

Item 5.1a

# LHCH Quality Report

## 2019-2020

# QUALITY REPORT

**Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH) is a single site specialist hospital serving a population of 2.8 million people living in Cheshire, Merseyside, North Wales and the Isle of Man. It provides the full range of heart and chest services with the exception of organ transplantation.**

Throughout 2019/20, this included:

1. procedures used to visualise the coronary arteries and treat narrowing's using balloons and stents (coronary angiography and intervention). Cardiology intervention procedures for those patients with congenital heart disease (CHD)
2. the implantation of pacemakers and other devices such as LinQ, and treatments used to control and restore the normal rhythm of the heart (arrhythmia management)
3. surgical procedures used to treat bypass coronary artery narrowings, replacing the valves of the heart or dealing with other problems with major vessels in the chest (cardiac surgery) that includes a transcatheter aortic valve replacement (TAVR) or transcatheter aortic valve implantation (TAVI). Enhanced technology with the use of robotic surgery for cardiac surgery and provision of cardiac surgery for those patients with congenital heart disease (CHD)
4. surgical procedures used to treat all major diseases that can affect the normal function of the lungs (thoracic surgery). Enhanced technology with the use of robotic surgery for thoracic surgery
5. drug management of asthma, chronic obstructive pulmonary disease and cystic fibrosis (respiratory medicine)
6. community cardiovascular, respiratory and chronic obstructive pulmonary care for the residents of Knowsley.

All clinical ward and operating theatres areas were assessed against the Trust's *Efficient Excellent Compassionate and Safe Care* standards (EECS) framework in 2019. Most areas have now achieved gold status with achievement plaques displayed outside each ward /department entrance. The wards who achieved

The ward areas achieving gold status has risen this year with awards being presented at the 'Best of the Best' LHCH Grand Awards ceremony held in November 2019 and in recognition for their outstanding delivery of patient and family centred care. These wards and departments were:

- Birch Ward
- Cedar Ward
- Cardiac Diagnostic Department
- Elm Ward
- Medical Engineering Department
- Therapy Department
- Outpatient Department
- Pharmacy Department
- Pulmonary Function Department

The Trust is the lead for the Cardiovascular Disease (CVD) Programme for Cheshire and Merseyside Health Care Partnership (C&M HCP).

As part of the 2019/2020 plan, the Trust led on a Single Cardiorespiratory Service pathway for the city of Liverpool. LHCH is working in partnership with Liverpool University Foundation Trust Hospitals (LUFT) in development of a single model of care for conditions such as transient loss of consciousness (Syncope) and breathlessness (heart failure), plus common central hubs for cardiac and pulmonary rehabilitation and diagnostics.

LHCH will continue, through 2020/21, to lead on the CVD programme for the City of Liverpool and for the region, and will continue to bring a focus to areas of CVD care in need of improvement.

## **Developments for 2019**

### **New Ward Area**

The Trust has continued to invest in its services with an improved Private Patient Unit which opened in June 2019, named Rowan Suite, providing nine en-suite bedrooms and three clinic rooms. This new facility will support our vision in continuing the delivery of the patient and family experience vision.

### **CT and MR scanning**

The Trust has purchased new CT and MRI scanners which are expected to be operational by August 2019. The new scanners provide state of the art functionality allowing for a wider range of complex testing, reduced scanning times and reduced radiology exposure for CT scanning.

LHCH manages a high level of referrals for patients being treated at our hospital and a range of other providers. This is due to the specialist nature of tests that can be undertaken, especially cardiac CT and MRI scanning. Installation of the new scanners will provide a much improved patient experience.

### **Cath Labs**

2020 will see the start of an upgrade and expansion of the Trust's existing Cath Lab suite. The vision is to create a world-class reference centre with facilities to match its outstanding care that will support anticipated changes in patient demand and service innovation.

The planned development will allow for essential replacement of imaging equipment which is critical to maintaining current service and has also provided the Trust with an opportunity to reconfigure the current footprint. This development will create six labs in total with a further seventh 'shell' for future development.

Creating an improved patient and family experience by addressing some privacy and dignity issues in the current layout, has been key to the design with the incorporation of a dedicated palliative care room with improved facilities for relatives. The new design will also ensure a significant reduction in crossover of planned and emergency admissions, thus improving the experience for both groups of patients, families and staff.

## Quality Account Summary

This Quality Account takes a look at the year past and reflects upon the commitment the Trust has made to improve quality.

The Trust is pleased to announce that significant progress has been made on the quality priorities agreed by its Governors and Stakeholders in 2019/2020.

- Delirium – assessment completed on admission.
- Patients to be discharged by 1600 hrs
- Pathways for our visual and hearing impaired patients
- Reduction in medication errors relating to insulin

It has been another good year for improving the quality of care at LHCH, with the focus on improving the quality of care and experience for all its patients, their families and carers.

This Quality Account also reassures readers regarding work that is a key enabler of quality, including clinical audit, research, data quality, workforce management and leadership. It draws upon the results from the Trust's survey work with patients and other quality improvement work supporting the different services and functions of the Trust.

