</tr>
<tr>
<td>Jan-16</td>
<td>1</td>
</tr>
<tr>
<td>Feb-16</td>
<td>0</td>
</tr>
<tr>
<td>Mar-16</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total 2015/16 YTD</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>
Whilst zero MRSA bacteraemia cases were not achieved at the end of the financial year two cases were reported against seven the previous year which is a significant improvement.

An investigation is undertaken for each MRSA involving the clinical and nursing team, clinical commissioning 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)**

C.Difficile can cause symptoms including mild to severe diarrhoea and sometimes severe inflammation of the bowel. However associated C.Difficile, in a number of cases, can be preventable. Patients are more vulnerable to infection when they are in hospital and reducing the risk of this is a top priority. There are some healthcare associated infections that the Trust has a statutory responsibility to report on. These include Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia and C.Difficile. NHS England sets targets to reduce the number of new cases of C.Difficile 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 44 hospital acquired cases of C.Difficile. The Trust has achieved this target, reporting 29 cases between April 15 – March 16. Each case is subject to a review process internally and externally. The target number of case for the coming year 2016/17 has been set at no more than 44 same as last year.

The table below shows the total number of C-Diff cases reported against the national annual target over the last 6 months.
Our goal for 2016-17 should be to further reduce the number of Trust attributable cases of *Clostridium difficile* infection and build upon collaborative working with the Clinical Commissioning Group Liverpool Community Health Infection Prevention and control team. The national target for 2016-17 is no more than 44 trust attributable cases. An internal goal of less than 29 based on the 2015-16 performance will be considered and agreed at appropriate committees.

The rate of C-Difficile per 100,000 bed days for 2014/15 is 15.60 and in 2015/16 rate per 100,000 bed days is 10.42 reported amongst patients aged two or over.
The Trust has taken the following actions to reduce the numbers of avoidable hospital acquired C.Difficile cases, and the quality of its services, by:

- Providing a proactive and responsive infection prevention service, with particular emphasis on increasing awareness of compliance

- Ensuring comprehensive guidance and audit on appropriate antibiotic prescribing is in place

- Covert Hand Hygiene Audits - unannounced observation audits focussing on the appropriate use of personal protective equipment (PPE) which includes hand hygiene compliance.

- Training and Education – Infection prevention and control team to continue to support induction and mandatory training sessions organised through learning and development in addition to student nurse local inductions, staff nurse preceptorship, medical student training and nurse training programmes at Liverpool John Moores.
• Implementation and delivery of the National AMR (antimicrobial resistance) CQUIN which will further focus efforts towards safer antibiotic prescribing

• The Trust aims to be amongst the best in the country with regard to this measure and as such is working in collaboration with the Clinical Commissioning Groups (CCGs) to adopt best practice across the health economy to reduce the rate of C.Difficile.
Patient Safety Incidents

This section reports the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period. It also includes the number and percentage of such patient safety incidents that resulted 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 significantly 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, resulting in no harm to person or people

**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 findings are shared Trust-wide, with the Clinical Commissioning Group (CCG) and most importantly the patient and/or family in accordance with the Trust’s Duty of Candour.

The Trust embraces its Duty of Candour and considers it vitally important when standards 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 the incident reporting rate.

The tables below provides data on the number and rate of incidents resulting in severe harm which was published on 19th April 2016. These incidents occurred between 1st April 2015 and 30th September 2015 and were reported to the National Reporting and Learning System (NRLS) by 30th November 2015.

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 2015 to 30 September 2015.

Our hospital reported 4,434 incidents (rate of 33.2) during this period. The median reporting rate for this cluster is 38.25 incidents per 1,000 bed days.
Are you actively encouraging reporting of incidents?

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 2015 to 30 September 2015. Your organisation reported 4,434 incidents (rate of 33.2) during this period.

Figure 1: Comparative reporting rate, per 1,000 bed days, for 136 Acute (non-specialist) organisations.

Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

How regularly do you report?

Your organisation reported incidents to the National Reporting and Learning System (NRLS) in 5 out of the 6 months between 01 April 2015 to 30 September 2015.

Report regularly: Incident reports should be submitted to the NRLS at least monthly.

Fifty per cent of all incidents were submitted to the NRLS more than 27 days after the incident occurred. In your organisation, 50% of incidents were submitted more than 55 days after the incident occurred.

Report serious incidents quickly: It is vital that staff report serious safety risks promptly both locally and to the NRLS, so that lessons can be learned and action taken to prevent harm to others.

The median reporting rate for this cluster is 38.25 incidents per 1,000 bed days.
What types of incidents are reported in your organisation?

Figure 2: Top 10 incident types

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Your Organisation</th>
<th>All Acute (non-specialist) organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient accidents</td>
<td>18.4%</td>
<td>22.7%</td>
</tr>
<tr>
<td>Implementation of care and ongoing monitoring / reviews</td>
<td>13.3%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Treatment, procedure</td>
<td>12.2%</td>
<td>14.2%</td>
</tr>
<tr>
<td>Medication</td>
<td>11.2%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Access, admission, transfer, discharge (including missing patients)</td>
<td>9.9%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Documentation (including records, identification)</td>
<td>9.4%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Infrastructure (including staffing, facilities, environments)</td>
<td>6.6%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Clinical assessment (including diagnosis, scans, tests, assessments)</td>
<td>6.5%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Consent, communication, confidentiality</td>
<td>4.8%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Medical device / equipment</td>
<td>3.3%</td>
<td>2.3%</td>
</tr>
<tr>
<td>All others categories</td>
<td>7.0%</td>
<td>21.2%</td>
</tr>
</tbody>
</table>

If your reporting profile looks different from similar organisations, this could reflect differences in reporting culture, the type of services provided or patients cared for. It could also be pointing you to high risk areas. The response system is more important than the reporting system.

Figure 3: Incidents reported by degree of harm for Acute (non-specialist) Organisations

<table>
<thead>
<tr>
<th>Degree of harm</th>
<th>All Acute (non-specialist) organisations</th>
<th>Your Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>75.1%</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>21.7%</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>11.1%</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>5.6%</td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td>0.3%</td>
<td></td>
</tr>
</tbody>
</table>

Do you understand harm?

Nationally, 72 per cent of incidents are reported as no harm, and just under 1 per cent as severe harm or death.

However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult.

Organisations should record actual harm to patients rather than potential degree of harm.

Recognising and reporting incidents resulting in severe harm or death is an important sign of an organisation’s reporting culture. If the numbers of incidents reported as severe harm or death are low compared with peers you should check that your reports reflect all incidents you are aware of through sources such as mortality review, inquests, litigation or complaints.

For further information on the reporting of serious incidents please see NHS England’s guidance [link](http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/about-reporting-patient-safety-incidents/)

Further information for you

The NRLS helps the NHS to understand why, what and how patient safety incidents happen, learn from these experiences and take action to prevent future harm to patients. Alerts and other learning resources can be found at: [link](www.england.nhs.uk/ourwork/patientsafety/psa/) and national data can be found at: [link](www.nrls.npsa.nhs.uk/patient-safety-data/).

Reviewing the results of the NHS staff survey relating to incident reporting alongside this report will provide an important indicator of your reporting culture.
Are you actively encouraging reporting of incidents?

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 October 2014 to 31 March 2015. Your organisation reported 4,308 incidents (rate of 31.46) during this period.

Figure 1: Comparative reporting rate, per 1,000 bed days, for 137 Acute (non-specialist) organisations.

The median reporting rate for this cluster is 35.34 incidents per 1,000 bed days.

Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

How regularly do you report?

Your organisation reported incidents to the National Reporting and Learning System (NRLS) in 4 out of the 6 months between 01 October 2014 to 31 March 2015.

Report regularly: Incident reports should be submitted to the NRLS at least monthly.

Fifty per cent of all incidents were submitted to the NRLS more than 26 days after the incident occurred. In your organisation, 50% of incidents were submitted more than 91 days after the incident occurred.

Report serious incidents quickly: It is vital that staff report serious safety risks promptly both locally and to the NRLS, so that lessons can be learned and action taken to prevent harm to others.
What types of incidents are reported in your organisation?

Figure 2: Top 10 incident types

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Your Organisation</th>
<th>All Acute (non-specialist) organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient accidents</td>
<td>19.7%</td>
<td>22.3%</td>
</tr>
<tr>
<td>Implementation of care and ongoing monitoring/</td>
<td>3.5%</td>
<td>13.7%</td>
</tr>
<tr>
<td>review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment, procedure</td>
<td>12.2%</td>
<td>11.0%</td>
</tr>
<tr>
<td>Medication</td>
<td>10.3%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Access, admission, transfer, discharge (including missing patients)</td>
<td>9.6%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Documentation (including records, identification)</td>
<td>7.2%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Infrastructure (including staffing, facilities,</td>
<td>7.1%</td>
<td>12.6%</td>
</tr>
<tr>
<td>environments)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical assessment (including diagnosis, scans,</td>
<td>6.2%</td>
<td>3.9%</td>
</tr>
<tr>
<td>tests, assessments)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consent, communication, confidentiality</td>
<td>3.9%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Medical device / equipment</td>
<td>3.2%</td>
<td>1.7%</td>
</tr>
<tr>
<td>All others categories</td>
<td>6.9%</td>
<td>15.4%</td>
</tr>
</tbody>
</table>

If your reporting profile looks different from similar organisations, this could reflect differences in reporting culture, the type of services provided or patients cared for. It could also be pointing you to high risk areas. The response system is more important than the reporting system.

Figure 3: Incidents reported by degree of harm for Acute (non-specialist) Organisations

<table>
<thead>
<tr>
<th>Degree of Harm</th>
<th>Your Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>3,491</td>
</tr>
<tr>
<td>Low</td>
<td>540</td>
</tr>
<tr>
<td>Moderate</td>
<td>257</td>
</tr>
<tr>
<td>Severe</td>
<td>17</td>
</tr>
<tr>
<td>Death</td>
<td>9</td>
</tr>
</tbody>
</table>

Do you understand harm?

Nationally, 71 per cent of incidents are reported as no harm, and just under 1 per cent as severe harm or death.

However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult.

Organisations should record actual harm to patients rather than potential degree of harm.

Recognising and reporting incidents resulting in severe harm or death is an important sign of an organisation's reporting culture. If the numbers of incidents reported as severe harm or death are low compared with peers you should check that your reports reflect all incidents you are aware of through sources such as mortality review, inquests, litigation or complaints.


Further information for you

The NRLS helps the NHS to understand why, what and how patient safety incidents happen, learn from these experiences and take action to prevent future harm to patients. Alerts and other learning resources can be found at: [www.england.nhs.uk/ourwork/patientsafety/psa/](http://www.england.nhs.uk/ourwork/patientsafety/psa/) and national data can be found at: [www.nrls.npsa.nhs.uk/patient-safety-data/](http://www.nrls.npsa.nhs.uk/patient-safety-data/).

Reviewing the results of the NHS staff survey relating to incident reporting alongside this report will provide an important indicator of your reporting culture.

Ref: Yourdata_RQ6_Sep2015
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 October 2014 to 31 March 2015. Our hospital reported 4,308 incidents (rate of 31.46) during this period. The median reporting rate for this cluster is 35.34 incidents per 1,000 bed days.

### Degree of Harm 01.10.14 – 31.3.15

<table>
<thead>
<tr>
<th>Degree of Harm</th>
<th>None</th>
<th>Low</th>
<th>Moderate</th>
<th>Severe</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,491</td>
<td>540</td>
<td>257</td>
<td>17</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>81</td>
<td>12.5</td>
<td>6.0</td>
<td>0.4</td>
<td>0.1</td>
<td></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 Meeting and Perfect Ward 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 CQC Duty of Candour regulation and report to appropriate committees.

**Never Events**

Never Events are described by NHS England as serious incidents that are wholly preventable as 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 type has a potential to cause serious harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that 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.

As of April 2014 NHS England publish provisional never events data as monthly updates throughout each financial year. Each report updates the previous month’s data as information on never events is reported or amended.

Nationally between April 2015 and February 2016 there were 309 Never Events, in the same period Royal Liverpool and Broadgreen Hospital had 4 Never Events.

**The Trust has taken the following actions to mitigate all risks associated with the occurrence of Never Events.**

- Improved safety surgery checklists
- Human factors training course and rolled out for theatre staff
- 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.
- Board accountable and robust governance arrangements to monitor and challenge actions associated within incidents.

The Trust is committed to using Root Cause Analysis (RCA) to investigate adverse events, including Never Events. This approach is underpinned by the Trusts’ commitment to working within 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.
**Patient Reported Outcome Measures (PROMs)**

PROMS are a series of measures recorded by patients’ pre and post operatively that measure how their quality of life and health outcomes have improved following their surgery.

There are 2 types of standard measures EQ-5D and EQ-Vas explained below and some areas have condition specific measures.

EQ-5D looks at 5 areas mobility, self-care, usual activities, pain/discomfort and anxiety/depression with questions that ask the patient to score themselves on 3 levels; no problems, some problem or severe problems. Formulas are added to produce a score with 1 being the best.

EQ-VAS is line marked from 0-100, 0 being the worst health state and 100 being the best. The patient is asked to mark a point in the line to indicate how they feel about their state of health.

We report PROMS measures scores for
(i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery, during the reporting period.
### PROMS reporting period: 1st April 2013 to 31st March 2014 Published August 2015

<table>
<thead>
<tr>
<th>Measure</th>
<th>EQ-5D Index</th>
<th>EQ-VAS</th>
<th>Condition Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Our Hospital Score</td>
<td>England Score</td>
<td>Our Hospital Score</td>
</tr>
<tr>
<td>Groin Hernia</td>
<td>48.3%</td>
<td>50.50%</td>
<td>48.1%</td>
</tr>
<tr>
<td>Hip Replacement - primary</td>
<td>78.4%</td>
<td>89.40%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Hip Replacement - revision</td>
<td>57.1% (8)*</td>
<td>70.40%</td>
<td>30% (3)*</td>
</tr>
<tr>
<td>Knee Replacement - primary</td>
<td>76.2%</td>
<td>81.40%</td>
<td>49.7%</td>
</tr>
<tr>
<td>Knee Replacement - revision</td>
<td>75.0% (6)*</td>
<td>67.50%</td>
<td>16.7% (1)*</td>
</tr>
</tbody>
</table>

*Figures based on a small number of records and therefore may be unrepresentative.

### PROMS reporting period: 1st April 2014 to 31st March 2015 – Published February 2016, these figures are provisional

<table>
<thead>
<tr>
<th>Measure</th>
<th>EQ-5D Index</th>
<th>EQ-VAS</th>
<th>Condition Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Our Hospital Score</td>
<td>England Score</td>
<td>Our Hospital Score</td>
</tr>
<tr>
<td>Groin Hernia</td>
<td>57.1%</td>
<td>50.70%</td>
<td>42.1%</td>
</tr>
<tr>
<td>Hip Replacement - primary</td>
<td>89.1%</td>
<td>89.60%</td>
<td>64.9%</td>
</tr>
<tr>
<td>Hip Replacement - revision</td>
<td>50.0% (4)*</td>
<td>72.50%</td>
<td>No data</td>
</tr>
<tr>
<td>Knee Replacement - primary</td>
<td>72.7%</td>
<td>81.00%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Knee Replacement - revision</td>
<td>No data</td>
<td>71.00%</td>
<td>50.0% (3)*</td>
</tr>
</tbody>
</table>

*Figures based on a small number of records and therefore may be unrepresentative.
The table shows the percentage of patients improving for various procedures, along with the EQ-5D Index and EQ-VAS scores. The data is reported for the period 1st April 2015 to 31st September 2015 and was published in February 2016. These figures are provisional and may be unrepresentative due to the small number of records.

<table>
<thead>
<tr>
<th>Measure</th>
<th>EQ-5D Index</th>
<th>EQ-VAS</th>
<th>Condition Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Our Hospital Score</td>
<td>England Score</td>
<td>Our Hospital Score</td>
</tr>
<tr>
<td>Groin Hernia</td>
<td>52.4% (11)*</td>
<td>51.10%</td>
<td>20.0% (4)*</td>
</tr>
<tr>
<td>Hip Replacement primary</td>
<td>100% (16)*</td>
<td>89.70%</td>
<td>64.3% (9)*</td>
</tr>
<tr>
<td>Hip Replacement revision</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>Knee Replacement primary</td>
<td>78.6% (11)*</td>
<td>82.80%</td>
<td>69.2% (9)*</td>
</tr>
<tr>
<td>Knee Replacement revision</td>
<td>100% (1)*</td>
<td>No data</td>
<td>100% (1)*</td>
</tr>
<tr>
<td>Varicose Vein</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
</tr>
</tbody>
</table>

*Figures based on a small number of records and therefore may be unrepresentative.
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 six monthly basis and includes deaths 30 days post 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 Summary Hospital-level Mortality Indicator reports on mortality at trust level across the NHS in England. 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 for this issue and 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.
Hospital Standardised Mortality Ratio (HSMR)

The HSMR is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect. The HSMR compares the expected rate of death in a hospital with the actual rate of death. It looks at those patients with diagnoses that most commonly result in death - for example, heart attacks, strokes or broken hips. For each group of patients it can be worked out how often, on average across the whole country, they survive their stay in hospital, and how often they die. This takes into account their age, the severity of their illness and other factors, such as whether they live in a more or less deprived area. The number of patients expected to die at each hospital is then compared with the number of patients that actually die. If the two numbers are the same, the hospital is scored at 100. If the number of deaths is 10% less than expected the score is 90. If it is 10% higher than expected the score 110.

The key differences between the SHMI and the HSMR are set out below: -

Hospital Standardised Mortality Ratio (HSMR)
- Indicator Developed by Dr Foster Intelligence
- Counts deaths for the 56 main diagnostic groups.
- Counts only deaths In-Hospital
- Adjusts for Palliative Care Patients
- Data is Published Monthly

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
<table>
<thead>
<tr>
<th>Trust Name</th>
<th>Discharge Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambridge University Hospitals NHS Foundation Trust</td>
<td>78.06 60.91 62.37 62.82 67.93 74.91 77.24 79.98 70.01</td>
</tr>
<tr>
<td>Salford Royal NHS Foundation Trust</td>
<td>96.36 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>University Hospitals Bristol NHS Foundation Trust</td>
<td>67.85 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>University Hospitals of Leicester NHS Trust</td>
<td>67.85 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>Royal Liverpool and Broadgreen University Hospitals NHS Trust</td>
<td>67.85 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>Leeds Teaching Hospitals NHS Trust</td>
<td>67.85 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>Central Manchester University Hospitals NHS Foundation Trust</td>
<td>67.85 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>National Average</td>
<td>67.85 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>The Newcastle Upon Tyne Hospitals NHS Foundation Trust</td>
<td>67.85 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>University Hospitals Birmingham NHS Foundation Trust</td>
<td>67.85 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>Sheffield Teaching Hospitals NHS Foundation Trust</td>
<td>67.85 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>University Hospital Southampton NHS Foundation Trust</td>
<td>67.85 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>Lancashire Teaching Hospitals NHS Foundation Trust</td>
<td>67.85 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>Oxford University Hospitals NHS Trust</td>
<td>67.85 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>University Hospital of South Manchester NHS Foundation Trust</td>
<td>67.85 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>Nottingham University Hospitals NHS Trust</td>
<td>67.85 68.41 67.85 63.95 76.99 84.93 84.93 84.93 74.91</td>
</tr>
<tr>
<td>Trust Name</td>
<td>Discharge Month</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST</td>
<td></td>
</tr>
<tr>
<td>SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST</td>
<td></td>
</tr>
<tr>
<td>SALFORD ROYAL NHS FOUNDATION TRUST</td>
<td></td>
</tr>
<tr>
<td>UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST</td>
<td></td>
</tr>
<tr>
<td>THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST</td>
<td></td>
</tr>
<tr>
<td>UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST</td>
<td></td>
</tr>
<tr>
<td>UNIVERSITY HOSPITALS BIRMINGHAM, NHS FOUNDATION TRUST</td>
<td></td>
</tr>
<tr>
<td>UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST</td>
<td></td>
</tr>
<tr>
<td>National Average</td>
<td></td>
</tr>
<tr>
<td>NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST</td>
<td></td>
</tr>
<tr>
<td>CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST</td>
<td></td>
</tr>
<tr>
<td>LEEDS TEACHING HOSPITALS NHS TRUST</td>
<td></td>
</tr>
<tr>
<td>UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST</td>
<td></td>
</tr>
<tr>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST</td>
<td></td>
</tr>
<tr>
<td>LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST</td>
<td></td>
</tr>
</tbody>
</table>

SHMI Benchmarking Jan 2014 - Dec 2016
Achieving a reduction of mortality is a three year plan and each year there are a number of priorities to drive this agenda. 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 are within expected number of deaths against the number reported.