## Part 1 Statement on quality from the Chief Executive of Liverpool Heart and Chest Hospital NHS Foundation Trust

It is my pleasure to introduce the Quality Account for 2019/2020 by Liverpool Heart and Chest Hospital NHS Foundation Trust, which demonstrates our commitment to deliver the very best in healthcare.

The Trust Board has a very strong commitment to quality which is reflected in our mission: ***“Excellent, compassionate and safe care for every patient every day”***, as well as our vision: ***‘to be the best - delivering and leading outstanding heart and chest care and research’***.

We have made significant improvements to quality since our Quality Account 2018/2019. Our front line staff have been involved in identifying and focusing on quality improvements that they have generated. This resulted in a high level of staff engagement through responses to the staff survey and at the subsequent staff improvement events.

Our Quality Strategy brings together the learning from the Francis Report, the Keogh Report and the Berwick Review with the Trust’s own programmes of work, for example our Safety Seven pledges, Listening into Action and Service Improvement. This ensures a cohesive approach to maintaining safe, quality care provision. This will be reviewed in 2020 and further reported in the next Quality Account.

Alongside this we have continued our focus on a culture of openness, honesty and transparency with our patients and their families. Liverpool Heart and Chest Hospital is committed to an open, transparent and safe culture. The Trust has a Freedom to Speak Up (FTSU) Policy, and a designated FTSU Guardian supported by a network of FTSU Champions. As Chief Executive, I have made a personal three-point pledge to all new starters and I repeat this pledge to all staff on a regular basis:

1. I will actively encourage staff to speak up about any concerns.
2. I will review fully, openly and transparently and will provide feedback wherever possible.
3. I will keep you safe and ensure you suffer no detriment.

This pledge forms the basis for the Trust’s ‘speaking up’ culture. The Trust has put in place a number of ways to encourage and support staff to speak up about any concerns they may have, including but not limited to, quality of care, patient safety and bullying and harassment. These are as follows:

- Access to Freedom to Speak Up Guardian and Champions
- Daily Trust-wide Safety Huddle led by the Chief Executive
- Incident reporting through DATIX
- Speak out Safely through the risk management team

- HALT – empowering all staff to call a ‘HALT’ if there is harm or the potential of harm to any patient
- Confidential hotline to report concerns anonymously
- Discussion with line manager
- Support from Human Resources and/or trade union representatives

Speaking up is explicitly referred to in the Trust’s values.

All staff who ‘speak up’ are given feedback in a timely manner by whoever they have spoken up to and there is a zero tolerance policy for staff who may experience any detriment due to ‘speaking up’. The process is overseen by the FTSU Guardian.

Quality of care is at the heart of everything we do. This is supported by a welcoming, honest and compassionate approach to our delivery of healthcare. We will continue to engage with our patients and families in order to improve our services whilst learning from incidents and errors. We will strive to deliver excellent healthcare, whilst supporting our staff to speak out safely to reduce avoidable harm. We will continue to hold engagement events with our patients and their families to consistently strive to improve our services for them.

This vision encapsulates our commitment to cardiothoracic (heart and chest) care as our core business, but advances our ambition to develop services which bridge the divide between general practitioners, local district hospitals and ourselves. Integration with our healthcare partners will allow us to reach further into the community and develop the high quality care and experience enjoyed by our patients.

We are committed to working with other healthcare colleagues in development of Sustainable Transformation Plans (STP) that focus on delivering excellent healthcare locally, in an evolving healthcare environment. I am the Senior Responsible Officer for leading the Single Cardiorespiratory Service Pathway programme. In addition, our Director of Strategic Partnerships is the Senior Responsible Officer for the Prevention at scale strategic programme.

This year has been positive for the quality of care provided to our patients.

Key achievements in 2019/20

- LHCH was rated ‘Outstanding’ for a second time by the Care Quality Commission in July 2019 – becoming one of only 5 NHS providers in the country to achieve the rating twice.
- LHCH is extensively featured in BBC2’s award-winning ‘Hospital’ documentary series filmed in Liverpool for a second time.
- LHCH ranked top the top performing acute specialist trust in the country for the new National Guardian’s Office Freedom to Speak Up Index
- LHCH was rated as one of the best hospitals in the country to receive care and treatment according to the NHS Staff Survey 2019.

- LHCH hosted its eighth biennial Aortic Surgery Symposium in June 2019.
- LHCH announced the launch of a new cardio-oncology service in partnership with the Clatterbridge Cancer Centre in Autumn 2019.
- Dr Sarah Sibley, Respiratory Consultant, was named Physician Associate Supervisor of the Year at the Royal College of Physicians' Faculty of Physician Associates Conference in October 2019.
- Professor Rod Stables, Consultant Cardiologist, was appointed to the role of Clinical Lead for the British Heart Foundation Clinical Research Collaborative in November 2019.
- Julie Tyrer, Tissue Viability Nurse Consultant, was shortlisted for 'Wound Care Nurse of the Year' in the British Journal of Nursing Awards 2020
- LHCH's MINIMISE Moisture campaign was shortlisted for a Patient Safety Innovation Award at the North West Coast Research and Innovation Awards 2020
- LHCH was announced as the new host for the Mary Seacole Local Programme for Cheshire and Merseyside in February 2020.
- All minimum standards of care met or exceeded as defined by the Department of Health.
- LHCH delivered strong performance against financial and operational targets for 2019/20.

The CQC carried out a 'Well Led' inspection of the Trust between 5-7<sup>th</sup> February 2019. This was preceded by an unannounced inspection on Wednesday 16<sup>th</sup> January – Friday 18<sup>th</sup> January 2019, with the inspection focus on the surgical division services. Following the final report approval in July 2019, the Trust retained its outstanding status for the second time.

## Current Status as 2019

**Provider:**  
**Liverpool Heart and Chest Hospital**  
**NHS Foundation Trust**

**Overall**  
**Outstanding**  
[Read overall summary](#)

**Safe** Good ●  
**Effective** Good ●  
**Caring** Outstanding ☆  
**Responsive** Outstanding ☆  
**Well-led** Outstanding ☆

**Latest inspection:** 5<sup>th</sup> Feb to 7<sup>th</sup> Feb 2019  
**Report published:** 3<sup>rd</sup> July 2019  
[www.cqc.org.uk/provider/RBQ](http://www.cqc.org.uk/provider/RBQ)  
**Liverpool Heart and Chest Hospital** Outstanding ☆  
Thomas Drive, Liverpool, L14 3PE  
 Tel: 0151 600 1616

Inspected and rated  
**Outstanding** ☆

## Clinical standards for seven day services

Through 2019/20 the trust has engaged with the national seven day services programme undertaking a self-assessment and audit of one of the four key clinical standards twice per year. It should be noted that the majority of emergency admissions attending LHCH are Primary PCI patients, which is a consultant-led service.

In line with the national agenda the Trust focussed on two of the four key clinical standards namely standard 2: time to initial consultant review and standard 8: all patients with high dependency needs should have ongoing daily consultant directed review.

The first audit undertaken in April 2019 demonstrated that the trust was fully compliant when assessed against standard 2. When auditing service provision against standard 8 the Trust failed to achieve a compliant position with 88% of patients being assessed against a target of 90%, just a marginal under performance that related to one patient. Based on this a second audit was undertaken in November 2019 that demonstrated compliance with both standards with standard 2 achieving 100% and standard 8 achieving 90%.

Clinical Standard	Compliance	Weekdays	Weekend
<b>Clinical Standard 2:</b> All <b>emergency admissions</b> must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	<b>35/35 (100%)</b>	<b>29/29 (100%)</b>	<b>6/6(100%)</b>
<b>Clinical Standard 8:</b> All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a	<b>26/29 (90%)</b>	<b>15/15 (100%)</b>	<b>11/14 (79%)</b>



clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.			
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Looking into 2020/21 the Trust does not envisage any areas that will require improvement when completing the seven day clinical standards self-assessment and audit. However to ensure that a continuous focus is placed on providing the best care for emergency patients, the Trust will continue to engage in the national programme and undertake audits as required to provide assurance on the standard delivery.

The start of 2020 has been challenging for LHCH alongside the NHS as a whole. The Trust expanded its critical care capability to react to the surge in numbers of Covid 19 patients requiring intensive care management. Following recovery all staff have come together to show their support for them and their families by lining their discharge route and clapping goodbye to them as they continue their road to recovery and hopefully return to normal living.

I am extremely proud of all achievements made during 2019-and into 2020, and we will continue to focus on ensuring our patients and their families receive the very best in compassionate, quality driven safe care whilst with us.

I confirm that the information in this document is an accurate reflection of the quality of our services.



**Jane Tomkinson**  
Chief Executive

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

### Priorities for improvement

**Priority One:** Pre-habilitation – Information required for our pre-operative surgical patients who are awaiting surgery within the hospital

**Priority Two:** Sepsis risk assessment completion on a consecutive MEWS score of 3 or above

**Priority Three:** Post discharge calls for patients who have left the hospital following surgery

**Priority Four:** Fasting compliance for against the fasting policy – ensuring our patients remain hydrated before procedure

## How our priorities were selected

In pursuit of its goal to deliver the best outcomes and be the safest integrated healthcare organisation in the country, throughout 2019/20 the Trust led a continuous and comprehensive consultation exercise. The focus was on the identification of those priorities for improvement which would bring the biggest benefits to the people the Trust serves. By people, this naturally includes patients, but importantly also carers, Foundation Trust members and other health and social care professionals with whom the Trust interacts with on a daily basis.

The Trust held a number of internal consultation events which have successively refined its decision making over which priorities to select. The final selection emerged from a synthesis of priorities contributed from:

1. Staff delivering front line services who know where improvements need to be made.
2. The Executive Team who have considered the wider agenda in terms of national targets, new policy directives and quality incentive schemes (eg commissioning).
3. The Trust's quality, safety and patient experience Council of Governors' interest group who are continuously identifying priorities from the Trust's 9,500 members.
4. Patient and family listening events.
5. Members and the general public, who have provided suggestions for improvement throughout the year via focus groups and a structured questionnaire which is handed out at every 'Medicine for Members' engagement event run in the local communities served by the Trust.
6. Healthwatch who were invited to the Trust's stakeholder event for Quality Accounts prioritisation.
7. Issues raised by LHCH patients through both national and local surveys.