During 2015/16 the Trust has continued to focus on the reduction of mortality. The systems introduced in 2013/14 have continued to develop along with the introduction of new pathways and review procedures. The work undertaken to reduce mortality is intrinsically linked to the wider patient safety agenda. The weekly safety meeting continues within the trust and all patient safety incidents including mortality are reviewed.

The following actions have been implemented to improve mortality

**Mortality Peer Review**
We set out to achieve 90% compliance with our Mortality Peer Review process which ensures all deaths are reviewed by the respective directorate at consultant level to ascertain any lessons that can be learned.

**Mortality alerts**
The Mortality Alert Group (formerly Dr Foster Alert Group) meets regularly to review any mortality alerts from Dr Foster. The scope of this group has been extended to include mortality alerts received by the Trust from other agencies. The group determine the best course of action to take and ensures the outcomes are reported appropriately.

**Clinical deterioration**
Early recognition, escalation and treatment of the deteriorating patient will reduce mortality. As such we have reviewed our observation chart and escalation plan and integrated the National Early Warning system (NEWS).
Palliative Care Coding Benchmarking Feb 2014 - Jan 2016

Palliative care coding for our trust appears to be higher than the national average and this may influence any further metrics of mortality rates. The SHMI (which includes deaths up to 30 days post discharge and does not include any correction for social deprivation and other factors) suggests that the mortality rate for our trust is not significantly higher than the expected rate as 1.037 within the expected range published in March 2016.

See Appendix 4 for full detail.
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.
The table below shows the trust’s responsiveness to patient experience by capturing this information from inpatients on a monthly basis.

<table>
<thead>
<tr>
<th>Local Inpatient Survey Results</th>
<th>Local Target</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-16</th>
<th>Feb-16</th>
<th>Mar-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you involved as much as you wanted to in decisions about your care?</td>
<td>&gt;90%</td>
<td>70.50%</td>
<td>68.60%</td>
<td>64.90%</td>
<td>74.20%</td>
<td>92.00%</td>
<td>97.50%</td>
<td>95.20%</td>
<td>99.20%</td>
<td>92.30%</td>
<td>90.30%</td>
<td>95.21%</td>
<td>90.46%</td>
</tr>
<tr>
<td>Were you given enough privacy when discussing your condition or treatment?</td>
<td>&gt;90%</td>
<td>76.70%</td>
<td>64.80%</td>
<td>69.00%</td>
<td>83.60%</td>
<td>93.20%</td>
<td>91.10%</td>
<td>97.00%</td>
<td>99.20%</td>
<td>95.30%</td>
<td>92.90%</td>
<td>94.61%</td>
<td>92.40%</td>
</tr>
<tr>
<td>Did you find someone to talk to about your worries and fears?</td>
<td>&gt;90%</td>
<td>89.30%</td>
<td>70.70%</td>
<td>67.90%</td>
<td>65.00%</td>
<td>78.40%</td>
<td>80.40%</td>
<td>92.80%</td>
<td>97.40%</td>
<td>85.80%</td>
<td>85.80%</td>
<td>83.83%</td>
<td>84.21%</td>
</tr>
<tr>
<td>Have your medications and possible side effects been discussed with you?</td>
<td>&gt;90%</td>
<td>64.80%</td>
<td>72.30%</td>
<td>78.40%</td>
<td>71.70%</td>
<td>83.00%</td>
<td>85.40%</td>
<td>90.20%</td>
<td>95.60%</td>
<td>85.30%</td>
<td>87.70%</td>
<td>89.82%</td>
<td>82.29%</td>
</tr>
<tr>
<td>Have you been kept informed of your discharge plans?</td>
<td>&gt;90%</td>
<td>45.10%</td>
<td>53.30%</td>
<td>56.90%</td>
<td>60.00%</td>
<td>62.50%</td>
<td>65.80%</td>
<td>65.20%</td>
<td>67.70%</td>
<td>69.00%</td>
<td>78.10%</td>
<td>74.25%</td>
<td>73.10%</td>
</tr>
<tr>
<td>Do you feel safe on this ward? (% ‘yes’)</td>
<td>&gt;90%</td>
<td>96.00%</td>
<td>97.80%</td>
<td>99.10%</td>
<td>99.20%</td>
<td>97.70%</td>
<td>98.70%</td>
<td>99.00%</td>
<td>98.20%</td>
<td>96.30%</td>
<td>98.10%</td>
<td>98.20%</td>
<td>94.70%</td>
</tr>
<tr>
<td>Patients report that their pain was managed effectively.</td>
<td>&gt;90%</td>
<td>81.30%</td>
<td>87.50%</td>
<td>91.30%</td>
<td>83.80%</td>
<td>86.70%</td>
<td>89.20%</td>
<td>97.10%</td>
<td>95.40%</td>
<td>85.90%</td>
<td>91.60%</td>
<td>95.21%</td>
<td>94.74%</td>
</tr>
<tr>
<td>Patient Experience Surveys total score</td>
<td>&gt;90%</td>
<td>70.20%</td>
<td>74.70%</td>
<td>79.40%</td>
<td>75.60%</td>
<td>84.50%</td>
<td>86.50%</td>
<td>88.90%</td>
<td>88.80%</td>
<td>89.40%</td>
<td>88.80%</td>
<td>89.22%</td>
<td>84.60%</td>
</tr>
</tbody>
</table>

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 to address the areas for improvement across the organisation.

- The implementation plan and progress report is presented to the monthly patient experience committee were colleagues from the patient council and health watch will 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 which will support our journey from 2016-18. This strategy sets out our direction of travel, focusing on delivering high quality patient care and will take us right up to the move into our new hospital.

• **End of Life Care** “Our aim” – to drive and sustain the quality of End of Life Care for our patients and to enable more patients to live and die in a place of their choice.

• **Safeguarding** “Our aim” – to ensure safeguarding mechanisms are in place to protect vulnerable patients.

• **Complaints, Compliments and Concerns** “Our aim” – to see improvement in response times for complaints with a key focus on sharing experiences and lessons learnt.

• **Outpatient Improvement Programme** “Our aim” – to improve the efficiency and experience to our entire group throughout our outpatient service.

• **Carer Strategy** “Our aim” – to empower carers through collaboration and engagement to ensure they can care for loved ones in our hospital

• **Volunteer Service** “Our aim” – to develop and expand the volunteer service that will deliver world class results across the health system.
National Inpatient Survey 2015

Introduction

Between September 2015 and January 2016, Royal Liverpool and Broadgreen University Hospitals NHS Trust invited 1250 patients to participate in the annual survey using a standardised questionnaire and 465 patients (39%) responded to the survey.

The methodology follows exactly the detailed guidelines determined by the survey co-ordination centre for the overall national Inpatient survey programme.

The survey required a sample of 1250 consecutively discharged inpatients, working back from the last day of July 2015, who had had a stay of at least one night in hospital.

Of the 1250 patients, 1189 were confirmed to be eligible cases, as 61 patients were excluded due to the survey being undelivered as patient not known at address or the patient having deceased following discharge.

Nationally, the 2015 national survey of adult inpatients attained responses from just over 83,116 people, which equates to a 47% response rate overall. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units.

The results were embargoed until they are uploaded onto the CQC website at the end of May 2015.

Findings

74 questions were included in the 2015 survey and a variety of acute trusts took part in this survey, however not all questions were applicable to every trust. There were modifications made to the survey. 6 new questions were added from the 2014 survey to the 2015 survey which include;
Q11 and Q13: The information collected by Q11 "When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?" and Q13 "After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?" are presented together to show whether the patient has ever shared a sleeping area with patients of the opposite sex. The combined question was numbered in report as Q11 and has been reworded as "Did you ever share a sleeping area with patients of the opposite sex?" The information based on Q11 could not be compared to similar information collected from surveys prior to 2006. This was due to a change in the question's wording and because the results for 2006 onwards have excluded patients who had stayed in a critical care area, which almost always accommodates patients of both sexes.

Q31: "In your opinion, did the members of staff caring for you well work together?" is a new question in 2015 survey and therefore not possible to compare with 2014.

Q56, Q57 and Q58: "Where did you go after leaving hospital?", "After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition? and “When you transferred to another hospital or went to a nursing or residential home, was there a plan in place for continuing you care?” are all new questions in 2015 and are therefore not possible to compare with 2014.

The total number of questions that were applicable to and scored for the Royal Liverpool and Broadgreen University Hospitals NHS Trust is 63. The detail in the table below is based on the results of those responses to the 63 questions that were scored within the survey. The survey uses an analysis technique called the ‘expected range’ to determine if the Trust is performing ‘about the same’, ‘better’ or ‘worse’ compared with other organisations.

The table below outlines the overall performance for all 63 questions comparing ourselves to last year’s data:
<table>
<thead>
<tr>
<th>Response Categories</th>
<th>Number of questions in this category</th>
<th>Number of questions in this category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014 Survey</td>
<td>2015 Survey</td>
</tr>
<tr>
<td>Best Performing Trusts</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>About the same</td>
<td>52</td>
<td>63</td>
</tr>
<tr>
<td>Worst performing Trusts</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

The trust has seen improvements in the following questions in comparison to results of the 2014 survey:

- **Q23**: Did you get enough help from staff to eat your meal?
- **Q49**: Did the Anaesthetist or another member of staff explain how would put you to sleep or control your pain?
- **Q51**: Did you feel you’re involved in decisions about your discharge from hospital?
- **Q73**: During your hospital stay were you ever asked to give your views on the quality of care?
- **Q74**: Did you see or were you given any information explaining how to complain in regards to the care you received?

**Areas for Improvement**

**Admission to Hospital**

Ensure that patients are given as much privacy as possible when being examined or treated in A&E. Completion of root cause analysis to identify the reasons for the number of times there have been changes of admission dates by the hospital particularly where these occur twice or more.

**The Hospital and Ward**

Investigation of the high levels of noise reported by patients and staff across individual wards to identify the areas for further investigation and improvement. If necessary, measure noise levels to ensure that staff are aware of actual levels and can take action where needed.
Ensure that there is a clear line of responsibility for the outcome of all environmental audits and cleaning audits and to continue to report the results and actions to relevant governance committee’s to evidence improvements and actions taken.

Evaluate the current security measures in place and revise if required to enhance patient and visitor security across the organisation.

**Your Care and Treatment**

There has been a drop in scores from 2014 to 2015 in particular about patients feeling they got enough emotional support from hospital staff. (Down from 79% to 71%) The trust will take further measures to ensure that patients know there is a member of staff to talk to if they have any worries or fears, or need emotional support.

There was some criticism of privacy particularly when discussing condition or treatment; and when being examined or treated. The trust will take further measures to examine ways of improving privacy around the patient’s bed, where most of these discussions take place.

The results of this survey will be shared with each division to determine how performance can be improved. An action plan will be developed for approval and monitored by the Patient Experience Sub Committee and further feedback will be attained through listening weeks and local survey questionnaires to ensure all feedback is captured and improvements are noted. The full results are published on the Care Quality Commission (CQC) website.
National Cancer Survey 2015

We are in the process of improving our scores on the National Cancer Patient Experience Survey and the results are due to published later on in the year. As a result of the 2015 survey results we have concentrated on a number of issues which required improving, namely patient information and support throughout their cancer Journey.

As a result we have developed a survivorship programme for all patients who have completed their treatment and are living with and beyond cancer. The programme has been developed by a steering group with patient feedback. The program is designed to better support our patients so they are equipped to self-manage their diagnosis and live their lives to the full following diagnosis.

We will also be developing a Macmillan backed support group for all cancer patients running alongside the programme so that patients still feel supported after the programme is completed.

In conjunction with this all Cancer Nurse Specialists are in to process of identifying where in the cancer journey they can complete Holistic Needs Assessments (HNA) with all their patients in order to again ensure out patients are being referred to the correct support services. A copy of the action plan derived from the Holistic needs assessment will be given to the patient as well as sent to their GP for their information. Progress against the 2015 action plan continues to be monitored through Patient Experience Committee.
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 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 vast majority of patients saying that it was “extremely likely” that they would recommend the Royal Liverpool and Broadgreen Hospital to their friends and family.

In-patient Friends and Family Test - April 2015 – March 2016

Percentage of patient recommending the hospital to friends and family (91.9%)

Overall percentage of patients not recommending the hospital to friend and family (3.60%)

- Extremely likely – 77.56%
- Likely – 14.37%
- Neither – 2.62%
- Unlikely – 1.61%
### Accident and Emergency National FFT April 2015 – March 2016

<table>
<thead>
<tr>
<th>Period</th>
<th>Trust Name (Accident and Emergency)</th>
<th>Total Responses</th>
<th>Response Rate</th>
<th>Percentage Recommended</th>
<th>Percentage Not Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-15</td>
<td>England</td>
<td>130,745</td>
<td>14.8%</td>
<td>87.5%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Apr-15</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST</td>
<td>1,370</td>
<td>15.1%</td>
<td>85%</td>
<td>8%</td>
</tr>
<tr>
<td>May-15</td>
<td>England</td>
<td>140,276</td>
<td>14.1%</td>
<td>88.3%</td>
<td>6.0%</td>
</tr>
<tr>
<td>May-15</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST</td>
<td>1,269</td>
<td>21.7%</td>
<td>84%</td>
<td>6%</td>
</tr>
<tr>
<td>Jun-15</td>
<td>England</td>
<td>147,551</td>
<td>15.1%</td>
<td>88.4%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Jun-15</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST</td>
<td>1,313</td>
<td>21.7%</td>
<td>86%</td>
<td>8%</td>
</tr>
<tr>
<td>Jul-15</td>
<td>England</td>
<td>154,267</td>
<td>15.2%</td>
<td>88.2%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Jul-15</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST</td>
<td>1,275</td>
<td>20.1%</td>
<td>84%</td>
<td>9%</td>
</tr>
<tr>
<td>Aug-15</td>
<td>England</td>
<td>141,952</td>
<td>14%</td>
<td>88%</td>
<td>6%</td>
</tr>
<tr>
<td>Aug-15</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST</td>
<td>1,295</td>
<td>21%</td>
<td>87%</td>
<td>5%</td>
</tr>
<tr>
<td>Sep-15</td>
<td>England</td>
<td>142,975</td>
<td>14.1%</td>
<td>88%</td>
<td>6%</td>
</tr>
<tr>
<td>Sep-15</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST</td>
<td>1,183</td>
<td>18.7%</td>
<td>83%</td>
<td>10%</td>
</tr>
<tr>
<td>Oct-15</td>
<td>England</td>
<td>142,320</td>
<td>13.6%</td>
<td>87%</td>
<td>7%</td>
</tr>
<tr>
<td>Oct-15</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST</td>
<td>1,397</td>
<td>20.4%</td>
<td>84%</td>
<td>10%</td>
</tr>
<tr>
<td>Nov-15</td>
<td>England</td>
<td>132,952</td>
<td>13.1%</td>
<td>87%</td>
<td>7%</td>
</tr>
<tr>
<td>Nov-15</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST</td>
<td>1,403</td>
<td>21.6%</td>
<td>80%</td>
<td>11%</td>
</tr>
<tr>
<td>Dec-15</td>
<td>England</td>
<td>127,888</td>
<td>12.7%</td>
<td>87%</td>
<td>7%</td>
</tr>
<tr>
<td>Dec-15</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST</td>
<td>1,214</td>
<td>20.1%</td>
<td>82%</td>
<td>10%</td>
</tr>
<tr>
<td>Jan-16</td>
<td>England</td>
<td>132,657</td>
<td>12.9%</td>
<td>86%</td>
<td>7%</td>
</tr>
<tr>
<td>Jan-16</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST</td>
<td>1,220</td>
<td>20.3%</td>
<td>81%</td>
<td>11%</td>
</tr>
<tr>
<td>Feb-16</td>
<td>England</td>
<td>133,861</td>
<td>13.3%</td>
<td>85%</td>
<td>8%</td>
</tr>
<tr>
<td>Feb-16</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST</td>
<td>1,271</td>
<td>20.5%</td>
<td>79%</td>
<td>13%</td>
</tr>
<tr>
<td>Mar-16</td>
<td>England</td>
<td>132,774</td>
<td>12%</td>
<td>84%</td>
<td>9%</td>
</tr>
<tr>
<td>Mar-16</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST</td>
<td>1,395</td>
<td>21.5%</td>
<td>78%</td>
<td>13%</td>
</tr>
</tbody>
</table>

- Extremely unlikely – 2.08%
- Don’t know – 1.76%
National Staff Friends and Family Test

From 1 April 2014, all NHS trusts providing acute, community, ambulance and mental health services in England were required to implement the FFT for staff.

NHS England’s vision for staff FFT is that all staff should have the opportunity to feedback their views on their organisation at least once per year. It is hoped that Staff FFT will help to promote a big cultural shift in the NHS, where staff have further opportunity and confidence to speak up, and where the views of staff are increasingly heard and are acted upon.

Staff are asked to respond to two questions. The ‘Care’ question asks how likely staff are to recommend the NHS services they work in to friends and family who need similar treatment or care. The ‘Work’ question asks how likely staff would be to recommend the NHS service they work in to friends and family as a place to work.

Staff FFT is conducted on a quarterly basis (excluding Quarter 3 when the existing NHS Staff Survey takes place)

The table below shows the staff responses to the national questions contained within the National Staff Friend and Family Test survey.

<table>
<thead>
<tr>
<th>Period</th>
<th>Org Name</th>
<th>Work</th>
<th>Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Percentage Recommended</td>
<td>Percentage Not Recommended</td>
</tr>
<tr>
<td>Q4 - 15 - 16</td>
<td>England</td>
<td>62%</td>
<td>19%</td>
</tr>
<tr>
<td>Q4 - 15 - 16</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS</td>
<td>72%</td>
<td>12%</td>
</tr>
<tr>
<td>Q2 - 15 - 16</td>
<td>England</td>
<td>62%</td>
<td>19%</td>
</tr>
<tr>
<td>Q2 - 15 - 16</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS</td>
<td>88%</td>
<td>4%</td>
</tr>
<tr>
<td>Q1 - 15 - 16</td>
<td>England</td>
<td>63%</td>
<td>18%</td>
</tr>
<tr>
<td>Q1 - 15 - 16</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS</td>
<td>67%</td>
<td>15%</td>
</tr>
<tr>
<td>Q4 - 14 - 15</td>
<td>England</td>
<td>62%</td>
<td>19%</td>
</tr>
<tr>
<td>Q4 - 14 - 15</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS</td>
<td>68%</td>
<td>16%</td>
</tr>
<tr>
<td>Q2 - 14 - 15</td>
<td>England</td>
<td>61%</td>
<td>19%</td>
</tr>
<tr>
<td>Q2 - 14 - 15</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS</td>
<td>70%</td>
<td>12%</td>
</tr>
<tr>
<td>Q1 - 14 - 15</td>
<td>England</td>
<td>62%</td>
<td>19%</td>
</tr>
<tr>
<td>Q1 - 14 - 15</td>
<td>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS</td>
<td>69%</td>
<td>13%</td>
</tr>
</tbody>
</table>
National Staff Survey 2015

The national staff survey is undertaken each year by the trust and the 2015 results were published on 22\textsuperscript{nd} March 2016. 2388 staff at Royal Liverpool and Broadgreen University Hospitals NHS Trust took part in this survey. This is a response rate of 39\% which is average for acute trusts in England, and compares with a response rate of 41\% in the 2014 survey.