Priorities were shortlisted by the Council of Governors and the Executive Team based upon the gap in performance between Liverpool Heart and Chest Hospital and the best performance, together with number of people likely to benefit. This is called 'the scope for improvement'. The shortlist was presented to the Trust's Governors who discussed the priorities and approved the final shortlisted priorities on behalf of the Board of Directors on 13<sup>th</sup> February 2020.

This process has resulted in four of the seven suggestions from stakeholders external to the Trust being accepted as a priority. This year, all of the suggested priorities have been influenced by our stakeholders and our Council of Governors, with engagement from staff. Monitoring of the quality priorities will be via the Patient and Family Experience Committee at each meeting.

It was in March 2020 NHSE/I confirmed the Quality Priorities approved should be placed on hold due to the Pandemic of Covid 19. The Quality Account for 2020/2021 will contain the performance achieved if NHSE/I direct all NHS Trusts to continue with this work.

## Duty of Candour

LHCH acknowledges the need for open and effective communication with all patients, carers and families. This effective communication begins at the start of a patient's care pathway and continues throughout their time spent at the hospital.

Openness and transparency with patients and their families, when an incident has been identified as causing patient harm, is both encouraged and supported by the Board of Directors.

The Trust has initiated a number of ways for implementing the duty of candour. These include:

- awareness raising for all staff groups
- inclusion of duty of candour training within the Trust's mandatory training policy
- human factors training for clinicians
- training for Board of Directors
- leaflets and posters informing staff of the Trust's commitment for open and honest communications
- strengthening Trust policies and procedures supporting Duty of Candour
- changes within the Datix reporting system to ensure duty of candour is considered and actioned.

## Review of priorities from 2019/20

### Priority One:

Those patients who have been identified as potentially developing delirium to be risk assessed on admission, and in-order for staff to be able to identify the signs of delirium to enhance care to undertake the training via a newly developed delirium training package.

- 85% surgical patient to have an delirium risk assessment on admission
- 40% of staff to have completed the new delirium training package as e- learning

#### Category:

- Safe

#### Why:

- Post-operative delirium can be extremely upsetting for patients; if LHCH can identify those patients most at risk it may be possible to reduce the incidence of this distressing post-operative complication.

#### How much:

- The Trust's aim is to identify those patients most at risk of delirium and ensure staff have received the appropriate training.

#### By When:

- March 2020

#### Who collects the data:

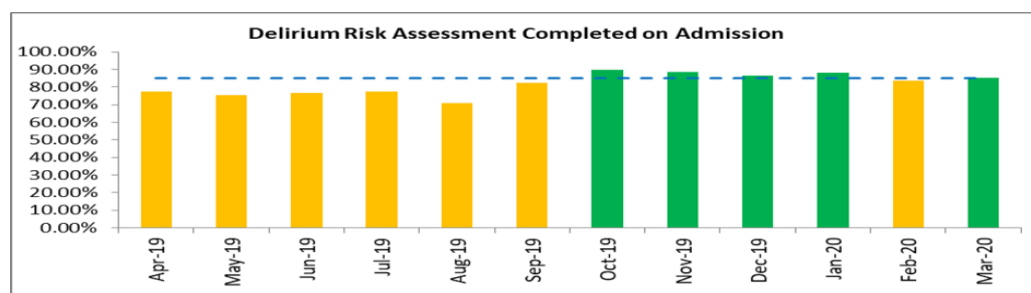
- Information will be collected by the nurses in the risk assessment document on admission.
- Training records from the Learning and Development Department.

#### Monitoring of Data:

- The Trust's Business Intelligence Team.
- The Education Team.

#### Current Position:

- 82.1% against a target of 85% for risk assessment to be completed  
94% of e-learning completed.



## Priority Two:

- Trust data provides the information to inform the Surgical Division of avoidable discharge delays. The focus for this priority is to increase the numbers of patients identified for discharge to home from Elm Ward and Cedar Ward.

### Category:

- Patient Experience

### Why:

- Healthcare is changing with the focus on ensuring patients, when medically fit, will be able to leave the hospital to their home timely, ensuring our surgical patient experience is optimised by timely discharge.

### How much:

- Improve patient flow when patients are medically fit for discharge to home on the day of discharge between the hours of 9am and 4pm.
- Increase the numbers of patients medically fit for discharge on the day of discharge by 10% for Elm Ward and Cedar Ward patients. Target 50% for each area

### By When:

- April – June explore changes to the discharge summary aspect of the TTO required to enable more timely discharge.

### Who collects the data:

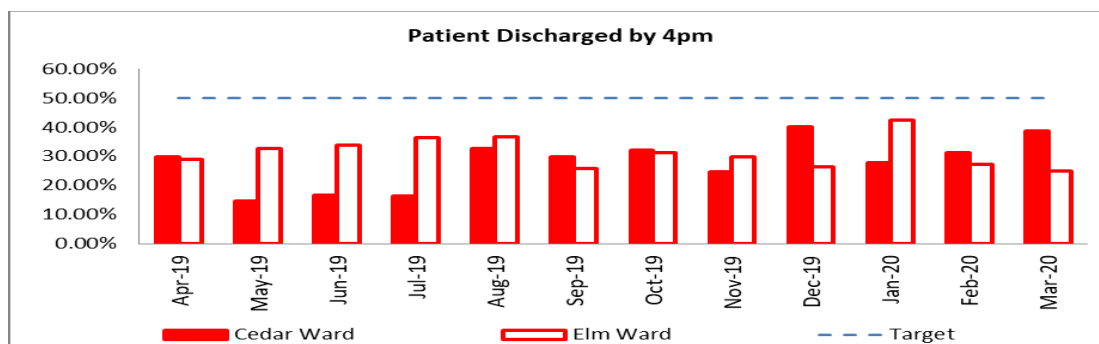
- The Information Team

### Monitoring of Data:

- On a weekly basis to ensure performance and actions can be identified in real time.

### Current Position:

- 21.9% of discharges to home from Cedar ward by after 16.00hrs
- 31.0% of discharges to home from Elm ward by after 16.00hrs



## Priority Three:

- Assessment of patients who have been identified on admission as having a complex/enhanced health condition, particularly significant hearing or visual needs, and when identified by admission they will receive an individualised risk assessment and care plan.

### Category:

- Patient Experience

### Why:

- Patients who require specialist care pathway planning pre-procedure and post procedure need to be identified before admission to enable correct plans of care to be considered and implemented.

### How much:

- Development of a risk assessment within flow sheet on EPR.
- The Trust's aim is to identify those patients with these complex health conditions to ensure appropriate care plans are in place.

### By When:

- April – June 2019 streamline the categories hearing and visual complexities within the admission document EPR, and develop the risk assessment document within EPR.
- July –September 2019 design and implement the care plan within the flowsheet in EPR.

### Who collects the data:

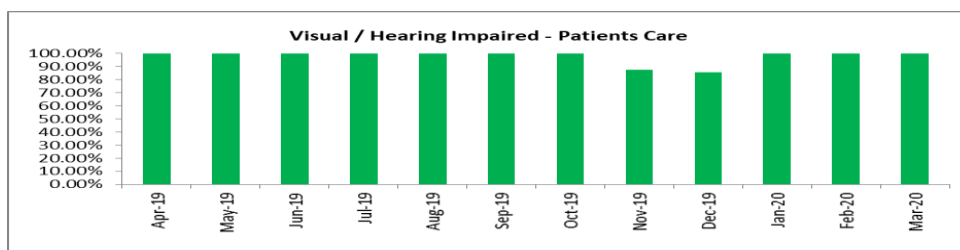
- Information will be collected via the risk assessment document in EPR, to be completed on admission and completed care planning.

### Monitoring of Data:

- The Trust's Business Intelligence Team

### Current Position:

- No individualised risk assessment or care plan for patients with significant hearing and visual needs.  
90.3% of patients had a risk assessment completed and care plan in place



## Priority Four:

- The Trust has an incident reporting system, Datix, which records all medication incidents. These incidents are reviewed by the Safe Medication Committee whereby the grade of potential harm is considered. 20% of all incidents reviewed relate to the second checking of infusions and the administration of insulin.

### Category:

- Safe

### Why:

- To target learning and analyse trends of potential harm to patients.

### How much:

- The Trust's aim is to improve safety by reducing medication errors of infusion medication and that of insulin by 10%.

### By When:

- Improve the education of second checking process for medication infusions which incorporates administration of insulin.
- April – June develop the education packages for clinical staff.
- June – March 2020 monitor reduction of reported incidents.

### Who collects the data:

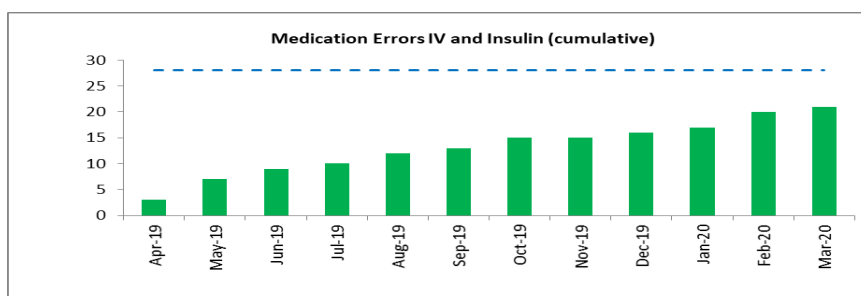
- Information will be collected by Datix and the Safer Medication Committee.

### Monitoring of Data:

- Datix

### Current Position:

A total of 21 incidents recorded against a target of 29





## Part 2.2 Statements of assurance from the Board

### Participation in clinical audits

During 2019/20, 21 national clinical audits and 2 national confidential enquiries covered relevant health services that Liverpool Heart and Chest Hospital provides.

During that period, Liverpool Heart and Chest Hospital participated in 90% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest Hospital were eligible to participate in during 2019/20 are as follows in Table 1.