The overall staff engagement score represents staff members’ perceived ability to contribute to improvements at work, their willingness to recommend the organisation as a place to work or receive treatment, and the extent to which they feel motivated and engaged with their work. The overall engagement score has increased nationally since 2011 reaching a peak score of 3.78 in 2015. The trust reported 3.79 in 2015 with an improvement noted from 2014.

Questions within the NHS Staff Survey tested the views of staff on our patient safety culture, their confidence in reporting unsafe clinical practice and whether they would recommend the trust to friends and family as a place to receive care to treatment, or as a place to work. Staff responded to questions on quality and patient safety based on their experience of a leadership culture which allows them to raise concerns safely, without fear of blame.

Actions to improve quality of care, patient safety, and leadership culture are evident in the staff survey results. It is positive that all the quality indicators such as staff confidence in reporting unsafe clinical practice, and effective use of patient feedback etc. are above average, or the same as previous years. The survey responses for 2015 are all better or the same as last year, and around half are better than the national average. We believe that our work on staff engagement and health and wellbeing is having a positive effect on these results.

The good news from the 2015 staff survey results is:

- Staff said they feel patient care and patient safety is generally better than the national average
- Staff were satisfied with the quality of work and patient care they can deliver
- Staff would recommend us to family and friends as a place to work or receive care or treatment
- Staff felt confident and secure in reporting unsafe clinical practice.
- Likewise staff said that our leadership style is also generally better than the national average.
- Staff said that they are able to contribute to improvements at work, that they feel part of an effective team, and that managers take an interest in their health and well-being.

There are also issues for us to work on. These were mainly in appraisal and staff motivation. Whilst appraisal uptake is much improved, staff have rated the quality of appraisal as poor and there will be a focus on improving this for 2016/2017. Whilst levels of staff motivation have significantly improved from last year, it remains an area of concern. We will address this during 2016/2017 through implementing coaching and collective leadership, encouraging staff to feel more supported, and empowered to develop and change things to make a difference.

The trust scored higher than the national average in a number of key indicators including: -
### NHS Staff Survey 2015

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Royal Liverpool &amp; Broadgreen Hospital 2015</th>
<th>Average (median for acute trusts) 2015</th>
<th>Royal Liverpool &amp; Broadgreen Hospital 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF1. Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.82</td>
<td>3.76</td>
<td>3.78</td>
</tr>
<tr>
<td>KF2. Staff satisfaction with the quality of work and patient care they are able to deliver</td>
<td>4.01</td>
<td>3.93</td>
<td>-</td>
</tr>
<tr>
<td>KF9. Effective team working</td>
<td>3.75</td>
<td>3.73</td>
<td>-</td>
</tr>
<tr>
<td>KF14. Staff satisfaction with resourcing and support</td>
<td>3.35</td>
<td>3.30</td>
<td>-</td>
</tr>
<tr>
<td>KF18. % feeling pressure in last 3 mths to attend work when feeling unwell</td>
<td>53%</td>
<td>59%</td>
<td>59%</td>
</tr>
<tr>
<td>KF19. Org and mgmt interest in and action on health /wellbeing</td>
<td>3.64</td>
<td>3.57</td>
<td>-</td>
</tr>
<tr>
<td>KF23. % experiencing physical violence from staff in last 12 mths</td>
<td>2%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths</td>
<td>27%</td>
<td>28%</td>
<td>26%</td>
</tr>
<tr>
<td>KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths</td>
<td>24%</td>
<td>26%</td>
<td>23%</td>
</tr>
<tr>
<td>KF7. % able to contribute towards improvements at work</td>
<td>71%</td>
<td>69%</td>
<td>67%</td>
</tr>
<tr>
<td>KF20. % experiencing discrimination at work in last 12 mths</td>
<td>9%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>KF21. % of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>86%</td>
<td>87%</td>
<td>87%</td>
</tr>
<tr>
<td>KF28. % witnessing potentially harmful errors, near misses or incidents in last mth</td>
<td>27%</td>
<td>31%</td>
<td>32%</td>
</tr>
<tr>
<td>KF31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.64</td>
<td>3.62</td>
<td>3.58</td>
</tr>
<tr>
<td>KF32. Effective use of patient / service user feedback</td>
<td>3.74</td>
<td>3.70</td>
<td>3.71</td>
</tr>
</tbody>
</table>

*In certain cases a dash (-) appears in the 2014 column in the above table. This is because of changes to the format of survey questions or the calculation of the Key Findings so comparisons with the 2014 score are not possible.*
Health, Work and Wellbeing

Staff health and wellbeing

This year we attained reaccreditation for the Health@Work Workplace Wellbeing Charter. The range of activity and support we offer staff enabled the Trust to get an “excellent” rating in seven areas of health and wellbeing. The health and wellbeing of our staff is extremely important. We have considerably improved management information to improve our understanding of issues surrounding stress. Staff have 24/7 access to a staff support service, supplied by colleagues in Merseycare NHS Trust. We also have a comprehensive range of training opportunities for all staff to assist in appraising stressors in their life and providing solutions to improving their lives including:

- Weight loss service, using our dieticians to manage a weight loss programme
- Workplace activity, enabling up to 100 staff to participate in workouts within the workplace on a weekly basis. Activities offered include Yoga, Dancercise, Tai Chi and Insanity workout
- Specific programmes to improve staff health and wellbeing, such as skin cancer awareness sessions, “love your liver” density checks and chiropody.

A staff therapy service has been established, which includes an occupational therapist for early intervention for staff suffering with stress and stress related conditions. The service also offers access to a physiotherapist to ensure that staff with musculoskeletal conditions receive early treatment. This service has been extended to include access to dieticians for staff with gastrointestinal conditions. During 2015 we also extended the staff therapy service to Broadgreen Hospital.

Work continues with staff to reach a greater understanding of stress, depression and anxiety. We are improving absence reporting procedures in this area. Health and Wellbeing activity continues to work towards our workplaces being a positive force for good work in this area. There are many recent initiatives, including:
- Improving the range of training opportunities available to increase the understanding of mental health issues in the Trust.

- Introduction of a health trainer programme following good results with post-operative breast surgery patients

- On-going analysis of health and wellbeing activity to highlight the correlation between participation and improved levels of sickness absence

- Introduction to mindfulness initiative to allow staff to improve resilience

- Improving understanding of sickness absence. This included the launch of new guides for managers and staff and a publicity campaign to highlight the costs of sickness absence and the range of support available. This included screensavers to highlight some associated costs

- The Trust has also been proactive in promoting the Freedom to Speak Up programme and is currently engaged in supporting staff champions.
How we did against our 2015/16 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.

Priority 1: Reducing Mortality: We will implement robust systems to improve mortality and improve patient outcomes

Aim: Adopt a zero tolerance approach to healthcare associated infections.

Deliver improved National Early Warning System (NEWS) escalation and further improvements in recognising the deteriorating patient.

Outcome: Overall Partial Achievement

Zero Tolerance to Healthcare Associated Infections Partial Achievement

MRSA

Whilst zero MRSA bacteraemia cases were not achieved at the end of the financial year two cases were reported against seven the previous year which is a significant improvement.
Meticillin Sensitive *Staphylococcus Aureus* (MSSA)

The Trust has reported 26 cases to date compared to 31 during a similar time period last year. The initial reduction in MSSA bacteraemia cases compared to the previous year has not been sustained as an increase in MSSA bacteraemia cases occurred in the third quarter. There will be a continued focus on reduction of MSSA bacteraemia cases in 2016 -17.

**Clostridium Difficile Infection**

The Trust remained under trajectory for *C. difficile infections* with 29 cases reported against a trajectory of 44 for the time period April 2015 to end March 2016

![CDT Graph]

*Escherichia Coli* (E.coli)

The Trust has reported 74 cases to date compared to 98 last year. Whilst this is a reduction from the previous year further focus and analysis is required to identify
contributory factors. Collaborative working between Infection Prevention and Control and the sepsis nursing team may help to highlight further priorities for action.

**Carbapenemase producing enterobacteriaceae (CPE)**

An increasing programme of screening, this now includes all critical care areas, haematology orthopaedic, hepatobiliary and now colorectal wards. In addition all readmissions to the Trust are identified for screening as well as patients whose stay exceeds 30 days. There is a robust system for screening contacts of cases identified and for reducing risk by isolation or cohort nursing and enhanced cleaning.

There have been 96 patients identified with Trust attributable CPE in this financial year, all but 2 have represented colonisation. The majority of these have been identified through the screening programme.

In August 2015 increased screening and outbreak actions were triggered by reports from hospitals receiving transfers positive on admission.

Robust screening, isolating, cohorting of patients, terminal cleaning, hydrogen peroxide misting and reinforcement of standard infection prevention precautions has reduced the numbers of new cases identified through weekly screening.

**Deliver improved National Early Warning System (NEWS) escalation and further improvements in recognising the deteriorating patient. Achieved**

The National Early Warning System has been fully implemented across the trust since April 2015, although the trust has seen a significant rise in the number of Medical Emergency Team (MET) calls there has been on average a 30% reduction in the number of cardiac arrests each month. The shift in emphasis from only calling the emergency team when patients are in cardiac arrest or perri arrest to calling them earlier is a result of the trust review of how the deteriorating patient is managed. This in turn has led to the development of a new policy which has clear guidance for the escalation of patients who are showing signs of deterioration.
An electronic observation and escalation system has been developed by our IT team and has been successfully trialled on a medical ward. A strategy is in place to trial the system on a surgical ward before roll out across the trust. The business case to support this is being progressed. It is hoped the system will be in place before the move to the new hospital in 2017.

Work is also underway to strengthen the Do Not Attempt CPR (DNACPR) process which will include introducing the regional Unified DNACPR form. Alongside this a group has been formed to case review the DNACPR decisions to provide assurance the decisions are appropriate, timely and have involved the patient and where appropriate the family.

The Resuscitation Training Team have been working closely with ward staff to not only complete an incident form for every MET call but to also give an account of how it came about and the actions taken along with completing the specific questions required for NCAA completion.

Going in forward into 2016-17 and the new hospital we need to reduce the number of MET calls by ensuring nursing and medical staff respond appropriately to the deteriorating patient from the outset and before the trigger is reached to call the MET.
Priority 2: Reduction in avoidable harm to our patients

Aim: Achieve no less than 97% new harm free hospital care and develop an Integrated Safeguarding Model

Outcome: Achieved

1. Maintain focus on reduction of harm to patients – 95% New Harm Free Care

2. Continue to work with stakeholders to anticipate patient care requirements in vulnerable groups.

3. Safe discharge arrangements for patients remain a priority for action this year. This priority has also been identified as a CQUIN target.

Reduction of harm to patients - National Safety Thermometer

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.

Types of Harm

- Pressure Ulcers
- Falls
- Catheter & Urinary Tract Infection
- VTE

Whilst the trust has remained fairly constant with regard to the level of harm free care, the Safety Team are going to work with ward staff to ensure data quality is improved and also use the output more proactively as a measure of harm free care. The safety team will report to the trust on the completion of the thermometer, accuracy of data and the outputs on a regular basis.
Whilst the trust has remained fairly constant with regard to the level of harm free care, the Safety Team are going to work with ward staff to ensure data quality is improved and also use the output more proactively as a measure of harm free care. The safety team will report to the trust on the completion of the thermometer, accuracy of data and the outputs on a regular basis.

Continue to work with stakeholders to anticipate patient care requirements in vulnerable groups

The trust continues to The Trust will work with the Safeguarding Boards, Clinical Commissioning Groups (CCG), statutory agencies and other provider organisations to ensure the effectiveness of multi-agency arrangements to safeguard and promote the well-being of adults, children and young people.

**Integrated Safeguarding Model**

The development of an integrated safeguarding model supports the strengthening of safeguarding governance arrangements, using an integrated model approach to safeguarding across the Trust for the next 3-years. This model incorporates 7 themes that relate to safeguarding as an agenda, to include children & young
people, adults, domestic abuse, mental health including Mental Capacity and deprivation of liberty, dementia, learning disabilities and autistic disorders and the anti-radicalisation programme PREVENT.

**Learning Disabilities**

The Trust is committed to meeting the needs of people with a learning disability as set out in the Care Quality Commission indicator on 'Access to healthcare for people with a learning disability', based on recommendations set out in *Healthcare for All* (2008):

The Trust has in place a mechanism to identify and flag patients with learning disabilities. It has pathways in place to ensure that the management of patients with a learning disability are reasonably adjusted to meet their health needs. A comprehensive training package is in place for all staff. The Trust is also committed to ensure that comprehensible information to patients with learning disabilities and their families / carers about the following:

- treatment options;
- complaints procedures; and
- appointments.

**Dementia**

Development and implementation of a Dementia Strategy to enable people with dementia and their carers to live well with dementia and outline the support and services our hospital can provide. Dementia patients are now flagged electronically under VP (vulnerable patient) status on the ward whiteboards, this will auto populate on further admissions.

The key priorities of the implementation plan for the Dementia Strategy are identified as:

- Early intervention diagnosis for all
- Improved quality of care for people with dementia in general hospitals
- Living well with dementia in care homes
- Reducing the use of Anti-psychotic drugs.
• Improved community personal support services

Our hospital has a robust dementia steering group which meets on a monthly basis. Memory café held monthly where patients and careers attend Costa for coffee and cakes each month different cognitive session helps patients and carers to meet and support each other with expert advice at hand from our dementia team. This was given an award to acknowledge outstanding contribution to dementia care. Further achievements are detailed in the patient experience section of the quality account.

Safe discharge arrangements for patients

The trust has implemented the Effective Discharge Planning CQUIN in 2015/16 as well as the Clinical Utilisation Review (CUR) CQUIN which both supports the safe and effective discharge for patients. The areas included are:

Implementation of a Clinical Utilisation Software System (Medworxx). The system acts as an enabler to patient flow. It requires every patient to be assessed against clinical criteria set every day which in turn provides the hospital with intelligence on which patients still require to be in the bed base at that level of care and those who are passing the Readiness for discharge clinical screen. This then provides the hospital with information on what every patient is waiting for on that day including internal and external factors such as social care packages, community support, equipment, medication, discharge documentation and clinical review. Further areas of implementation are:

- Discharge Checklist completed for all patients

- Estimated Date of Discharge established within 24 hours of admission

- Development of a Clinical Management Plan for discharge. Clear evidence that discharge management plan identified patient and carer involvement

- Medication is issued to the patient in an accessible format to ensure the safe administration of medication either by the patient or carer.
- Discharge Documentation is completed and sent to the GP within 24 hours. All relevant information is communicated to the patients GP and relevant agencies to support a safe transfer/discharge of care.

- Adoption of a Home of Lunch scheme

The adoption of a transformational change to discharge planning across the hospital has resulted in the development and implementation of a discharge strategy to support the agenda. The strategy includes a 4 lane approach to discharge which will support safe, effective and well-led discharges for all patients.

**Discharge Strategy – 4 Lane Approach**

<table>
<thead>
<tr>
<th>Lane</th>
<th>Discharge</th>
<th>Process and personnel</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lane 1</td>
<td>Uncomplicated –straight home usual residence no input no change in care needs</td>
<td>Clinical decision made, patient is RFD ,no MDT involvement discharge straight from clinical decision</td>
<td>Named Nurse EDD</td>
</tr>
<tr>
<td>Lane 2</td>
<td>Simple Discharge – Straight home Usual Residence minimal input</td>
<td>Clinical decision made patient is RFD discharge MDT input Referrals needed via Ice ,TTOS,EDS,</td>
<td>Named nurse ,nurse in charge EDD</td>
</tr>
<tr>
<td>Lane 3</td>
<td>Complex –care need change</td>
<td>Clinical decision ,MDT assessment ,patient is RFD change in care need , Out of area Increase Package of care ,CHC</td>
<td>Nurse in charge with Support of MDT and hospital case Manager EDD</td>
</tr>
<tr>
<td>Lane 4</td>
<td>Highly complex –full MDT</td>
<td>Clinical decision, patient is RFD –change in care need ,best interest meeting Application Of CHC checklist</td>
<td>Led by hospital case manager with Full ward and clinical support EDD</td>
</tr>
</tbody>
</table>
Priority 3: Delivering patient centred care, treating all patients with dignity and respect and obtaining feedback that more than 75% of patients would be extremely likely to recommend this Trust to a family member or friend

Aim: 75% of patients would be extremely likely to recommend this Trust to a family member or friend

Outcome: Achieved

In-patient Friends and Family Test - April 2015 – March 2016

The overall percentage achievement from April 2015 – March 2016 is 77.56% of patients are Extremely likely to recommend the trust to family and friends.

Percentage of patient recommending the hospital to friends and family (91.9%)

Overall percentage of patients not recommending the hospital to friend and family (3.60%)

- Extremely likely – 77.56%
- Likely – 14.37%
- Neither – 2.62%
- Unlikely – 1.61%
- Extremely unlikely – 2.08%
- Don’t know – 1.76%

As part of our two year plan to improve patient experience we are aiming for 75% of our patients to rate extremely likely to recommend our hospital to friends and family.

Patient feedback is the most important indicator of how well an organisation is doing. We undertake regular feedback surveys with our patients in a variety of ways. The introduction of the Friends and Family Test (FFT) has given us an opportunity to understand in more detail how patients are feeling about their experience.

Throughout the year, the trust reported an average of 91.2 % inpatients who responded to the FFT and would be extremely likely to recommend this hospital to friends and family. Emergency department 83.4% of patients who responded to the FFT and would be extremely likely to recommend this hospital to friends and family.
The trust is currently looking at new initiatives to improve responses rates for FFT, ward based postcards are in place to post-boxes and online surveys will be commencing in the coming months.

Work is underway to triangulate of our staff survey, friends and family survey data and inpatient survey to identify whether there are any common themes relating to patient experience or quality care concerns.

**Priority 4: To ensure that people with learning disabilities and/or autistic spectrum conditions are able to access our services when necessary including making reasonable adjustments to services**

**Aim:** To improve the care for patients with learning disabilities and/or autistic spectrum conditions by:

- Developing and launching a Learning Disability Strategy 2015 to 17.
- Develop an electronic system to flag and record patients accessing our services with learning disabilities
- Develop a risk assessment process for patients admitted with learning disabilities.

**Outcome: Achieved**

A learning disability strategy has been development which drives this agenda and is supported by a robust work plan to monitor performance and drive improvements

The Trust has in place a mechanism to identify and flag patients with learning disabilities. It has pathways in place to ensure that the management of patients with a learning disability are reasonably adjusted to meet their health needs. A comprehensive training package is in place for all staff. The Trust is also committed to ensure that comprehensible information to patients with learning disabilities is available across all services.

The trust has development a comprehensive risk assessment for learning disabilities which will be rolled out across the hospital. The safeguarding team are supporting this process with training and implementation. Progress will continue to be monitored through the local learning disabilities CQUIN which the hospital has committed to deliver during 2016/17 and risk assessments for all patients with learning disabilities is an indicator of the overall requirements.
Review of Quality Performance: Safety

Sepsis: Improved recognition and documentation of patients with Sepsis

Sepsis claims 37,000 lives annually in the UK and costs the NHS an estimated £2.5 billion. Early intervention with the Sepsis 6 bundle certainly saves lives, but has also been shown to reduce the length of hospital day and the need for critical care admissions. Evidence shows that addressing an organisation’s response to sepsis will save an extra 100 lives per year for a typical medium sized District General Hospital, and £1.25 million annually; just by getting the basics right.