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest Hospital participated in during 2019/20 are as follows in Table 1.

The national clinical audits and national confidential enquiries that Liverpool Heart and Chest Hospital participated in, and for which data collection was completed during 2019/20, 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.

Table 1: A list of national clinical audits and national confidential enquiries			
	Eligible to participate in	Participated in Yes / No	% cases submitted
<b>Acute</b>			
1	Intensive Care National Audit and Research Centre (ICNARC)	Yes	<p>The Trust is part of the ICNARC CMP and part of the Cardio-Thoracic sub-group. The data is submitted on a quarterly basis:</p> <p>For Q1-Q3 2019/20 submitted data on 1837/1837 (100%) of patients admitted to Critical Care 1837/2453 (75%) for full year 2019/20 Q4 616/616 to be submitted in May 2020</p>
<b>Cancer</b>			

2	Lung cancer (NLCA)	Yes	<p>Data for patients diagnosed in 2019 is submitted via the trust's monthly Cancer Outcomes and Services Dataset submissions to the National Cancer Registration System.</p> <p>Currently 932/932 (100%) records for suspected lung cancer have been submitted for patients diagnosed from January to December 2019</p>
<b>Heart</b>			
3	Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	<p>Data submission for Apr 2019 – Mar 2020</p> <p>STEMI cases 815/815 (100%) STEMI cases submitted to NICOR</p> <p>nSTEMI / ACS 1568/1568 (100%) nSTEMI cases submitted to NICOR</p> <p>42/42 (100%) Takotsubo cases submitted</p>
4	Cardiac Rhythm Management (CRM)	Yes	<p>1716/1716 (100%) cases submitted for pacing and implantable cardiac defibrillators for period</p> <p>1354/1354 (100%) EPS cases have been submitted for the reporting period</p>
5	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	Yes	<p>FY 201920</p> <p>Q1-Q4 200/200 (100%) cases submitted for catheter or surgical procedures.</p> <p>Q1-Q4 106/106 (100%) cases submitted for ICD &amp; Pacing procedures</p> <p>Q1-Q4 15/15 (100%) cases submitted for Other procedures</p>

6	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	<p>Data submission April 2019 – Mar 2020 Total 2240 interventions</p> <p>1923/1923 (100%) PCI + 317/317 (100%) Coronary pressure studies + Other</p>
7	National Adult Cardiac Surgery Audit	Yes	<p>Adult cardiac surgery data submissions are undertaken every 12 weeks as required by NICOR.</p> <p>FY 19/20 total 1794 cases Q1 x 429 Cases Submitted (100%) Q2 x 457 Cases Submitted (100%) Q3 x 446 Cases Submitted (100%) Q4 x 462 Cases Submitted (100%)</p>
8	National Cardiac Arrest Audit (NCAA)	Yes	<p>April 2019– March 2020</p> <p>Q1 x 40/40 Cases Submitted (100%) Q2 x 38/38 Cases Submitted (100%) Q3 x 34/34 Cases Submitted (100%) Q4 x 31/31 Cases Submitted (100%)</p> <p>Final submission is due by 30/06/2019.</p>
9	National Heart Failure Audit	Yes	<p>Q1 to Q3: 2019/20 41/41 (100%) cases submitted</p> <p>Q4 17 draft cases submitted</p> <p>Q4 is due by 30/06/2020.</p>
Long term conditions			

10	Sentinel Stroke National Audit programme (SSNAP) - Post-acute provider organisational audit	Yes	<p>Knowsley service provider 2019-20</p> <p>Data provided from 1st April 2019 to 29th Feb 2020</p> <p>Early Supported Discharge: 58 of 90 (64%) of patients referred for ESD have been eligible to enter onto SSNAP by acute providers. Some of these patients have completed rehabilitation and some are still on-going with the team. Data is entered when patients are discharged from service (not when transferred to CSR)</p> <p>Data for 37 ESD patients has been entered by the team onto SSNAP during this time period (4 of these records for patients referred in 2018-19). 30 of these patients have transferred from ESD to CSR on SSNAP.</p> <p>Community Stroke Rehabilitation: 49 of 72 (68%) of patients referred directly for CSR (not including transferred from ESD) have been eligible to enter onto SSNAP (by acute providers or transferred from ESD) Some of these have completed rehabilitation and some are still on-going with the team. Data for 77 CRT patients have been submitted during this time period (8 of these records for patients referred in 2017/18).</p>
11	National Smoking Cessation Audit 2019	Yes	<p>Data Collection July - August 2019</p> <p>93/93 (100%) submitted cases as per the audit criteria</p>
12	National Audit of Cardiac rehabilitation (Sarah Ashworth / Sharon Faulkner) Kelly -email sent	Yes	<p>Phase 1 cardiac rehabilitation (CR) locally, is provided by Liverpool Heart and Chest Hospital team (0%) submitted Trust - working on electronic upload from EPR. Referrals from LHCH 1/4/19 to 31/3/20 is</p> <p>Phase 2 The Knowsley community Cardiovascular service for cardiac rehabilitation Referral for Knowsley CR 1/4/19 to 31/3/20 is xxx with xxx accepting for full completion of 100%</p>

13	National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)  - Pulmonary rehabilitation organisational and clinical audit	Yes	The Trust registered 2 services: Liverpool and Knowsley. <b>Liverpool service</b> (128/128) 100% Patient assessed and consented after 1 March 2019 and 31 August 2019  (224/224) 100% Patient assessed and consented after 1 September 2019 and 29 February 2020  <b>Knowsley service</b> (90/110) 82% Patient assessed (110) and consented (90) after 1 March 2019 and 31 August 2019  (48/67) 72% Patient assessed (67) and consented (48) after 1 September 2019 and 29 February 2020
14	National Audit of Care at the End of Life (NACEL)	Yes	12/12 (100%) submitted cases as per the audit criteria.
15	UK Cystic Fibrosis Registry	Yes	341/341 (100%) submitted for calendar year 01/01/2019 -31/12/2019 as per the UK CF Registry.
16	Mandatory Surveillance of HCAI (Nicky)	Yes	x/y (%) submitted to Public Health England
17	National Comparative Audit of Blood Transfusion programme - 2019 Re-audit of the Medical Use of Blood	Yes	Data collection 1st October to 31st December 2019 7/7 (100%) submitted cases as per the audit criteria.
18	Surgical Site Infection Surveillance Service	No	The Trust is eligible to participate in the surveillance service, on a voluntary, not mandatory basis. However the Trust does not participate.
19	Serious Hazards of Transfusion (SHOT)	Yes	The Trust participates with SHOT by reporting transfusion incidents and completing their investigation process. No incidents during 2019/20 to report. Trust completed the SHOT Strategy Survey in January 2020
20	NaDIA-Harms - reporting on diabetic inpatient harms in England	Yes	The National Diabetes Inpatient Audit - Harms (NaDIA-Harms) is a continuous collection of four diabetic harms which can occur during an inpatient stay. The Trust registered to participate in this from February 2020. No Harms reported since participation.

21	Perioperative Quality Improvement Programme (PQIP)	No	LHCH did not enrol to this project. Two reasons: First, we can only include our thoracic patients and most data will be duplication from the thoracic audit data we already collect. Second, the number of patients enrolled will be limited as many of them are already part of other trials.
<b>Medical and Surgical Clinical Outcome Review Programme: National Confidential Enquiry into Patient Outcome and Death</b>			
22	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Dysphagia in Parkinson's Disease	Yes	As per NCEPOD criteria  2/2 (100%) Clinical Questionnaires submitted 1/1 (100%) Organisational Questionnaire submitted This study is still open
23	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - In-hospital management of out-of-hospital cardiac arrest	Yes	As per NCEPOD criteria  1/1 (100%) Organisational Questionnaire submitted Clinical questionnaires not yet requested. This study is still open
<b>Total = 23</b>		<b>Yes = 21</b>	

The reports of 17 national clinical audits were reviewed by the provider in 2019/20 and Liverpool Heart and Chest Hospital intends to take the following actions to improve the quality of healthcare provided.

## **Cancer - National Lung Cancer Audit**

### **National Lung Cancer Audit: annual report 2018 (for the 2017 audit period) published May 2019**

The Clinical lead has reviewed the report and completed a self-assessment.

- We intend to carry out audits to look at nurse staffing levels.
- Secondary care data continues to be polluted with tertiary care patients at LHCH such that and we have allocated resource and contacted the national upload team in attempt to rectify this.
- Otherwise, The Liverpool Lung Cancer Unit continues to process a large number of patients and has good resection and survival rates.

### **Lung cancer clinical outcomes publication 2019 (for the 2017 audit period) published January 2020.**

This audit report forms the sixth lung cancer clinical outcomes publication (LCCOP). This is the sixth report on the activity of surgical teams and their contribution to lung cancer care. The data relate to patients diagnosed with lung cancer (excluding small-cell lung cancer (SCLC)) who underwent surgery between 1 January and 31 December 2017.

- The number of operations performed by individual surgeons has risen to a median of 50. Unit activity has risen to a median of 235 cases/year. LHCH thoracic surgeons perform a mean of 85 lung resections per year and its activity is 420 cases/year. All LHCH surgeons rank in the highest quartile for number of cases performed. This is in keeping with a trend towards surgery being performed by more experienced surgeons in larger surgical units than previously.
- The majority of lung cancer surgery is performed using minimal access approaches, mostly video-assisted thoracic surgery (VATS) (55%). LHCH performs over 70% of its cases using minimally invasive techniques.

30 day and 1 year survival was as expected.

LHCH is in the top quartile for resection rates and is the only unit in the North West to achieve this.

Length of stay is 6 days which is the median stay nationally however LHCH is one of the few units which did not have a Day of surgery admission process at the time which extends the length of stay by one day. Adoption of DOSA process will result in an immediate improvement.

LHCH has the lowest 90-day readmission after lung cancer resection nationally

## **Heart - National Cardiac Audit Programme (NCAP) Annual Report (Published September 2019)**

### **Adult Percutaneous Coronary Interventions (Angioplasty audit BCIS) and Myocardial Ischaemia National Audit Project (MINAP)**

LHCH remains a high volume centre for PCI/PPCI. All operators fulfil minimal requirements for PCI numbers with outcome data that is in line or better than the norm. The Trust is one of the highest users of day case PCI in the country. This includes stable ACS patients.