Sepsis….time is life project

The sepsis time is life project was established as part of the wider patient safety strategy. The aim of the project was to improve the identification, management and treatment of patients with sepsis. Sepsis has been high on the political agenda and as such has remained a strategic focus for our hospital. A sepsis strategy was devised in line with our hospital values and objectives to highlight key aims utilising quality improvement methodology. To date, the project has been key in improving outcomes for patients with sepsis, and responsible for the delivery of various trust objectives, including a reduction in mortality and reduced length of stay.

This project has also involved patients in co-designing services and used patient experience to drive changes in sepsis care. The project is implementing and evaluating an innovative approach to sepsis improvement by using a nurse-led sepsis team.

Team Development and Governance

Our sepsis team has continued to meet once a week on a Monday morning to discuss sepsis improvement activities. We have been successful in securing funding for 3 more Sepsis Nurses and they commenced in the hospital in January 2015.

The nurses will see and a fast-track patient with sepsis to ensure the “sepsis bundle” is completed in a timely manner. They will also collect real time data and reduce our
reliance on notes to collect data. The team will also work with other clinical staff to support improvements in care for patients who develop sepsis on inpatient wards.

Our hospital Sepsis Steering Group continues to meet on a monthly basis to oversee sepsis improvement. Membership has grown and it now has representation from nonclinical staff such as medical records, audit and coding departments. Most importantly a representative patient expert from the UK Sepsis Trust is now a member of the group and provides invaluable input.

The ED/AMU Sepsis Group meet on a weekly basis to review cases. Lessons learnt are circulated to staff and interventions to improve our systems and work is being done to develop a sepsis sticker and improve triage of patients admitted via AMU/ED with sepsis.

We have improved our links with North West Ambulance Service (NWAS) to implement a pre-hospital sepsis screening tool and management bundle which will alert the trust.

**Education and training**

- We have continued to run our over-subscribed sepsis simulation course and so far we have trained over 400 nurses and over 200 doctors in the last year.

- Sepsis is now part of induction for all clinical AND non-clinical staff. We are working with the Simulation Department to deliver Insitu (ward-based) sepsis simulation training in January 2016

- We continue to be involved in regional sepsis related workshops and conferences organised by Advancing Quality and the Royal College of Physicians

- We have delivered sepsis teaching to out of hours GP in Liverpool through two teaching sessions with Urgent Care 24.
• We have also delivered University teaching sessions for medical students, nursing and paramedic students in the region.

• We also presented our work at the National Patient Safety Congress in July 2015, Birmingham and we were shortlisted for a Clinical Leadership Award.

Service improvement

• We have revised our sepsis pathway to focus on rapid administration of antibiotics and fluid resuscitation as these is areas we need to work on.

• Sepsis pathways are now part of the NEWS chart however we recognise that sepsis screening and use of the pathways needs to be improved. We plan to incorporate sepsis screening into electronic recording or EWSs in 2016 and we are developing sepsis stickers to encourage use of sepsis bundles. We are also developing a prompt on ICE when blood cultures are requested. The NCEPOD Audit report suggested that use of sepsis bundles can improve care so we need to focus on ensuring that the sepsis bundle is completed for patients with sepsis.

• Blood culture packs were introduced in March 2015. We received a lot of interest from Trusts in the UK and we have shared our packs with other hospitals. Staff members have provided very positive feedback about the packs. We now have data which suggests blood culture contamination rates have reduced by about 25% as a result of introducing the packs.

• We have also developed links and shared our work with international programmes such as the “Sepsis Kills Programme” in New South Wales, Australia and the Scottish Patient Safety Programme. We plan to develop our links with these sites and share our experience.

What does success look like?

To date, the project has been extremely successful. By adopting various quality improvement methodologies the project team has been able to identify various
improvements alongside a backdrop of challenging targets. In relation to mortality, we have observed a 20% reduction in septic shock mortality over the duration of the project. For all sub groups of sepsis (sepsis, severe sepsis and septic shock) there has been a 5% reduction in mortality whilst admissions for sepsis have almost doubled since the project inception.

<table>
<thead>
<tr>
<th>Sepsis Spells</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis</td>
<td>858</td>
<td>1282</td>
<td>1407</td>
</tr>
<tr>
<td>Severe Sepsis</td>
<td>45</td>
<td>76</td>
<td>113</td>
</tr>
<tr>
<td>Septic Shock</td>
<td>48</td>
<td>75</td>
<td>75</td>
</tr>
</tbody>
</table>

In relation to length of stay, the project has continued to deliver efficiencies as part of the Trust QEP programme. In its first year, the project managed to identify Length of stay savings of over £600k. In the second year of the project, over £300k has been identified through the QEP tracker, whilst continuing to reduce variation.

The project is a great example of how the Trust can bring about change, using quality improvement tools, such as mapping, analysis and engagement which result in improved outcomes for patients that can be sustained over a number of years.

Patient involvement has been a key part of this project with involvement of a patient expert in the steering group. In addition patient stories have been used effectively to highlight the improvement work and educate staff.
**Campaign**

We celebrated World sepsis day in style on the 13th September 2015. The Sepsis Team used World Sepsis Day to highlight the work being done in our hospital to improve recognition and treatment of sepsis. The day was a great success in terms of raising awareness amongst staff and the general public.

We ran a sepsis campaign in September 2015 via screen savers which received very positive feedback. The campaign focused on sepsis screening, timely administration of antibiotics and administration of adequate amounts of intravenous fluids.

Grand Round on the 11th of September focused on sepsis and was well attended. Guest speakers from North West Ambulance Service spoke about pre hospital sepsis care. This was preceded by a presentation of a patient story, who has had sepsis and is a patient representative for the UK Sepsis Trust. The patient story highlighted the need for recognising sepsis and ensuring patient’s receive antibiotics without delay – within one hour. It also highlighted the need to involve senior doctors and nurses when a patient has sepsis and the potential long term complications of sepsis.
Challenges and focus for next year

- Ensure at least 90% of patients admitted with severe sepsis/shock receive antibiotics within 1 hour

- Using the nurse led sepsis team to extend our work from AMU/ED to the rest of the hospital. This will be done by working closely with ward teams, ANPs and critical care.

- Delivering and achieving all elements of the National Sepsis CQUIN.

- Support development of a robust triage process in ED/AMU to ensure patients with sepsis are identified rapidly and fast-tracked to treatment

- Achieve consistent care by improving sepsis screening and use of sepsis care bundles across the trust.

- Collect data real time and reduce reliance on medical notes to collect data.

- Develop a patient support group for sepsis and ensure patients with sepsis are discharged with information about sepsis.
• Improve collaboration with other Advancing Quality teams e.g. AKI team

• Strengthen GP training for sepsis and develop a formal pre-hospital alert system for patients with sepsis

• Develop sepsis related research

• Run a Northwest wide sepsis symposium in collaboration with NW AHSN and AQ

We have continued to set ambitious targets.

Our mission is to continuously transform sepsis care in the Royal Liverpool and Broadgreen University Hospitals NHS Trust. To do this, we must maintain our focus on continuous improvement and pushing the boundaries.
Sign up to Safety – Listen, Learn, Act

As a Trust we signed up to and engaged with the three year national Sign up to Safety Campaign and declared the below pledges in support of NHS England’s patient safety improvement quest to reduce avoidable harm by 50% in three years.

Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients. Our pledges were composed using performance against qualitative and safety indictors, and, importantly, feedback received from our staff and patients. We have focused on areas where we know we can make improvements and have included areas of change where work may have already begun. Our Trust pledges that have been launched are available on our website.

Our hospital is committed to providing the highest quality healthcare to the health economy it serves. As such, the Trust has signed up to the “sign up to safety” campaign and has made the following pledges;

Put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

We will;

- Engage with patients, carers and their families by actively encouraging engagement and involvement with issues surrounding patient safety.
- Review of current Modified Early Warning Score and its use across the Trust. Trial the use of the National system, and consider an electronic bedside observation tool.
- Implement the sepsis screening tool across the Trust in order to improve the identification and treatment of patients with sepsis.
- Review of every patient death through the current Mortality Peer Review (MPR) process - Reduce the number of patient falls, medication errors, cases of tissue viability and VTE whilst also monitoring performance through an overarching dashboard.
2. Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

We will;
- Create a culture of honesty, openness and transparency
- Use data intelligently in order to understand potential improvement opportunities at ward level
- Use the outcomes of complaints and serious incidents intelligently to ensure that lessons are learned.
- Ensure that there is a robust process in place to guarantee that incidents and complaints are effectively investigated and reported.
- Empower and educate patients
- Continue the Trust Board safety walkabouts

3. Honesty. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

We will;
- Continue to publish the weekly Patient Safety and Experience bulletin, that explains current issues
- All serious incidents reviewed through a multi-disciplinary group and reported appropriately
- Number of complaints received per ward are displayed on patient information boards, alongside patient stories, commendations and through monthly Team Brief
- Rollout and raised awareness of the Trusts responsibility re Duty of Candour

4. Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

We will;
- Participate in improvement initiatives facilitated by AQuA
- Continue to hold monthly the multi-disciplinary MAPS (Mortality and Patient Safety) subcommittee in order to identify and monitor current Trustwide workstreams relating to mortality and patient safety. Over the coming year, consider widening the membership of the group to the public and local primary, secondary and tertiary healthcare providers.

- Continue strong links with local universities and colleges and consider how we can improve engagement with local healthcare economy including the local Council.

5. **Support.** Help people to understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress and improvements made.

**We will;**

- Continue to provide tailored courses for staff for example Human Factors
- Generate innovation across the Trust, by empowering and challenging to staff to develop ideas for improvement
- Develop a ‘no blame culture’ across the Trust to ensure that patient safety incidences are reported appropriately.

Further work is being undertaken to take forward all of these pledges and drive the improvements. These pledges are also integrated within the Trust’s Quality and Safety strategies.
Safeguarding Children and Adults

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 Boards and Safeguarding Adults’ Boards within its footprint and is actively engaged in Serious Case Review (SCR) and Domestic Homicide Review activity.

The development of an integrated strategy incorporating safeguarding Adults, Children and young people, Domestic Abuse and associated agenda’s will support the Trust in meeting its 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.

The table below shows the achievement of safeguarding training for all staff across the hospital as off 31st December 2015.
<table>
<thead>
<tr>
<th>Safeguarding Training Requirements</th>
<th>Threshold</th>
<th>Quarter 3 Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 Adult Safeguarding Training for all staff (Bournemouth Competencies, 2010)</td>
<td>90%</td>
<td>97%</td>
</tr>
<tr>
<td>Level 2 Adult Safeguarding Training - eligible cohort of staff (Bournemouth Competencies, 2010)</td>
<td>80%</td>
<td>85%</td>
</tr>
<tr>
<td>Level 3 Adult Safeguarding Training - eligible cohort of staff (Bournemouth Competencies, 2010)</td>
<td>80%</td>
<td>87%</td>
</tr>
<tr>
<td>Level 4 Adult Safeguarding Training - for all relevant staff (Bournemouth Competencies, 2010)</td>
<td>50% by Q4</td>
<td>Reporting in Q4</td>
</tr>
<tr>
<td>Level 1 Training for all staff</td>
<td>90%</td>
<td>97%</td>
</tr>
<tr>
<td>Level 2 Training for all relevant staff</td>
<td>80%</td>
<td>85%</td>
</tr>
<tr>
<td>Level 3 Training for all relevant staff</td>
<td>80%</td>
<td>87%</td>
</tr>
<tr>
<td>Level 4 Training for all relevant staff</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>Level 3 Children in Care Training (Intercollegiate role framework, 2014)</td>
<td>Count</td>
<td>-</td>
</tr>
<tr>
<td>Prevent Strategy/Awareness Training</td>
<td>90% year end</td>
<td>97%</td>
</tr>
<tr>
<td>Prevent Strategy/HealthWrap Training</td>
<td>40% year end</td>
<td>87%</td>
</tr>
<tr>
<td>Prevent Strategy/HealthWrap Training</td>
<td>70% by year end</td>
<td>Reporting in Q4</td>
</tr>
<tr>
<td>Prevent Strategy/HealthWrap Training</td>
<td>90% by year end</td>
<td>Reporting in Q4</td>
</tr>
<tr>
<td>Mental Capacity Act &amp; Deprivation of Liberty Safeguards (2005)</td>
<td>90%</td>
<td>97%</td>
</tr>
</tbody>
</table>
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 2015 - 2017 and is the start of 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

- 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 Sexual Exploitation (CSE), the PREVENT Agenda, and implementation of the Care Act 2014 agenda which are key priority areas for Local safeguarding boards and the Trust including preparation for inspections across health and local authority.

- Support designated individuals to contribute to the work of the LSCB and LSAB subgroups and other 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), 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, PREVENT and Female Genital Mutilation, 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.
**Integrated Safeguarding Framework**

The integrated safeguarding model recognises the necessity for safeguarding to be every one's business. It highlights the cohesion between themes and the importance of maintaining partnership relationships with key stakeholders, including the individual themselves, their family and carers; and in particular with partners such as the police, social care to support a multi-agency approach to prevention and protection of the most vulnerable. Awareness has been raised across the hospital this framework will direct the development of work plans to support a more robust and joined up approach to the safeguarding agenda, including its governance and partnership working arrangements. It will provide clarity to the Trust's Directorates with regard to their responsibilities and accountabilities for safeguarding and the associated governance requirements.

**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. The Francis report recommendations relating to improving safety for vulnerable groups to develop an on-going culture of quality across the health economy including assurance in relation to the legal requirements for Duty of Candour will also be implemented.
Advancing Quality Alliance (AQUA), the North West’s health quality organisation published its six year figures showing the Trust has continued to improve in key clinical areas since the schemes’ launch in October 2008. The Advancing Quality programme aims to give patients a better experience of the NHS by ensuring the highest standards of care are consistently achieved.

The North West has higher than average smoking rates and alcohol consumption compared to other areas and is the region with the second highest rate of hospital stays related to alcohol and deaths from smoking. In addition to these socio-economic factors the population of the North West is also living longer but with more health complications, the impact of this on the health of patients in the North West led to the following clinical areas being launched in 2008;

- Heart Attack
- Heart Bypass Surgery
- Heart Failure
- Pneumonia
- Hip and Knee Replacement Surgery

Between 2010 and 2012, AQ extend the programme to include the following clinical areas to further enhance the quality of care provided and to improve overall patient outcomes.

- Stroke
- Dementia
- Psychosis

In April 2015 Advancing Quality launched a further set of clinical areas across the following pathways: -

- Acute Kidney Injury
- Alcohol Related Liver Disease
- Chronic Obstructive Pulmonary Disorder
- Diabetes
- Hip Fracture
- Sepsis

The following clinical areas are no longer part of the Advancing Quality bundle in 2016. However performance continues to be monitored locally and nationally against CQUIN schemes, national and local operational standards.

- Stroke
- Asthma
- Atrial Fibrillation
- COPD
- Diabetes
- Heart Failure

**Appropriate Care Score (ACS)** number of patients receiving all measures out of the total eligible for the measure

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>Period (Y9)</th>
<th>Rank Across Northwest</th>
<th>CQUIN Target 15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Myocardial Infarction: Appropriate Care Score</td>
<td>94.9%</td>
<td>5th out of 15</td>
<td>95%</td>
</tr>
<tr>
<td>AMI: Data Completeness</td>
<td>100.0%</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>Acute Kidney Injury: Appropriate Care Score</td>
<td>10.3%</td>
<td>7th out of 14</td>
<td>50%</td>
</tr>
<tr>
<td>AKI: Data Completeness</td>
<td>87.2%</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>Alcohol Related Liver Disease: Appropriate Care Score</td>
<td>26.2%</td>
<td>3rd out of 14</td>
<td>50%</td>
</tr>
<tr>
<td>ARLD: Data Completeness</td>
<td>99.5%</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease: Appropriate Care Score</td>
<td>23.2%</td>
<td>7th out of 14</td>
<td>50%</td>
</tr>
<tr>
<td>COPD: Data Completeness</td>
<td>85.6%</td>
<td>6th out of 12</td>
<td>95%</td>
</tr>
<tr>
<td>Diabetes: Appropriate Care Score</td>
<td>23.1%</td>
<td>6th out of 12</td>
<td>50%</td>
</tr>
<tr>
<td>DIAB: Data Completeness</td>
<td>88.4%</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>Heart Failure: Appropriate Care Score</td>
<td>59.5%</td>
<td>7th out of 15</td>
<td>77.50%</td>
</tr>
<tr>
<td>Heart Failure: Data Completeness</td>
<td>97.7%</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>Hip Fracture 2015: Appropriate Care Score</td>
<td>59.5%</td>
<td>2nd out of 13</td>
<td>50%</td>
</tr>
<tr>
<td>HF 2015: Data Completeness</td>
<td>85.1%</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>Hip and Knee: Appropriate Care Score</td>
<td>94.2%</td>
<td>11th out of 21</td>
<td>95%</td>
</tr>
<tr>
<td>HK: Data Completeness</td>
<td>97.9%</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>Pneumonia 2015: Appropriate Care Score</td>
<td>59.0%</td>
<td>9th out of 15</td>
<td>50%</td>
</tr>
<tr>
<td>PNEU 2015: Data Completeness</td>
<td>90.5%</td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>SEPSIS: Appropriate Care Score</td>
<td>56.0%</td>
<td>3rd out of 14</td>
<td>50%</td>
</tr>
<tr>
<td>SEPSIS: Data Completeness</td>
<td>94.0%</td>
<td></td>
<td>95%</td>
</tr>
</tbody>
</table>

Each clinical area has a clinical lead allocated to this to continually drive and monitor performance against all measures. The Advancing Quality Steering group is well
established within the hospital and gains assurance for all the clinical areas across the trust. The purpose and scope of the steering group is to maintain performance, gain assurance from the clinical teams and share best practice across all clinical areas. The following supports the AQ agenda and drives improvements.

- The development of strategies to meet the AQ measures and milestones
- Production of monthly compliance reports for each clinical area and measure, highlighting missed opportunities and areas for further improvement.
- Report to Board on a monthly basis.
- Benchmark trust performance against all trusts across the northwest.
- Ensure compliance with external audit for the AQ programme
- Ensure staff are trained appropriately in the AQ pathways
- Review clinical coding reports where appropriate
- Introduction of electronic data collection templates
- Ensuring collaborative working of all clinical teams involved in the pathway.

7 Day Hospital Services

The Royal Liverpool and Broadgreen University Hospital Trust has demonstrated significant progress in its “7 day” journey with an ambition to reduce variance in quality of care across 7 days and to optimise positive clinical outcome and safety for people in receipt of urgent and emergency services. A further driver to establish a truly “7 day” service is a requirement to improve flow and capitalise on capacity such that the hospital can successfully migrate to a new build with reduced inpatient bed stock in 2017. The Trust is well on track to delivering the 4 priority clinical standards by 2017.

In respect of the 4 priority national standards:

Standards 2 (Time to first consultant review) and Standard 8 (On-going review) and via the programme of work described above), the ambition will be to have full compliance for both surgery and medical specialities by the end of the summer 2016.
The quality and efficiency of review processes will be further enhanced by an electronic patient healthcare record system being introduced in 2017.

Standards 5 (Diagnostics) and Standard 6 (Intervention / key services) these are being achieved however at cost pressure and without additional resource – further work is required to ensure sustainable affordability.

In April 2016 the Trust participated in a national survey into compliance against the 4 priority standards and when available these results will be shared. The Trust is proactively engaging with NHS England, local partners as well as other acute Trusts within Liverpool to develop a patient-centric delivery programme to achieve seven day services across the city. This will further enhance the Trusts plans to strive towards achieving the remaining six clinical standards for acute seven day service.

Discussions have taken place with the lead for Healthy Liverpool, to ensure alignment of 7 days with a number of improvement initiatives occurring within the programme’s footprint. NHSE’s SIT have worked closely with Liverpool commissioners and facilitated an event on the 31/3/2016 where the RLUH was represented by senior clinical leads/ managers and the Trust’s progress to date with actions going forward was presented. Commissioning intention and support will also be discussed and ongoing wider system governance /support will be agreed.

The Trust is performing strongly in terms of proportion of discharges over a seven day period. Operational data continues to show that RLUH discharges a higher proportion of patients at the weekend than other peer Trusts across the region and wider.

Other notable achievements are:

- 24hr access to endoscopy 24/7
- Medical consultant in reach to AMU at the weekends
- Development of ambulatory services which has led to a reduction in gastroenterology beds and the concept of the “virtual” ward is being further explored.
- General Surgery Sub-specialty rotas and increased consultant cover within Emergency Surgical Admissions are expected to be fully implemented in September 2016

To date the Trust has measured length of stay impact within the Respiratory Directorate where seven day consultant-led ward rounds were implemented in August 2015. The impact has observed:

- A significant reduction in the Mean LOS from 11.3 to 8.5 days while Median LOS improved from 7 to 6 days
- Variation of length of stay significantly reduced from 2.8 to 1.45 days
- The proportion of spells less than a week improved from 48% to 55% whilst spells longer than two weeks reduced from 25% to 16%

It is recognised that other quality measures are important to understand. Initial analysis year to date has found that certain conditions within Respiratory, notably COPD, that mortality and readmissions have improved. This methodology of measuring benefits will now be extended to incorporate other implemented areas and will be used for all future projects delivering an improvement in seven day provision.
Review of Quality Performance: Patient Experience

End of Life Care

The End of Life Care Audit – Dying in Hospital was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England.

The Royal College of Physicians (RCP) published National care of the dying audit for hospitals in 2014, using data collected in 2013 when the Liverpool Care Pathway was still being used. As well as building on the recommendations of the 2014 report, this 2015 RCP audit is designed to ensure that the five priorities of care for the dying person have been implemented and are monitored at a national level.

The RLBUHT participated fully in the audit and was one of the 139 sites out of a possible 145 sites eligible. The sample had a median age of 82 years (RLBUHT 80 yrs) and 19.8% (RLBUHT 12%) had a primary diagnosis of cancer: 51% (RLBUHT 54%) of patients were female. The audit covered all patients who had died after a minimum of 4 hours following admission (by comparison, the 2013 audit included deaths that had occurred 24 hours following admission).

Key Findings

- We are one of 98% of Trusts who have a named member of the Trust Board for End of life care

- We are 1 of 78% of Trusts who have a mechanism for flagging end of life care complaints

- We are 1 of 14% of Trusts with an End of Life Care Strategy Group

- We are 1 of only 22% of Trusts who provide and end of life care session as part of the Trust mandatory training programme

- We are 1 of 58% of Trusts who provide and end of life care session as part of the Trust staff induction programme
We are 1 of 97% of Trusts who provide a specialist palliative care service

We are 1 of 70% of Trusts who have access to a specialist palliative care service based and funded outside of the Trust

We are 1 of 37% of Trusts who provide a specialist palliative care service 9 – 5 Mon to Sun (7 day service)

We are 1 of 80% of Trusts who sought the views of bereaved relatives or friends during the last 2 financial years

We are 1 of 27% of Trusts who sought the views of bereaved relatives or friends during the last 2 financial years using the CODE questionnaire

We believe at RLBUHT that caring for patients at the end of their lives is a very high priority in our hospitals so it is good to see that the high quality of care we strive for is reflected in the findings of this national audit. We only have one chance to get this care right for each patient and, importantly, for those they leave behind. Because of this, we also conduct locally, in addition to this national audit of patient records and organisational indicators, a local survey of the experiences of the bereaved relatives of patients who have died in our hospitals. This has found that relatives feel their loved ones receive a high standard of end of life care at our hospitals, whilst also identifying areas where we can continue to further improve our services. There is clearly still too much variation in the quality of care for dying patients between hospitals in England and we remain determined here at our Trust to work with patients, families, clinicians, researchers and our unique volunteer’s service to maintain and continually improve on the high quality of care that we provide.
# The End of Life Care Audit – Dying in Hospital Published March 2016

<table>
<thead>
<tr>
<th>Audit Criteria</th>
<th>National Data</th>
<th>Royal Liverpool and Broadgreen Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recognition of Dying</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where a death was expected this was documented in cases</td>
<td>93%</td>
<td>100%</td>
</tr>
<tr>
<td>Discussion with Consultant</td>
<td>76%</td>
<td>98%</td>
</tr>
<tr>
<td>Patient regularly reviewed</td>
<td>91%</td>
<td>100%</td>
</tr>
<tr>
<td>Discussion with family</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Advance care plan in place prior to admission</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Local Death</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>66.10%</td>
<td>55%</td>
</tr>
<tr>
<td>Critical Care</td>
<td>12.60%</td>
<td>20%</td>
</tr>
<tr>
<td>Surgery</td>
<td>8.20%</td>
<td>16%</td>
</tr>
<tr>
<td>AMU / ESAU</td>
<td>7.20%</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Length of Stay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All cases Median</td>
<td>8.6 days</td>
<td>7.8 days</td>
</tr>
<tr>
<td><strong>Resuscitation and final care decisions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resuscitation decision made</td>
<td>94%</td>
<td>100%</td>
</tr>
<tr>
<td>Resuscitation discussed with family</td>
<td>78%</td>
<td>87%</td>
</tr>
<tr>
<td>DNACPR in place at death</td>
<td>78%</td>
<td>87%</td>
</tr>
<tr>
<td><strong>Concerns listened to and questions answered</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion patient and healthcare professional during last episode of care</td>
<td>80%</td>
<td>90%</td>
</tr>
<tr>
<td>Family - needs discussed</td>
<td>54%</td>
<td>86%</td>
</tr>
<tr>
<td>Identified needs addressed successfully</td>
<td>73%</td>
<td>98%</td>
</tr>
<tr>
<td><strong>Priority of care needs family and others</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family psychological needs</td>
<td>71% assessed</td>
<td>100% assessed</td>
</tr>
<tr>
<td></td>
<td>97% addressed</td>
<td>100% addressed</td>
</tr>
<tr>
<td>Spiritual / religious</td>
<td>40% assessed</td>
<td>90% assessed</td>
</tr>
<tr>
<td></td>
<td>92% addressed</td>
<td>98% addressed</td>
</tr>
<tr>
<td>Cultural</td>
<td>28% assessed</td>
<td>98% assessed</td>
</tr>
<tr>
<td></td>
<td>92% addressed</td>
<td>100% addressed</td>
</tr>
<tr>
<td>Practical</td>
<td>88% assessed</td>
<td>100% assessed</td>
</tr>
<tr>
<td></td>
<td>95% addressed</td>
<td>100% addressed</td>
</tr>
<tr>
<td>Family present at death</td>
<td>63%</td>
<td>75%</td>
</tr>
<tr>
<td>Family support immediately after a death</td>
<td>64%</td>
<td>88%</td>
</tr>
<tr>
<td>Culturally sensitive verbal information given after a death</td>
<td>56%</td>
<td>88%</td>
</tr>
<tr>
<td>Culturally sensitive written information given after a death</td>
<td>44%</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Holistic assessment of care in the last days or hours of life</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Holistic assessment in place</td>
<td>66%</td>
<td>68%</td>
</tr>
<tr>
<td>Symptoms controlled: -</td>
<td>72%</td>
<td>73%</td>
</tr>
<tr>
<td>Agitation / delirium</td>
<td>68%</td>
<td>77%</td>
</tr>
<tr>
<td>Dyspnoea</td>
<td>55%</td>
<td>90%</td>
</tr>
<tr>
<td>Nausea and vomiting</td>
<td>79%</td>
<td>80%</td>
</tr>
<tr>
<td>Pain</td>
<td>62%</td>
<td>71%</td>
</tr>
<tr>
<td>Noisy breathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuous infusion of medication in place in the last 24hrs of life</td>
<td>5.2%</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Review by Palliative Care Team</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the last admission</td>
<td>31%</td>
<td>35%</td>
</tr>
<tr>
<td>In the last 24hrs of life</td>
<td>23%</td>
<td>33%</td>
</tr>
<tr>
<td><strong>Drinking and assisted hydration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment re ability to drink in last 24 hrs of life</td>
<td>67%</td>
<td>75%</td>
</tr>
<tr>
<td>Patient was drinking in the last 24hrs of life</td>
<td>39%</td>
<td>43%</td>
</tr>
<tr>
<td>Discussion re assisted forms of hydration with the patient</td>
<td>18%</td>
<td>19%</td>
</tr>
<tr>
<td>With the family</td>
<td>39%</td>
<td>59%</td>
</tr>
<tr>
<td>In the last 24hrs of life Clinically assisted (artificial hydration was in place)</td>
<td>43%</td>
<td>52%</td>
</tr>
<tr>
<td><strong>Eating and assisted hydration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment of ability to eat in the last 24hrs of life</td>
<td>61%</td>
<td>75%</td>
</tr>
<tr>
<td>Discussion with patient re ability to eat</td>
<td>14%</td>
<td>20%</td>
</tr>
<tr>
<td>Discussion with family</td>
<td>28%</td>
<td>52%</td>
</tr>
<tr>
<td>At the time of death was clinically assisted (artificial nutrition in place)</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Individual plan of care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All team aware of individual plan of care</td>
<td>56%</td>
<td>64%</td>
</tr>
<tr>
<td>Was the individualised plan followed</td>
<td>96%</td>
<td>100%</td>
</tr>
<tr>
<td>Was the individualised plan reviewed</td>
<td>86%</td>
<td>100%</td>
</tr>
<tr>
<td>Review by a doctor or nurse in the last 24hours of life - no of reviews (median)</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td><strong>Care immediately prior to and after death</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of the patient</td>
<td>73%</td>
<td>84%</td>
</tr>
</tbody>
</table>
The Academic Palliative Care Unit (APCU) Ward 4Y

Our vision shared by our colleagues across the health economy is for all patients and their carers across Liverpool to have 24/7 equitable access to high quality, consistent integrated care and services to support those living well and dying well at the end of life.

To continue to build on the clinical excellence in EoLC throughout the Trust, the Academic Palliative Care Unit (APCU) has been developed for those patients and those important to them, with the most complex specialist palliative care needs and who require high dependency palliative care.

The APCU incorporates twelve high dependency specialist palliative care beds (comprising of two 4 bedded bays and four single rooms) and together with the Hospital Specialist Palliative Care Team (HSPCT) consultancy service, forms part of the Directorate of Palliative Care.

The APCU will:

- Build on the Specialist Palliative Care Service provision in Liverpool to include a 12 bedded high dependency inpatient unit on the Royal Liverpool Hospital site that will then transition into the new hospital build.

- Enhance patient and carer experience, patient choice and safety at the end of life and develop a specific, appropriate environment for the support of patients and those identified as important to them.

- Reduce the length of stay whenever possible, utilising the specialist skills of the EoLC Discharge Coordinators, to enable timely return to home, or other preferred place of care for the more complex specialist palliative care patients.

- Drive up quality and promote productivity, partnership working and the academic development of personnel by providing a hub of best practice in end of life care. To ensure high quality, effective, equitable specialist palliative
care services with its partners, the University of Liverpool and Marie Curie Cancer Care, in the Marie Curie Palliative Care

- Institute Liverpool (MCPCIL). Living and dying well is a core value that informs the work of the MCPCIL, and good communication, care and compassion are paramount in supporting the dying person to achieve this goal.

- Enhance the local, national and international reputation and profile of the Trust as part of the leading integrated EoLC Programme within the Trust and the MCPCIL Research and Development, Service Innovation and Improvement, and Learning and Teaching portfolios.

We share the aim to reduce the number of deaths in hospital from 56.5% to 40% by 2018/19 and reduce emergency admissions for people at the end of life. We work within local and national guidance supported by our International Collaborative at our Institute to embed the very best learning into our practice at the bedside and continue to influence bedside to policy.

We continue to strive for a trained and supported workforce, operating in the right kind of commissioning and assessment environment unconstrained by professional boundaries to support our patients and those important to them.

The palliative care agenda aims to ensure that all people who need it, have access to rapid high quality palliative care in a setting of their choice.

The Trust has an End of Life Care Strategy in line with both the Corporate Objectives and the Organisational Strategy. We have set a clear direction in our Forward Plan for End of Life Care over the next 2 years within our trust and progress against the plan will be reviewed at 3 monthly intervals through the trust quality governance arrangements.

**Quotes from Patients:**

“The staff on the academic palliative care unit (Ward 4Y), are truly a credit to the NHS and the trust. My Mother was treated with the upmost dignity and respect and
care was delivered in such a compassionate manner, from every member of the medical and nursing team”

“The trust has every right to be proud of this wonderful team of individuals, as soon as you enter the unit you feel the beating heart of the team, supporting you through, every decision. It made a difficult time for my family bearable, knowing my mother was safe in their care. As a family we will be forever grateful to the dedicated team of nurses and doctors on this ward. Thank you all so very much.”
Improving care for patients with Dementia

The term dementia describes a set of symptoms which include loss of memory, mood changes and problems with communication and reasoning. For someone with dementia, changes such as moving to an unfamiliar place or meeting new people who contribute to their care can be unsettling or distressing.

Our dementia service has evolved and is helping to support patients and carers in the Trust, allowing us to deliver the highest quality care. We provide a number of different initiatives to staff, patients and their carers to help care for dementia sufferers in our hospitals. We have a robust trust dementia steering group, champions network all supported with the dementia forward plan 2016-2017

Achievements

Dementia training delivered in line with national dementia education standards (SCIE dementia programme) total to date 3,370. All trust staff and allied health professionals access this training. JMU and LU as well as the Liverpool Women’s Hospital 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 which 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.

Dementia patients are now flagged electronically under VP (vulnerable patient) status on the ward whiteboards which is accessible to staff through a unique login for each staff member. This information 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. A copy is also kept in the medical records to support any further admissions.

The pack also includes information as to what our service is and includes information re early diagnosis, accessing community services and our provision of memory café and our range of bedside activities.

Memory café held monthly where patients and careers attend Costa for coffee and cakes each month different cognitive session helps patients and carers to meet and support each other with expert advice at hand from our dementia team. This was given an award to acknowledge outstanding contribution to dementia care.

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.

We have also won a 25k grant from Bluecoat Chambers and we are currently providing art activities that engage patients, relatives and occasionally staff. These are all transferable to the new build and will help prevent social isolation and help keep patients safe. The activities impact is measured to identify what works for individual patients. We are currently looking to share a more enhanced clinical tool with another trust that can identify delirium prevention opportunities.

The National CQUIN measures for Dementia (Commissioning for Quality and Innovation). The trust failed to achieve the 90% target for Find, Assessment and Referral section of the Dementia CQUIN from April – June 2015 (Quarter 1). However Since July 2015 we have continually evidenced compliance against the national target for all elements of the national dementia CQUIN and will continue to embed these improvements across the trust during 16/17. Identification of patients, assessing patients and referring on to specialist services if appropriate are all key elements of the CQUIN. Other requirements include offering patients and carers support and providing the required levels of dementia training to staff across the organisation.

The trust intranet dementia site allows easily accessible links to training, and general information about the service and its team.
Memory clinic provides diagnostics and treatments for patients and access to the overall dementia service pre and post diagnosis.

A forward plan has been generated following engagement events with service users, healthcare professional, service providers and our allied universities achieving meaningful actions for further development. Progress will be monitored through the appropriate governance arrangements within the trust.
Nutritional Support

Many patients at the RLBUHT receive artificial nutritional support via the enteral or parenteral route. This can be a temporary means of nutritional support during their hospital stay or a long term requirement. The RLBUHT nutrition team provide a wealth of knowledge and support to patients who require nutritional support. The team review patients on a daily basis referred for nutritional support, assess their individual needs, discuss options to suit the patients’ requirements, agree the type of feeding device for the treatment with careful consideration of how this impacts on the patients’ quality of life.

Inpatients

The extensive knowledge and skills of the nutrition team at the RLBUHT allows for the provision of a regional first class nutritional support service. The wide range of options in feeding tube design, placement techniques and advance skills provided by the team, leads to an impressive response rate to patients’ needs, greater patient choice, informed decision making and low rates of complications associated with artificial nutritional support.

The daily visibility of the nutrition team on the wards throughout the trust creates effective communication between all members of the multidisciplinary team and leads to improved coordination of patient care.

The provision of ward based and lecture based training for all health care professionals, patients and their carers’, enhances the quality of care delivered and received by our patients.

Outpatients

A twice weekly nutrition nurse clinic enables patients to be seen in a timely fashion. This unique service empowers patients and provides reassurance knowing that they will be seen promptly, by experts in the field of nutritional support. The clinic setting is suitable for consultation and examination ensuring that problems and clinical issues can be dealt with at the time. At these clinics, the patient and family are informed about the options available, explore ideas and see different types of feeding tubes enabling them to make an informed choice regarding their care.
These clinics also allow for the routine review of patients or used to see patients having problems with their devices. The responsiveness of the nutrition nurses prevents further complications arising, prevents admission to hospital or attendance to the A&E department and reduces the patients and carers anxieties, knowing support is at hand.

Out of the clinic hours, help is always at hand from the nutrition team. Arrangements can be made to urgently see a patient on the same day as the referral on the 5Y Day care unit or in the endoscopy unit. Through excellent communication and effective coordination with multidisciplinary teams throughout the organisation, patients’ needs can often be met without an unnecessary admission to hospital. The team are able to address and resolve feeding device issues promptly, resulting in a short attendance in the department and quick turnaround of the patient.

**Power of Three**

The implementation of a three spoke approach to nutrition has proved extremely beneficial in supporting our patients’ nutritional needs and it has been developed with the aim of the to improve communication by identifying needs sooner utilising a collaborative approach involving the dietician, catering and nursing staff.
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.

In the past 12 months, we have provided improved signage outside the Patient Advice Liaison Service (PALS), which is at the front entrance of the Royal to make the location of our office more visible to patients and their relatives.

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

In July 2015 we established a new weekly patient experience meeting. The aim of this meeting is to:

- Review written responses and ensure the complainants concerns have been investigated thoroughly and the response demonstrates what actions the Trust has taken to improve our patient experience
- Agree action plans where we have identified our services did not meet expectations
- Establish a mechanism to ensure all action plans are monitored until completed, through our governance arrangements.
- Discuss trends from informal/formal complaints and identify lessons learned.
In November 2015, we reviewed and updated our complaints policy to reflect our changes in practice and to improve upon the quality of our complaints services.

**Informal complaints**
These are complaints or concerns that are raised at ward or departmental level. In the last 12 months we received 1,162 informal complaints. This compares to 1,383 the previous year, a decrease of 19%. All of these informal complaints were dealt with by PALS within the response target of five working days.

**Formal complaints**
In 2015/2016, 407 formal complaints were received. This is an increase of 1.5% from 401 last year (2014/2015). 62% of these were responded to within the target of 35/45 working days.

**Cross-boundary complaints**
These are complaints that involve other organisations such as other NHS hospitals; GP’s or social care organisations. In 2015/2016 we received 29 cross-boundary complaints compared to 17 last year, an increase of 70%. 46% of these cross-boundary complaints were responded to within the target of 60 days.

**Referrals to the Parliamentary Ombudsman**
Eight new cases were referred to the Parliamentary and Health Service Ombudsman (PHSO) during the year. Three cases were returned to the trust from PHSO. Of these, two were returned, which were not upheld and in a further case the PHSO decided not to investigate. Five cases remain with the PHSO under review.

We continue to strive to improve our service and our aim for the next 12 months is to:

- Further improve our response times to complaints to ensure patients receive responses more quickly
- Engage with patients to improve our service by seeking their views on the complaints process.
Participation in National Clinical Audits and Confidential Enquires

During 2015/16, 77 national clinical audits and five national confidential enquiries covered NHS services that the Royal Liverpool and Broadgreen University Hospitals NHS Trust provide.

During that period the Royal Liverpool and Broadgreen University Hospitals NHS Trust participated in 100% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Royal Liverpool and Broadgreen University Hospitals NHS Trust were eligible to participate in during 2015/16 can be viewed in Appendix 3.

The reports of 27 national clinical audits were reviewed by the provider in 2015/16 and the Royal Liverpool and Broadgreen University Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

- NHSBT - National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in adults undergoing elective, scheduled surgery – It was identified that a cell salvage standard operating procedure was required along with a Restrictive transfusion policy; these are estimated to be implemented by August 2016.
- National Audit of Inpatient Falls (Clinical / patient observations) - Part of FFFAP (NICE CG161) – All patients assessed at risk of fall should have a lying and standing blood pressure performed as soon as practicable, and that actions are taken if there is a substantial drop in blood pressure on standing. This has been embedded into the Trust with prompts being added to electronic assessments to support completion.
- National Diabetes Audit (NDA): National Pregnancy in Diabetes Audit (NPID)) – the outcome of this audit was at a regional level (Northwest), a number of recommendations were made and these will be implemented as part of the Liverpool Diabetes Partnership (LDP). Further to these recommendations at a Trust level include providing written information in regards to importance of,
and options for, safe effective contraception and pregnancy planning, supporting women to achieve optimal glucose control prior to pregnancy by fortnightly appointments to 30 weeks pregnancy and then weekly.

- National Rheumatoid & Early Inflammatory Arthritis – Joint working with GP’s and community is taking place to improve early recognition and the need for prompt referral. The department amended their clinic slots to ensure there is capacity for urgent appointments.

- Emergency Use of Oxygen (BTS) - A working group has been established which includes a respiratory consultant, pharmacy representative, the medical director and other members of the Trust to establish how the prescribing of Oxygen can be improved

Further action plans have also been developed to address any other areas of need.

For the following it was felt that we achieved comparably or better than nationally:

- National Cardiac Arrest Audit (NCAA)
- Stroke Improvement National Audit Project (SSNAP) includes the National Sentinel Stroke Audit Severe Trauma / Trauma Audit & Research Network (TARN)
- NHSBT - National Comparative Audit of Blood Transfusion - Patient information and consent
- National Hip Fracture Database (NHFD) - Part of FFFAP
- National Audit of Inpatient Falls (Organisational audit) - Part of FFFAP
- Mental health (care in emergency departments)
- Older people (care in emergency departments)
- IBD UK Inflammatory Bowel Disease Audit Round 5: Biological therapy audit
- NCEPOD Gastrointestinal Haemorrhage
- NCEPOD: Sepsis
- National Joint Registry
- National Prostate Cancer Audit
- National Vascular Registry - AAA & CEA outcomes
It should be noted the national reports reviewed during 2015/16 are not explicit to the list of audits in Appendix 1 but are, however, the reports published/reviewed during 2015/16. Also of note is this figure in regards to reports reviewed at the Trusts Clinical Effectiveness Sub Committee

The reports of 150 local clinical audits were reviewed by the provider in 2015/16 and examples of actions to be taken by the Trust to improve the quality of healthcare provided are as follows:

- Within in General Surgery all patient letters to be copied to the patients GP
- The transfusion form has been amended to include weight of patient and Octaplex will not be provided until this is completed to ensure accurate does.
- A pathway has been introduced into the Emergency department to aid early identification of patients who require Venous Intervention for Ilio-Femoral DVT
- Junior doctors within Diabetes have been provided with a booklet in how to complete VTE assessment; this has also taken place within Trauma and Orthopaedics.
- A patient information sheet is to be developed for postoperative wound care in vascular surgery.
- An IV Fluid working group has been established to address issue of IV fluid prescribing, with emphasis on education and training. A further trust wide audit will take place in the summer of 2016.
Engagement in clinical audits

During 2015/16 the clinical audit database continued to be developed and reporting and monitoring of audits and action plans continue to be embedded within the governance structure.

The Healthcare Quality Improvement Partnership (HQIP) clinical audit training module continues to be completed by all Directorate Audit Leads, and the Effectiveness Team continues to encourage all staff wishing to conduct audit to complete these prior to commencement of their audit.

Due to staff shortages within the team the annual audit symposiums and clinical audit poster completion did not take place during 2015/16, however for 2016/17 the Effectiveness team has plans to reinvigorate this in a new format and will link into the Trust staff award process in order to gain greater awareness of clinical audit and its impact on the services the Trust provides.
Quality Account Priorities 2016/17

Our corporate and quality objectives 2016 – 2018 outline a number of projects which we will be focusing on in the coming years. We would however, like to highlight the following projects as key priorities for 2016/17. Consideration has also been given to feedback received from patients, staff and the public in the identification of the following priorities.

Quality in the NHS is described in the following ways:

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

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

**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.
Patient Safety

Priority 1: Delivery against the Patient Safety Strategy Objectives

Rationale:

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 two hospital sites. One of our five strategic themes is to improve the quality of life for our patients by providing safe and accessible healthcare which puts patient’s wellbeing at the heart of what we do. Patient Safety Strategy will drive the safety agenda to overall reduce mortality and avoidable harm through continuous learning and improvement.

Aim:

- Mortality – 95% compliance with Mortality Peer Review
- Deteriorating Patient – 100% of Broadgreen transfers to be safe and appropriate with an overall 40% reduction
- Sepsis – Improve AQ sepsis measure set compliance to 80%> by 2017
- VTE – 40% reduction in Hospital Acquired Thrombosis
- Falls – Reduction of falls that cause head injuries by 20%
- Tissue Viability – Maintain improvement in reduction in Grade 2 hospital acquired pressure ulcers
- Infection Control – working towards a zero tolerance approach to MRSA, compliance with national targets for C-Difficile and implementation of Public Health England toolkit for CPE
- Medicine Management – 85%+ of patients to have their medications reconciled on admission within 24 hours and any issued identified resolved within 48 hours.
How progress to achieve the priority will be monitored

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.
Patient Safety

Priority 2: Effective Discharge Planning

Rationale

Proactive discharge planning for patients in secondary care beds is essential to patient flow and therefore has a direct link to trust performance of the A&E four hour target. Most patients routinely leave hospital without requiring additional services, however a proportion of patients will have health and social care support needs upon discharge and therefore will require assessment of need and planning to ensure that the patient is not only clinically stable but also that their discharge is safe and timely.

Discharge from hospital can be delayed by many different factors, both internal and external. If discharges from the bed base of clinically optimised patients are slow or even late in the day, this quickly impacts upon the emergency floors ability to cope with demand and thus struggles to meet the target.

For discharge planning to be successful and achieve patient flow, discharge needs to become the responsibility of all staff groups across the organisation, second only to sick patients. Therefore, every profession involved in patient care should be driving the patient journey towards discharge, as silo working prevents good communication and creates delays in the patient journey. The following objectives will support and facilitate effective discharge planning for all patients and will have a positive effect upon experience and outcomes.

Aim:

- Implementation of the 4 Lane approach to Discharges through the trusts Discharge Strategy
- Delivery and achievement of all the requirements within the Specialist Commissioned Services CQUIN - Clinical Utilisation Review (CUR)
- Engagement and involvement in the wider health economy to achieve effective discharge planning across the system.
- Demonstration of an improvement in the percentage of patients discharged before 12pm and 4pm
Planning a patient’s discharge from hospital is crucial to ensure that patients do not remain in hospital any longer than is necessary. Decisions to discharge patients need to be made on a daily basis to ensure that there is capacity to meet the demand of acutely ill patients who are admitted from the A&E department. If discharges occur later in the day, then patients wait longer than they should on the Emergency floor awaiting an inpatient bed. This then impacts on 4 hour performance and the quality of patient experience.

**How progress to achieve the priority will be monitored**

Performance on this will be monitored through Quality Governance Committee on a quarterly basis and also reported to Board quarterly.
Clinical Effectiveness

Priority 3: Develop an Education and Research Strategy

Rationale:
In order to achieve our vision, mission and objectives - the shape, skills and knowledge of the hospitals workforce needs to constantly evolve and adapt within the context of some challenging and seemingly conflicting targets e.g. the need to make large cost savings whilst improving the quality of service and patient experience. Integral to success is the provision of relevant, effective and efficient education, learning and development of all staff groups at every level within the organisation. The development of an education and research strategy will ensure we have a framework in place to give assurance that our staff are confident and competent to deliver safe, effective, personalised and compassionate care to every patient every time. This strategy will further develop a highly skilled, motivated and engaged workforce which will continually strives to improve patient care and the trust performance.

Aim:
As a Trust we need to actively participate in the development and implementation of these changes at national, regional and local level in order to determine how we wish to position ourselves within the region in order to maximise the potential opportunities available for us to develop our potential and our reputation as a learning organisation.

The aim of the strategy will be to develop a competent, capable and compassionate workforce built on research and innovation in order to:

- Develop excellent leaders at every level in the organisation
- Provide high quality and effective Education, Learning and Development Opportunities across the hospital

The Education and Research Strategy will contain the following elements:
• Leadership
• Education
• Policies & Guidance
• Engagement

**How progress to achieve the priority will be monitored**

Performance on this will be monitored through Quality Governance Committee on a quarterly basis and reported to Board quarterly.
Clinical Effectiveness

Priority 4: Developing a world class workforce: Nurse Training Programmes

Rationale:

The RLB Nurse Programme is an education initiative that aims to further develop registered nurses who are committed to delivering the highest quality of care for the health and wellbeing of patients.

This will be achieved by ensuring that they have the support to achieve all the competencies required for them to deliver safe and excellent care. Nurses already have most, if not all, of these competencies. The RLB Nurse Programme will formalise and reaffirm this.

The programme includes: (1) a competency-based portfolio which will help foster a culture of reflective practice and life-long learning. It will also help nurses prepare for NMC Revalidation; (2) a one-day study day which introduces the concepts of human factors in relation to patient safety, elicits healthy discussions of contemporary local and national issues and provides an opportunity to engage with other nursing colleagues to foster a sense of community.

Aim:

The roll out of the RLB programme to the following staff groups in 2016/17.

- Dental nurses
- Allied health professionals
- Healthcare assistants (from July 2016)
- Assistant practitioners (from July 2016)
- Volunteers (from August 2016, date to be confirmed)

To develop and deliver the RLB programme to the core competency framework in line with NICE Guidelines as endorsed by NICE.
How progress to achieve the priority will be monitored

Performance on this will be monitored through Quality Governance Committee on a quarterly basis and reported to Board quarterly.
Patient Experience

Priority 5: To empower carers through collaboration and engagement to ensure they can care for loved ones in our hospital

Rationale:
Carers and families are often the first to notice signs of illness or a relapse. Carers and relatives have told us they would like:

- To be listened to when they have concerns.
- Healthcare professionals to be understanding and responsive.
- Clear information about what to do and who to contact in a crisis.
- Clear information on where they can get help, support and advice.

The implementation of this priority will set out our commitment to carers, relatives and also staff who are carers through the development of an operational framework for the trust. It will also improve carers and relative experiences of our services and offer the support and advice needed.

Aim:

Develop a Carers Strategy. Engaging with patients, stakeholders, Liverpool City Council and Liverpool CCG. Alignment with Liverpool's Supporting Carers Strategy (LCCG & LCC)

- Establish a Carers and relative forum – including internal and external membership.
- Design a carer/relative passport with the help of our patients and stakeholders. This forum will report to the Patient Experience Committee on progress and achievements.
- Conduct a pilot on 3 wards (2 Royal site) and (1 Broadgreen site). Pilot to commence in September 16 – January 2017.
- Evaluation of the pilot and development of a plan for further roll-out across the trust in preparation of moving into the new Royal 2017.
• Sign up to be a Johns Campaign Hospital

How progress to achieve the priority will be monitored

Monthly data will be presented to Patient Experience Committee as part of the patient experience dashboard. Performance on this will also be monitored through the Quality Governance Committee and also reported to Board on a quarterly basis.
Care Quality Commission

The Royal Liverpool and Broadgreen University Hospital NHS Trust is required to register with the Care Quality Commission (CQC). The CQC is the independent national body responsible for regulating the quality of care provided by NHS Trusts, social services and independent care providers. Our current registration status is compliant with no conditions attached to registration. The CQC has not taken enforcement action against The Royal Liverpool and Broadgreen University Hospital NHS Trust during the period 2015/16, nor has the CQC taken any enforcement action against hospital Hospitals NHS Trust since its inception.

In March 2016, the Care Quality Commission (CQC) undertook a scheduled inspection of the trust from 14th March 2016 to 3rd April 2016. The inspection focused on urgent and emergency care, medical care, surgical care, critical care, outpatients, diagnostic imaging and end of life care. The trust strives to provide excellent care for patients and estimated an overall “good” rating across all domains as part of the pre-assessment process for the CQC inspection in March 2016.

The CQC inspections are now focused on five key lines of enquiry, determining whether services are:-

● Safe
● Effective
● Caring
● Responsive to people’s needs
● Well-led

Inspectors observed care across various services, reviewing patient notes and speaking to staff, patients and carers to examine whether our services were safe, caring, responsive, effective and well-led.

Initial feedback following their scheduled inspection was encouraging. Inspectors said they found staff to be well motivated, friendly and engaging and that they worked well during an exceptionally busy period of time.
The initial report following the inspection is due 55 working days from the last day of the inspection. The report is therefore expected on 23rd June 2016. When providers receive a copy of the draft report (which will include their ratings) they are invited to provide feedback on its factual accuracy. Any factual accuracy comments that are upheld may result in a change to one or more rating. The trust will have 10 working days to review draft reports for factual accuracy and submit their comments to CQC.

From April 2015 we are required to clearly display CQC ratings at each and every premises from which we provide a regulated activity this includes head office and on the trust website. The trust is committed to do this once the report is published to make sure the public can view the report and it is accessible to everyone who accesses our service. The inspection report is due for publication in August 2016 and can be found on the following websites.

CQC website: http://www.cqc.org.uk/provider/RQ6

RLBUHT website: http://www.rlbuht.nhs.uk/Pages/RoyalHome.aspx
Investing and Engaging in our staff

Effective staff engagement and empowerment is very important to us. Our ‘Everyone Matters’ staff engagement programme drives a culture of listening to staff, empowering them to lead the changes needed for the benefit of patients and for themselves.

Everyone Matters is a key component of our People Strategy which supports the development of an environment where staff work together to ensure patients receive the highest standards of care and where talented people want to come to work, learn and research. A detailed action plan has been implemented over the last two years, and the strategy is due to be reviewed in 2016/2017.

Our own model for staff engagement ‘Going Local’, is starting to become embedded in our divisions as the chief of service and divisional directors of operations ‘meet and greet’ staff to listen to their ideas about improving services for patients and their families, implementing and feeding back what action has been taken. Executive directors also hold ‘meet and greet’ sessions, chief executive question time, and ‘back to the floor’ days where executives work alongside staff to experience work on the front line. This has helped improve understanding of day to day issues and pressures from wards and departments.

Our quarterly ‘Share and Learn’ events have become well established in 2015/2016. These events were put in place in 2014 following a staff engagement suggestion that we could do more to recognise and reward the many and varied contributions of staff in addition to our prestigious annual ‘Make a Difference’ Awards evening. The ‘Share and Learn’ event is both a ‘mini awards’ ceremony and a sharing of good practice. Staff are personally invited to be presented with certificates and awards ranging from the Certificate in Care completed in-house by new healthcare assistants, which ensures they have skills and knowledge to undertake safe and compassionate patient care, through to recognition of staff who have recently retired, and staff who have achieved 25 years and 40 years long service within the NHS. Other staff receive recognition for achieving qualifications the trust is
accredited for, including leadership and management qualifications and coaching, and recognition for those who have submitted viable suggestions into ‘Ideas Street’ which will be taken forward through our quality and efficiency programme.

This year, we re-vamped our ‘Employee of the Month’ scheme to create a ‘Staff Star’ award. Staff and patients/patients relatives are able to nominate staff, entries are shortlisted and both the winners and those rated highly commended are invited to the ‘Share and Learn’ event to be recognised for their success. In addition to the awards ceremony, there is opportunity for our divisional teams to ‘showcase’ excellent practice which is making a difference to patients and their families or to the well-being of staff, so that others can learn from them. Most recently, we heard patient success stories from the frailty unit, the impact of preceptorship for newly recruited Spanish nurses, and a meet and greet scheme to enhance local induction.

Clinical summit
We hold regular clinical summits, attended by clinical directors, directors and other senior managers. Clinical summits focus on a range of current issues affecting the medical workforce. These sessions have been well received, with discussions focusing on exploring new ways of working across the city.
Leading our staff

Leadership capacity and capability - We encourage managers to provide a working environment where staff feel they can be compassionate and respectful and that they have a sense of control and influence on their working lives. Leaders are encouraged to work with their teams to learn from patient experience, concerns and complaints and they are also encouraged to learn from excellent practice. This year, we reviewed our leadership and organisational structures to move accountability and decision making closer to the patient. We did this through revising clinical leadership structures and devolving operational and financial responsibilities under a ‘clinical business unit’ model that we called care groups. An audit of management capacity has been undertaken to understand the unique requirements of each care group. During 2016/2017 we will implement governance plans for devolved accountabilities, leadership arrangements and development programmes. This will help us to support our managers in leading and transforming services across the city.

Appraisal - We have demonstrated a significant improvement in our compliance with appraisal throughout 2015 to over 90%. However feedback in the NHS Staff Survey highlighted quality of appraisals and staff experience of them as being an area for improvement for 2016/17. The documentation and recording of appraisal has been simplified to facilitate this and training and support is available to managers. An audit process will be undertaken following the closure of the appraisal window in June to assess the quality of the appraisals that have taken place.

Coaching - Seventy two team leaders have been trained to use an ‘anytime’ coaching style through our five day in-house accredited courses. In addition, a further 16 coaches have been trained to post graduate level to be able to act as champions, acting as role models for coaching behaviour and offering formal coaching programmes, accessible to all staff via our coaching for success scheme. The executive team has also participated in regular team and individual coaching to support the embedding of a coaching culture in the trust. The plan for 2016/17 is to train a further 140 team leaders to reach a critical mass and to increase sustainability and reduce cost by developing our internal resource of coach trainers and supervisors.
Collective leadership - A small team of staff from different departments have been working together with the King's Fund to look at the culture and leadership styles used in our hospitals. The team has been gathering and analysing data from many sources, including reports, interviews, focus groups and questionnaires. They then compared this information with a framework of the requirements, which research show are necessary to develop a culture of collective leadership. Collective leadership is where everyone takes personal responsibility for getting things right with patient safety, patient experience and staff experience firmly in mind. We encourage our staff to accept personal responsibility to work together, to look out for and fix things where they can and raise issues where they can’t. Now we have this information, we are working with our staff to ensure that we have the necessary components in place to deliver the best care and wellbeing for our patients and staff.

Care and Concern - Six hundred staff have attended one of the regular care and concern workshops delivered over the last 12 months. The programme aims to raise awareness about the right attitudes and behaviours that are important for all staff to be able to provide an excellent patient and staff experience. This contributes to reducing staff attitude complaints. The workshops are very well received and the impact of the programme is currently being evaluated with a view to deciding on how best to take it forward to address the current needs of the organisation.

Transforming our services by supporting our staff to do things differently - The service improvement and excellence team provide expertise and training to improve processes linked to our strategic objectives and performance indicators, such as reducing length of stay and maximising theatre capacity. During 2015, the team have embedded all work to the delivering of the new hospital transformation programme, our strategic objectives and delivery of quality and efficiency programmes. In conjunction with finance, the team have also developed a ‘benefits realisation model which measures the added value of work, where projects are not cash releasing.

Communicating with staff
We have continued to communicate with our staff, using a variety of different methods, such as Core Brief, our intranet, our quarterly newsletter Insight and weekly e-bulletins. We have also held events to engage staff with the new Royal and
we provide support and advice to clinical teams aimed at promoting their services and health awareness campaigns.

**Our website**

Work on developing a new website for the Trust has begun. We are working with Liverpool based specialists in web development to design and build our website to make it easier to use and more interactive for patients and other stakeholders. As part of the design process we have been working with various stakeholders to assess their requirements and how they use websites to get the information they need. We expect the new site to go live by September 2016.

**Using social media**

We continued to use social media and during the year, we have engaged with the public via Twitter, Facebook, Instagram and YouTube. We have over 4,500 followers on Twitter and our Facebook messages reach over 6,000 users. Analysis of our followers on Twitter and Facebook show that the majority are women, aged between 25 and 45. We use social media to thank staff, promote health, give updates about our hospitals and update people on the new Royal and to gather and respond to feedback.

**Multimedia communications**

With the advent of social media and huge advances in visual technologies, modern communications are increasingly dependent on multimedia content – films, audio, photos. This is particularly important for communicating effectively with groups of people with low levels of literacy. As a forward thinking organisation renowned for its clinical innovations, we have recognised the importance in using new ways of communicating our messages to a wider and more agile audience, via social media and in the new Royal via TV screens. This year we employed a full time videographer whose role is to produce multimedia content to help get our messages across in a more engaging, innovative and effective way.
Media coverage
Throughout the year, there were estimated to be over 400 mentions of the trust in the media. Around 85% were positive with the corporate communications team and other specialists helping to generate around 365 positive mentions – roughly one a day.
Our new Royal Liverpool University Hospital

The new Royal has continued to take shape throughout the year; however construction has fallen behind schedule.

In December, construction of the new hospital had reached its highest level. This achievement was celebrated with a festively themed ‘topping out’ ceremony. By March, the construction was made watertight as the external envelope of the new Royal was completed. Inside the new Royal, work on the internal fit outs have been ongoing throughout the year. Earlier in the year, construction teams were installing heating, plumbing and electrics, and later in the year were fitting doors, painting walls and furnishing some areas of the hospital with mock up rooms for members of clinical staff to evaluate.

Construction of the new Royal has brought positive benefits to the local economy and community, through investment in local business, the creation of work opportunities and support for local groups. Carillion has spent over £1m with organisations in the local supply chain, holding regular events to provide information and support for local businesses to bid for tenders. 45% of the construction workforce are from local areas, with 10% from priority wards, which have high levels of unemployment and social deprivation. In addition, Carillion has organised various schemes and work placements aimed at upskilling the local workforce to provide further opportunities and has created over 100 apprenticeships. In addition, the Liverpool Community Fund, set up by Carillion and the trust as part of the deal for the new Royal, provided £34,500 to 33 local groups that support; healthy living, building stronger communities, cleaner, safer, greener communities and education.

We have been working hard to prepare for the move into the new Royal in 2017. Commissioning teams for each speciality are ensuring staff understand and are preparing for how they will work in the new Royal. Numerous staff engagement events have been held across the trust, targeting key groups of clinical staff. Several IT projects are underway, such as paper free health records, electronic safe room, automated staff presence, patient self-check in and the introduction of hand held electronic devices will ensure we deliver the most up to date technologies in the new
Royal. Work has been undertaken to equip the new Royal with state of the art imaging equipment that will provide rapid diagnostics and treatment for patients. There will also be more support from front of house services to ensure patients and visitors feel welcomed. We have been working with our volunteers, service to enhance their role in supporting these services and in helping provide additional way finding support for patients and visitors to the new Royal.

**The Liverpool Life Sciences Accelerator**

In November, work began on the Liverpool Life Sciences Accelerator. This £25m laboratory development will co-locate the trust, the Liverpool School of Tropical Medicine (LSTM) and a raft of relevant small and medium-sized enterprises.

Situated on Daulby Street, within the grounds of the Royal Liverpool University Hospital, the 70,000 square foot building will provide state-of-the-art laboratory space and offices across five floors. Two floors will be available for commercial laboratories and office facilities for small and medium-sized enterprises involved in developing products that will improve patient care and treatment outcomes. A further two floors will be devoted to the LSTM’s world leading research in the global fight against the growing threat of antibiotic resistance.

The Accelerator is expected to open in 2017 and will provide a hub for life sciences, enabling clinicians, academics and industry to collaborate in research and innovation to develop their ideas into the very latest life-saving treatments.

This building is the first development in the creation of a city centre health campus that will be built on the site of the existing Royal Liverpool University Hospital. This Liverpool Health Campus will consist of 200,000 square feet of space, attracting life sciences, biomedical research companies and health organisations.
**Working with our partners**

Over the past year we have worked with many partners on a range of different projects. We have close links with all the universities in Liverpool, with key regeneration bodies and other NHS trusts.

We continued to work closely with the Clatterbridge Cancer Centre on plans to build a dedicated cancer centre on the same site as the Royal. We have been in discussion with Aintree University Hospital and the Liverpool Women’s Hospital about developing models for closer collaboration between our clinical teams, with a view to transforming services to improve care for our patients.

We have also been working ever closer with our partners in community care to develop new ways of working that will enable more patients to be discharged to appropriate community based care settings once they are medically fit to leave our hospitals.

Like all other NHS organisations in Liverpool, the trust, its clinicians and other healthcare professionals, are working alongside one another and with Liverpool City Council to transform local health and care services to improve the health of local people as part of the Healthy Liverpool programme.

**Healthy Liverpool**

Healthy Liverpool is the city’s plan to improve the health of people in Liverpool and make sure the local health and care system is focused on their needs, supporting more people to stay well for longer and providing the very best treatment and care when needed.

This plan is focused on five areas:

1. Living well
2. Digital care and innovation
3. Community services
4. Urgent and emergency care
5. Hospital services
Liverpool Clinical Commissioning Group, which is leading Healthy Liverpool, has been engaging with local people to get their views on how health and care services should be shaped.

Part of what Healthy Liverpool is looking at for hospitals, is reducing duplication of services and variation of standards in hospital care across Liverpool. Healthy Liverpool is considering whether establishing single specialist teams working together across various organisations would improve standards of care. This may help share expertise, train and recruit the best talent, as well as enable seven day services for local people.
Future aims
We must continue to deliver our aims and objectives during challenging economic times, as demand for hospital services and care is increasing across the NHS.

The key longer term initiatives include:

- Completing the building of the new Royal Liverpool University Hospital and transforming healthcare
- Finalising our plans for moving into the new Royal
- Continuing with our plans to develop Broadgreen Hospital into a significant centre for elective (planned) operations and appointments
- An on-going programme of substantial quality, efficiency and productivity improvements in order to improve quality whilst maintaining financial balance and value for money, something all NHS Trusts in the country have to do
- Development of integrated patient pathways, which ensure the best outcomes and experience for our patients using the available resources
- Making changes to the way local healthcare systems work to improve services
- Strengthening our research, development and innovation in order to improve Liverpool’s regional competitive position
- We continue to maintain and refresh our Business Plans to support the delivery of our strategy

Future challenges
We must continue to deliver effective current services and achieve national targets. We will continue to work with healthcare partners to develop the Healthy Liverpool programme and implement on-going improvements across health and social care including enhancing links to community based services. We will continue to develop and finalise plans for moving into the new Royal in 2017. Like all NHS Trusts, we have to make significant efficiency savings every year and will continue to make those savings beyond 2016.
Healthwatch Liverpool welcomes the opportunity to provide a commentary on the 2015-16 Quality Account of the Royal Liverpool and Broadgreen University Hospitals NHS Trust. This commentary relates to a draft document that was provided to Healthwatch by the Trust prior to its publication.

The Trust’s priorities for 2015-16 were grouped under three headings: reducing mortality, a reduction in avoidable harm to patients, and delivering patient-centred care. Healthwatch is pleased to note that most priorities were achieved, and the overall impression Healthwatch gains from the report and from our ongoing engagement is that the Trust has continued to make improvements this year.

The report also bears out some of the challenges, including meeting the 4-hour wait target for Accident and Emergency. Healthwatch is aware that this relates to other system-wide issues, however we welcome that the Trust is investigating ways to increase patient flow and to ensure the targets are met. There are also some challenges in waiting times after referral to treatment.

Healthwatch Liverpool notes that the Trust had mixed results for infection control, but welcomes the substantial reduction in MRSA and C Diff infections. It was also positive to see that the work the Trust carried out during 2015-16 to identify and treat sepsis sooner has led to improved outcomes for patients.

Healthwatch is pleased to note the progress made to ensure patients with a learning difficulty or a dementia diagnosis receive appropriate care. The report provides positive examples of a variety of initiatives by the Trust, including the monthly ‘Memory Cafes’ held for patients with dementia and their carers. Healthwatch
welcomes that the Trust intends to sign up to 'John's Campaign' to increase the involvement of relatives of patients with dementia in their care.

The Trust achieved its target of 75% of patients stating they would be extremely likely to recommend the Trust to friends and family. However, Healthwatch notes that other feedback received from patient questionnaires, although improved during the year, did not meet targets. Healthwatch welcomes the actions to improve patient experience outlined in the report, including the continued regular engagement with patients and carers.

We were pleased to see information about the work the Trust has carried out to achieve its equality objectives included in the report, and the Trust's progress on Equality Delivery System 2 (EDS2) outcomes.

The priorities for 2016-17 are clearly outlined. We particularly welcome that effective discharge planning continues to be a priority in 2016-17, as this is a crucial area and one with which Healthwatch is involved through its work with providers and commissioners on the Merseyside Hospital Discharge Network.

The Trust invited Healthwatch to carry out a 'Listening event' at its sites to get patient feedback about the services provided, and on the Royal site about the new-build hospital due to open in 2017. It was pleasing to hear much positive feedback from patients; however some unease was also expressed about the new Royal hospital having only single rooms.

Healthwatch Liverpool will follow the Trust's engagement with patients and the public around this with interest, and we look forward to continuing engagement with the Royal Liverpool and Broadgreen University Hospitals in 2016/17.
Sefton Overview and Scrutiny Committee

I write to advise you that Members of Sefton Council’s Overview and Scrutiny Committee (Adult Social Care and Health) met informally last Friday, 20th May 2016, to consider the various draft Quality Accounts that had been received.

Members had no particular comments or concerns to raise in relation to the Royal’s Quality Account and will not be submitting a formal commentary on your Trust’s Quality Account this year.

However, Members were very pleased to have the opportunity to peruse the Quality Account and look forward to receiving your draft Quality Account next year.
NHS Liverpool Clinical Commissioning Group – Quality Account Statements – Royal Liverpool and Broadgreen University Hospitals NHS Trust

South Sefton, Liverpool and Knowsley CCGs welcome the opportunity to jointly comment on Royal Liverpool and Broadgreen University Hospitals NHS Trust Draft Quality Account for 2015/16. We have worked closely with the Trust throughout 2015/16 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 good progress on most indicators.

This Account indicates the Trust’s commitment to improving the quality of the services it provides with commissioners supporting the key priorities for the improvement of quality during 2015/16.

Priority 1: Reducing Mortality: We will implement robust systems to improve mortality and improve patient outcomes

Priority 2: Reduction in avoidable harm to our patients

Priority 3: Delivering patient centred care, treating all patients with dignity and respect and obtaining feedback that more than 75% of patients would be extremely likely to recommend this Trust to a family member or friend

Priority 4: To ensure that people with learning disabilities and/or autistic spectrum conditions are able to access our services when necessary including making reasonable adjustments to services

This is a comprehensive report that clearly demonstrates progress within the Trust. It identifies where the organisation has done well, where further improvement is required and what actions are needed to achieve these goals, in line with their Quality Plan.

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

Through this Quality Account and on-going quality assurance process the Trust clearly demonstrates their commitment to improving the quality of care and services delivered. Royal Liverpool and Broadgreen University Hospitals NHS Trust continues to develop innovative ways to capture the experience of patients and their families in order to drive improvements in the quality of care delivered.
The Trust places significant emphasis on its safety agenda, with an open and transparent culture, and this is reflected throughout the account with work continuing on the reporting of incidents and the embedding of learning across the organisation.

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

- 77.56% of patients are extremely likely to recommend the trust to family and friends. The CCGs note the new initiatives to improve response rates for FFT are continuing in the Trust.
- Dementia training rolled out to 3,370 staff in the Trust.
- Reduction of MRSA in comparison with previous year and the Infection Control strategy.

The CCGs would like to acknowledge the Trust on the development of the Academic Palliative Care Unit which has built upon clinical excellence in end of life care and acknowledge this is a two yearly project. This unit offers support for those patients who have the most complex specialist palliative care needs and who require high dependency palliative care.

The Trust should also be commended regarding the engagement of the clinical teams on the process of reviewing all cases of C.Difficile and the CCGs acknowledge the number of cases which have no identifiable lapses in care. This has demonstrated ownership of learning amongst respective clinical teams across the Trust.

Commissioners are aspiring through strategic objectives and 5 year plans 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 both challenging and reflective of the current issues across the health economy. We therefore commend the Trust in taking account of new opportunities to further improve the delivery of excellent, compassionate and safe care for every patient, every time.

**Liverpool CCG**

Signed

Katherine Sheerin, Chief Officer

Date: 3/6/2016
South Sefton CCG

Signed

[Signature]

Fiona Clark, Chief Officer

Date: 23rd May 2016

Knowsley CCG

Signed

[Signature]

Dianne Johnson, Accountable Officer

Date: 3rd June 2016
Independent Auditor’s Limited Assurance Report to the Directors of The Royal Liverpool and Broadgreen University Hospitals NHS Trust on the Annual Quality Account

We are required 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 2016 (“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, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 (“the Regulations”).

Scope and subject matter
The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following indicators:

- Percentage of reported patient safety incidents resulting in severe harm or death during the reporting period;
- Rate of Clostridium difficile infections (“CDIs”) per 100,000 bed days for patients aged two or more on the date the specimen was taken during the reporting period.

We refer to these two indicators collectively as “the indicators”.

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHIS Quality Accounts Auditor Guidance 2014-15 issued by DH 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 to consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2015 to June 2016;
- papers relating to quality reported to the Board over the period April 2015 to June 2016;
- feedback from the Commissioners dated 03/06/2016;
- feedback from Local Healthwatch;
- the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated 08/06/2016;
- the latest national staff survey dated 22/03/2016;
- the Head of Internal Audit’s annual opinion over the trust’s control environment dated March 2016;
- the annual governance statement dated 01/06/2016; and
- the Care Quality Commission’s Intelligent Monitoring Report dated May 2015;

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.

This report, including the conclusion, is made solely to 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 save 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;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

**Limitations**

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

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

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

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Royal Liverpool and Broadgreen University Hospitals NHS Trust.
Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016

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

Grant Thornton UK LLP
The Royal Liver Building
Liverpool
L3 1PS

29 June 2016
## Appendix 1 – Acute Services CQUIN Scheme 2015-16

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Indicator Weighting (% of CQUIN scheme available)</th>
<th>Total Value (£6,019.255)</th>
<th>CQUIN Performance 2015/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>National CQUIN - Acute Kidney Injury</td>
<td>0.250%</td>
<td>£601,926</td>
<td>Achieved</td>
</tr>
<tr>
<td>National CQUIN - Sepsis. Screening</td>
<td>0.125%</td>
<td>£300,963</td>
<td>Achieved</td>
</tr>
<tr>
<td>National CQUIN - Sepsis. Antibiotic Administration</td>
<td>0.125%</td>
<td>£300,963</td>
<td>Achieved</td>
</tr>
<tr>
<td>National CQUIN - Dementia. Find, Assess, Investigate, Refer.</td>
<td>0.100%</td>
<td>£240,770</td>
<td>Partial Achievement</td>
</tr>
<tr>
<td>National CQUIN - Delirium. Inform Section</td>
<td>0.050%</td>
<td>£120,385</td>
<td>Achieved</td>
</tr>
<tr>
<td>National CQUIN - Dementia. Staff Training.</td>
<td>0.025%</td>
<td>£60,193</td>
<td>Achieved</td>
</tr>
<tr>
<td>National CQUIN - Dementia. Supporting Carers</td>
<td>0.075%</td>
<td>£180,578</td>
<td>Achieved</td>
</tr>
<tr>
<td>National CQUIN - Urgent &amp; Emergency Care. Improving recording of diagnosis in A&amp;E</td>
<td>0.250%</td>
<td>£601,926</td>
<td>Achieved</td>
</tr>
<tr>
<td>National CQUIN - Urgent &amp; Emergency Care. Reduction in A&amp;E MH re-attendances</td>
<td>0.250%</td>
<td>£601,926</td>
<td>Achieved</td>
</tr>
<tr>
<td>Local CQUIN - AQ. Acute Kidney Injury</td>
<td>0.030%</td>
<td>£72,231</td>
<td>Partial Achievement</td>
</tr>
<tr>
<td>Local CQUIN - AQ. Acute Myocardial Infarction</td>
<td>0.000%</td>
<td>£0</td>
<td>Achieved</td>
</tr>
<tr>
<td>Local CQUIN - AQ. Alcohol Related Liver Disease</td>
<td>0.030%</td>
<td>£72,231</td>
<td>Partial Achievement</td>
</tr>
<tr>
<td>Local CQUIN - AQ COPD</td>
<td>0.030%</td>
<td>£72,231</td>
<td>Partial Achievement</td>
</tr>
<tr>
<td>Local CQUIN - AQ. Diabetes</td>
<td>0.030%</td>
<td>£72,231</td>
<td>Partial Achievement</td>
</tr>
<tr>
<td>Local CQUIN - AQ. Hip and Knee Replacement Surgery</td>
<td>0.000%</td>
<td>£0</td>
<td>Achieved</td>
</tr>
<tr>
<td>Local CQUIN - AQ. Hip Fracture</td>
<td>0.030%</td>
<td>£72,231</td>
<td>Partial Achievement</td>
</tr>
<tr>
<td>Local CQUIN - AQ. Heart Failure</td>
<td>0.030%</td>
<td>£72,231</td>
<td>Partial Achievement</td>
</tr>
<tr>
<td>Local CQUIN - AQ. Pneumonia</td>
<td>0.030%</td>
<td>£72,231</td>
<td>Partial Achievement</td>
</tr>
<tr>
<td>Local CQUIN - AQ. Sepsis</td>
<td>0.030%</td>
<td>£72,231</td>
<td>Achieved</td>
</tr>
<tr>
<td>Project Description</td>
<td>Percentage</td>
<td>Cost (£)</td>
<td>Status</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>-----------</td>
<td>--------</td>
</tr>
<tr>
<td>Local CQUIN Digital Maturity - Assessment</td>
<td>0.100%</td>
<td>£240,770</td>
<td>Achieved</td>
</tr>
<tr>
<td>Local CQUIN Digital Maturity - Life Enhancing Technology</td>
<td>0.150%</td>
<td>£361,155</td>
<td>Achieved</td>
</tr>
<tr>
<td>Local CQUIN Digital Maturity - Single Instance of ICE for Orders and Requests</td>
<td>0.150%</td>
<td>£361,155</td>
<td>Achieved</td>
</tr>
<tr>
<td>Local Effective Discharge Planning - Audit Compliance: Effective Discharge Planning Outcomes</td>
<td>0.100%</td>
<td>£240,770</td>
<td>Achieved</td>
</tr>
<tr>
<td>Local Effective Discharge Planning - Implementation of Transformational Change to Discharge Planning</td>
<td>0.100%</td>
<td>£240,770</td>
<td>Achieved</td>
</tr>
<tr>
<td>Local CQUIN Effective Discharge Planning - Home for Lunch Project</td>
<td>0.100%</td>
<td>£240,770</td>
<td>Achieved</td>
</tr>
<tr>
<td>Local CQUIN Improving the transition from Children and Young People Services to Adult Services</td>
<td>0.310%</td>
<td>£746,388</td>
<td>Achieved</td>
</tr>
</tbody>
</table>
## Appendix 2 - Specialist Commissioning Services CQUIN Scheme 2015/16

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Indicator Weighting (% of CQUIN scheme available)</th>
<th>Total Value</th>
<th>CQUIN Performance 2015/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Utilisation Review (CUR)</td>
<td>0.75%</td>
<td>273,313</td>
<td>Partial Achievement</td>
</tr>
<tr>
<td>Management of SACT. (QIPP) Oral formulation of anti- cancer therapy</td>
<td>0.75%</td>
<td>273,313</td>
<td>Achieved</td>
</tr>
<tr>
<td>Embedding quality systems in HIV Networks</td>
<td>0.15%</td>
<td>54,663</td>
<td>Achieved</td>
</tr>
<tr>
<td>Bone Marrow Transplant: Comorbidity scoring of patients</td>
<td>0.15%</td>
<td>54,663</td>
<td>Achieved</td>
</tr>
<tr>
<td>Haemoglobinopathy Networks</td>
<td>0.15%</td>
<td>54,663</td>
<td>Achieved</td>
</tr>
<tr>
<td>Increasing Home Renal Dialysis (QIPP)</td>
<td>0.15%</td>
<td>54,663</td>
<td>Partial Achievement</td>
</tr>
<tr>
<td>Vascular services Quality improvement programme for outcomes of major lower limb amputation.</td>
<td>0.15%</td>
<td>54,663</td>
<td>Achieved</td>
</tr>
<tr>
<td>Hepatitis C Networks</td>
<td>0.15%</td>
<td>54,663</td>
<td>Achieved</td>
</tr>
</tbody>
</table>
Appendix 3: Mandatory Clinical Audit Programme

To note the following two tables do not equate to the 77 national audits stated as being covered by the services the Trust provides, this is due to a number of national audits being open to submission and/or publishing reports on a number of occasions throughout the year in these instances the national audit has been counted for each submission/report i.e.

<table>
<thead>
<tr>
<th>List of Mandatory Audits applicable to the Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
</tr>
<tr>
<td>Myocardial Infarction National Audit Project (MINAP) Validation Audit</td>
</tr>
<tr>
<td>Bowel cancer (NBOCAP)</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
</tr>
<tr>
<td>Care of dying in hospital (NCDAH)</td>
</tr>
<tr>
<td>National Diabetes Footcare Audit</td>
</tr>
<tr>
<td>National Pregnancy in Diabetes Audit</td>
</tr>
<tr>
<td>National Diabetes Adults</td>
</tr>
<tr>
<td>Elective surgery (National PROMs Programme)</td>
</tr>
<tr>
<td>Emergency Use of Oxygen</td>
</tr>
<tr>
<td>National Hip Fracture Database (NHFD) - Part of FFFAP</td>
</tr>
<tr>
<td>National Audit of Inpatient Falls (Organisational audit) - Part of FFFAP</td>
</tr>
<tr>
<td>National Audit of Inpatient Falls (Clinical / patient observations) - Part of FFFAP (NICE CG161)</td>
</tr>
<tr>
<td>IBD UK Inflammatory Bowel Disease Audit Round 5: Biological therapy audit</td>
</tr>
<tr>
<td>Lung cancer (NLCA)</td>
</tr>
<tr>
<td>Major Trauma: The Trauma Audit &amp; Research Network (TARN)</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Patient information and consent</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Transfusion in children and adults with Sickle Cell disease</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion – Use of blood in Haematology</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Patient Blood Management in Surgery</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Use of Blood in Lower GI Bleeding</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Red Cell and Platelet Transfusion in Haematology</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
</tr>
</tbody>
</table>
The national clinical audits and national confidential enquiries that The Royal Liverpool and Broadgreen University Hospitals NHS Trust participated in during 2015/16 are as follows:

<table>
<thead>
<tr>
<th>List of Mandatory Audits the Trust submitted to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
</tr>
<tr>
<td>Myocardial Infarction National Audit Project (MINAP) Validation Audit</td>
</tr>
<tr>
<td>Bowel cancer (NBOCAP)</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
</tr>
<tr>
<td>Care of dying in hospital (NCDAH)</td>
</tr>
<tr>
<td>National Diabetes Footcare Audit</td>
</tr>
<tr>
<td>National Pregnancy in Diabetes Audit</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</td>
</tr>
<tr>
<td>National Diabetes Adults</td>
</tr>
<tr>
<td>Elective surgery (National PROMs Programme)</td>
</tr>
<tr>
<td>Emergency Use of Oxygen</td>
</tr>
<tr>
<td>National Hip Fracture Database (NHFD) - Part of FFFAP</td>
</tr>
<tr>
<td>National Audit of Inpatient Falls (Organisational audit) - Part of FFFAP</td>
</tr>
<tr>
<td>National Audit of Inpatient Falls (Clinical / patient observations) - Part of FFFAP (NICE CG161)</td>
</tr>
<tr>
<td>IBD UK Inflammatory Bowel Disease Audit Round 5: Biological therapy audit</td>
</tr>
<tr>
<td><strong>Lung cancer (NLCA)</strong></td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>Major Trauma: The Trauma Audit &amp; Research Network (TARN)</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Patient information and consent</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Transfusion in children and adults with Sickle Cell disease</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion – Use of blood in Haematology</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Patient Blood Management in Surgery</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Use of Blood in Lower GI Bleeding</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Red Cell and Platelet Transfusion in Haematology</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
</tr>
<tr>
<td>NJR Quality Data Audit</td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
</tr>
<tr>
<td>Renal replacement therapy (Renal Registry)</td>
</tr>
<tr>
<td>Procedural Sedation in Adults</td>
</tr>
<tr>
<td>Rheumatoid and Early Inflammatory Arthritis</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
</tr>
<tr>
<td>Vital signs in Children</td>
</tr>
<tr>
<td>VTE risk in lower limb immobilisation</td>
</tr>
<tr>
<td>Mental health (care in emergency departments)</td>
</tr>
<tr>
<td>Older people (care in emergency departments)</td>
</tr>
<tr>
<td>DAHNO - Data for Head and Neck Oncology</td>
</tr>
<tr>
<td>ICNARC - Case Mix Programme (CEM)</td>
</tr>
<tr>
<td>National Vascular Registry - AAA &amp; CEA outcomes</td>
</tr>
<tr>
<td>Potential Donor Audit</td>
</tr>
<tr>
<td>National Complicated Diverticulitis Audit (CAD)</td>
</tr>
</tbody>
</table>

It must be noted that a number of National audits were included on the Quality Account list but following further investigation these audits were not open for submission.

The national clinical audits that The Royal Liverpool and Broadgreen University Hospitals NHS Trust was eligible to participate in during 2015/15 but did not are as follows:
The national clinical audits and the national confidential enquiries the Royal Liverpool and Broadgreen University Hospitals NHS Trust participated in, and for which data collection was completed during 2015/16, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. Please note audits are duplicated where they are a continuous process producing reports based on a particular time frame, each record representations a data collection period.

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>% submitted to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rhythm Management audit (Cardiac Arrhythmia)</td>
<td>Open</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>100% (140 of 140)</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>Open</td>
</tr>
<tr>
<td>Potential Donor Audit</td>
<td>100% (6 of 6)</td>
</tr>
<tr>
<td>Stroke Improvement National Audit Project (SSNAP) includes the National Sentinel Stroke Audit</td>
<td>100% (586 of 586)</td>
</tr>
<tr>
<td>Stroke Improvement National Audit Project (SSNAP) includes the National Sentinel Stroke Audit</td>
<td>Open</td>
</tr>
<tr>
<td>Severe Trauma / Trauma Audit &amp; Research Network (TARN)</td>
<td>Open</td>
</tr>
<tr>
<td>Severe Trauma / Trauma Audit &amp; Research Network (TARN)</td>
<td>100% (500 of 500)</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Patient information and consent</td>
<td>75% (18 of 24)</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Transfusion in children and adults with Sickle Cell disease</td>
<td>Open</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion – Use of blood in Haematology</td>
<td>Open</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Patient Blood Management in Surgery</td>
<td>100% (45 of 30)</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Use of Blood in Lower GI Bleeding</td>
<td>Open</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Red Cell and Platelet Transfusion in Haematology</td>
<td>Open</td>
</tr>
<tr>
<td>NHSBT - National Comparative Audit of Blood Transfusion - Red Cell &amp; Platelet transfusion in adult haematology patients</td>
<td>Open</td>
</tr>
<tr>
<td>National Oesophago-Gastric Audit (NOGCA / NAOGC) (upper GI)</td>
<td>Open</td>
</tr>
<tr>
<td>National Oesophago-Gastric Audit (NOGCA / NAOGC) (upper GI)</td>
<td>100% (112 of 112)</td>
</tr>
<tr>
<td>National/QA/PROMs: Hernia 13/14</td>
<td>50% (166 of 332)</td>
</tr>
<tr>
<td>National/QA/PROMs: Hernia 14/15</td>
<td>57.6% (185 of 312)</td>
</tr>
<tr>
<td>National/QA/PROMs: Hernia 15/16</td>
<td>321)</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>National/QA/PROMs: Knee Replacement 13/14</td>
<td>67% (308 of 460)</td>
</tr>
<tr>
<td>National/QA/PROMs: Knee Replacement 14/15</td>
<td>84.3% (391 of 345)</td>
</tr>
<tr>
<td>National/QA/PROMs: Knee Replacement 15/16</td>
<td>Open</td>
</tr>
<tr>
<td>National/QA/PROMs: Hip Replacement 13/14</td>
<td>61.5% (238 of 387)</td>
</tr>
<tr>
<td>National/QA/PROMs: Hip Replacement 14/15</td>
<td>76.1% (249 of 327)</td>
</tr>
<tr>
<td>National/QA/PROMs: Hip Replacement 15/16</td>
<td>Open</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>Open</td>
</tr>
<tr>
<td>National Hip Fracture Database (NHFD) - Part of FFFAP</td>
<td>Open</td>
</tr>
<tr>
<td>National Hip Fracture Database (NHFD) - Part of FFFAP</td>
<td>100% (374 of 374)</td>
</tr>
<tr>
<td>National Audit of Inpatient Falls (Organisational audit) - Part of FFFAP</td>
<td>100% (1 of 1)</td>
</tr>
<tr>
<td>National Audit of Inpatient Falls (Clinical / patient observations) - Part of FFFAP (NICE CG161)</td>
<td>100% (30 of 30)</td>
</tr>
<tr>
<td>Mental health (care in emergency departments)</td>
<td>100% (50 of 50)</td>
</tr>
<tr>
<td>Older people (care in emergency departments)</td>
<td>100% (100 of 100)</td>
</tr>
<tr>
<td>Myocardial Infarction National Audit Project (MINAP) Validation Audit</td>
<td>Open</td>
</tr>
<tr>
<td>Myocardial Infarction National Audit Project (MINAP) Validation Audit</td>
<td>Open</td>
</tr>
<tr>
<td>Myocardial Infarction National Audit Project (MINAP)</td>
<td>Open</td>
</tr>
<tr>
<td>Myocardial Infarction National Audit Project (MINAP)</td>
<td>Open</td>
</tr>
<tr>
<td>IBD UK Inflammatory Bowel Disease Audit Round 5: Biological therapy audit</td>
<td>100% (33 of 33)</td>
</tr>
<tr>
<td>National Diabetes Audit (NDA): Core Audit</td>
<td>Open</td>
</tr>
<tr>
<td>National Diabetes Audit (NDA): Core Audit</td>
<td>Open</td>
</tr>
<tr>
<td>National Diabetes Audit (NDA): Core Audit</td>
<td>Open</td>
</tr>
<tr>
<td>National Diabetes Audit (NDA): National Pregnancy in Diabetes Audit (NPID)</td>
<td>100% (1 of 1)</td>
</tr>
<tr>
<td>National Diabetes Audit (NDA): National Diabetes Foot Care Audit (NDFA)</td>
<td>Open</td>
</tr>
<tr>
<td>National Diabetes Audit (NDA): National Pregnancy in Diabetes Audit (NPID)</td>
<td>Open</td>
</tr>
<tr>
<td>DAHNO - Data for Head and Neck Oncology</td>
<td>100% (27 of 27)</td>
</tr>
<tr>
<td>NCEPOD Gastrointestinal Haemorrhage</td>
<td>80%</td>
</tr>
<tr>
<td>Bowel Cancer (NBOCAP)</td>
<td>135% (203 of 200)</td>
</tr>
<tr>
<td>Category</td>
<td>Status</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Bowel Cancer (NBOCAP)</td>
<td>Open</td>
</tr>
<tr>
<td>Bowel Cancer (NBOCAP)</td>
<td>Open</td>
</tr>
<tr>
<td>NCEPOD: Sepsis</td>
<td>Open</td>
</tr>
<tr>
<td>NCEPOD: Mental Health</td>
<td>Open</td>
</tr>
<tr>
<td>ICNARC - Case Mix Programme (CEM)</td>
<td>Open</td>
</tr>
<tr>
<td>ICNARC - Case Mix Programme (CEM)</td>
<td>Open</td>
</tr>
<tr>
<td>Renal Registry / Renal Replacement Therapy</td>
<td>Open</td>
</tr>
<tr>
<td>Renal Registry / Renal Replacement Therapy</td>
<td>Open</td>
</tr>
<tr>
<td>Lung Cancer (LUCADA / NLCA)</td>
<td>Open</td>
</tr>
<tr>
<td>Lung Cancer (LUCADA / NLCA)</td>
<td>Open</td>
</tr>
<tr>
<td>Rheumatoid &amp; Early Inflammatory Arthritis</td>
<td>Open</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>Open</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>Open</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>Open</td>
</tr>
<tr>
<td>National Joint Registry</td>
<td>Open</td>
</tr>
<tr>
<td>National Joint Registry</td>
<td>Open</td>
</tr>
<tr>
<td>NJR Quality Data Audit</td>
<td>Open</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>Open</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>Open</td>
</tr>
<tr>
<td>National Vascular Registry - AAA &amp; CEA outcomes</td>
<td>Open</td>
</tr>
<tr>
<td>National Vascular Registry - AAA &amp; CEA outcomes</td>
<td>Open</td>
</tr>
<tr>
<td>National Vascular Registry - AAA &amp; CEA outcomes</td>
<td>Open</td>
</tr>
<tr>
<td>National Vascular Registry - AAA &amp; CEA outcomes</td>
<td>Open</td>
</tr>
<tr>
<td>National Care of the Dying Audit of Hospitals (2 aspects Organisational and Clinical Audit)</td>
<td>Open</td>
</tr>
<tr>
<td>NCEPOD Acute Pancreatitis</td>
<td>Open</td>
</tr>
<tr>
<td>NCEPOD Non-Invasive Ventilation Study</td>
<td>Open</td>
</tr>
<tr>
<td>Emergency Use of Oxygen (BTS)</td>
<td>Open</td>
</tr>
<tr>
<td>Procedural Sedation in Adults (CEM)</td>
<td>Open</td>
</tr>
<tr>
<td>Vital signs in Children (CEM)</td>
<td>Open</td>
</tr>
<tr>
<td>VTE in patients with Lower Limb Immobilisation (CEM)</td>
<td>Open</td>
</tr>
</tbody>
</table>
### Appendix 4 – Palliative Care Coding Benchmarking Feb 2014 - Jan 2016

<table>
<thead>
<tr>
<th>Trust Name</th>
<th>Discharge Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UNIVERSITY HOSPITALS OF SOUTH MANCHESTER NHS FOUNDATION TRUST</strong></td>
<td></td>
</tr>
<tr>
<td>3.7%</td>
<td>4.26%</td>
</tr>
<tr>
<td><strong>UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST</strong></td>
<td></td>
</tr>
<tr>
<td>15.86%</td>
<td>17.95%</td>
</tr>
<tr>
<td><strong>LEEDS TEACHING HOSPITALS NHS TRUST</strong></td>
<td></td>
</tr>
<tr>
<td>15.86%</td>
<td>15.69%</td>
</tr>
<tr>
<td><strong>LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST</strong></td>
<td></td>
</tr>
<tr>
<td><strong>THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST</strong></td>
<td></td>
</tr>
<tr>
<td>21.43%</td>
<td>21.43%</td>
</tr>
<tr>
<td><strong>CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST</strong></td>
<td></td>
</tr>
<tr>
<td>22.03%</td>
<td>22.03%</td>
</tr>
<tr>
<td><strong>UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST</strong></td>
<td></td>
</tr>
<tr>
<td>26.05%</td>
<td>26.05%</td>
</tr>
<tr>
<td><strong>CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST</strong></td>
<td></td>
</tr>
<tr>
<td>35.55%</td>
<td>35.55%</td>
</tr>
<tr>
<td><strong>UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST</strong></td>
<td></td>
</tr>
<tr>
<td>24.95%</td>
<td>24.95%</td>
</tr>
<tr>
<td><strong>NATIONAL AVERAGE</strong></td>
<td></td>
</tr>
<tr>
<td>23.80%</td>
<td>23.80%</td>
</tr>
<tr>
<td><strong>NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST</strong></td>
<td></td>
</tr>
<tr>
<td>22.07%</td>
<td>22.07%</td>
</tr>
<tr>
<td><strong>ROCK LEVRON AND BIDGRO GREEN UNIVERSITY HOSPITALS NHS TRUST</strong></td>
<td></td>
</tr>
<tr>
<td>25.36%</td>
<td>25.36%</td>
</tr>
<tr>
<td><strong>SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST</strong></td>
<td></td>
</tr>
<tr>
<td>25.55%</td>
<td>25.55%</td>
</tr>
<tr>
<td><strong>OXFORD UNIVERSITY HOSPITALS NHS TRUST</strong></td>
<td></td>
</tr>
<tr>
<td>35.32%</td>
<td>35.32%</td>
</tr>
<tr>
<td><strong>SALESHYROX ALMS FOUNDATION TRUST</strong></td>
<td></td>
</tr>
<tr>
<td>38.37%</td>
<td>38.37%</td>
</tr>
<tr>
<td><strong>UNIVERSITY HOSPITALS SOUTHAMPTON NHS FOUNDATION TRUST</strong></td>
<td></td>
</tr>
<tr>
<td>36.22%</td>
<td>36.22%</td>
</tr>
</tbody>
</table>
Changes since draft Quality Account submitted to external stakeholders for comments (7th June 2016)

- Cancelled operations 15/16. After further validation the number of cancelled operations for 2015/16 increased by 2. Total number is 376.
- Cancer waiting times 15/16. Table updated for March 2016.
- Access to cancer services – After further validation and analysis the performance for 31 day wait from diagnosis to first treatment, 31 day wait for second or subsequent treatment: (surgery) has been amended following year-end review.
- CQUIN Framework – National Acute Kidney Injury the requirement for quarter four was to achieve a combined achievement of 90%. On further validation the trust had achieved this CQUIN.
- CQUIN Framework – National Sepsis. The financial reduction has been confirmed based on actual performance against the national CQUIN.
- VTE – Following the publication of national data, quarter four information included within the quality account.
- NHS Staff Survey – Performance updated and the inclusion of KF21
- About Us section the actual amount of income generated for patient care 15/16 has been included within the account.
The enclosed information is available on request in alternative formats including community languages, easyread, large print, audio, braille, moon and electronically. Visit our website at www.rlbuht.nhs.uk for details about the Trust.