Our radial PCI rate is over 90%. We have an established research programme specifically aimed at continued improvement in the safety of the radial approach.

The Trust has a 24/7 PPCI service for all regional partner hospitals with long established protocols. There is an established referral pathway to a single phone number at switchboard with a dedicated PPCI entrance directly into Cath lab recovery area.

DTB times are slightly shorter than the national mean.

#### **Gaps - PPCI**

As per national figures, CTB times for direct and inter-hospital transfers continue to lengthen. Our own internal audit processes clearly indicate that the overwhelming majority of the delay is due to delayed attendance by the ambulance service. Inevitably this delay has lengthened with the National policy downgrading of PPCI calls to Category 2.

#### **Gaps - NSTEMI**

Transfer times for ACS patients do not meet national guidelines. The reasons are multifactorial. Electronic referrals are used and assessed three times a day at LHCH. However, they are often sent a significant time after admission or after the decision to refer due to a general lack of consultant leadership/clear ACS pathway at partner hospitals. Patient transfers are hampered by the lack of ambulances. Our dedicated multi-occupancy vehicle is now used for patient transfers in other disciplines which is out of our control.

Continued efforts are being made at regional level to standardise and streamline the ACS service to reduce time to angiography duration. This includes the ability to refer at an early stage higher risk NSTEMI directly or via consultant discussion. Unfortunately this service is not taken up in the region as often as needed.

### **National Cardiac Audit Programme (NCAP) Report**

#### **National Heart Failure Audit**

- Established interventional and heart failure (HF) teams on-call 24/7
- All patients are referred to their local cardiac rehab service post-discharge
- All HF patients are reviewed by the HF team and community HF review organised

### **National Cardiac Audit Programme (NCAP) Report**

#### **National Audit of Cardiac Rhythm Management (Published July 2019)**

The Clinical lead has benchmarked against national and regional tertiary centres. Whilst our data is of very high quality many centres do not and this has to be borne in mind when interpreting comparative results.

The Trust is the largest complex device implanting centre (ICDs and CRTS) in the country and one of the largest pacemaker implanting centres. We are fully compliant with BHRS standards for the number of procedures performed as a centre and as individual consultants.

Our complication rate for complex devices is one of the lowest in the country and is in fact lower than our pacemaker complication rate. This reflects the fact that most complex devices are implanted by consultants rather than trainees and that a high percentage of our pacemaker implants are acute admissions or post TAVI or cardiac surgery. The complication rate may rise in the future as we take on more CHD work.

The Trust is one of the largest EP centres in the UK. We have a higher than average percentage of complex atrial ablation and scar-related VT. We are fully compliant with BHRS standards for the number of procedures performed as a group and as individual consultants.

### **National Congenital Heart Disease**

#### **30-day survival after 83 specific procedures**

- Survival at 30 days was analysed for 83 major surgical, transcatheter cardiovascular and electrophysiological interventions undertaken to treat congenital heart disease at any age (children and adults analysed separately), excluding minor and non-cardiovascular procedures
- This year, NICOR are unable to publish specific procedure activity numbers or 30-day outcomes as performed by individual centres with funnel plots, for data protection reasons so as to ensure anonymity of patient data where case numbers are less than three.

#### **30-day aggregate survival after surgery in adults**

- For the first time the Congenital Audit has used a risk model to assess outcomes in adults (aged 16 years and older) born with congenital heart disease, namely an adult congenital heart surgery mortality score derived from the Society of Thoracic Surgeons–European Association for Cardio-thoracic Surgery (STAT) mortality score used in North America and Europe.
- All centres performed 'as predicted' with no negative or positive outliers.



The NCHDA standard for data quality is 90% accuracy across all domains.

- Liverpool Heart and Chest Hospital commenced as a full Level 1 service and will receive a DQI validation site visit in 2019. Prior to this remote validation of data quality was undertaken.

In 2020, as the ACHD Database manager, we provide a report with a monthly breakdown of surgery and intervention in relation to the morbidity and mortality, which will be presented at our monthly Clinical Governance session.

### **National Cardiac Arrest Audit (NCAA) Published from 1/4/2019 to 31/3/2020**

The NCAA Report covering April 2019 to March 2020 specifically by risk adjusted comparative analyses compared the LHCH with four other cardiothoracic hospitals in this audit period. The whole report in its entirety was presented to the Resuscitation Committee for its findings to be reviewed.

For the fifth year running compared with all other hospitals (at least 75% of all acute hospitals in this country now participate in this audit), the LHCH is performing better than the national average in both patient survival to hospital discharge by shockable and non-shockable presenting / first documented rhythm.

Going forwards for the next NCAA annual report:

- Each NCAA quarterly report is closely analysed by the Resuscitation Committee and the annual NCAA report will be presented to the Resuscitation and Quality Patient / Family Experience Committees with an accompanying presentation of the salient points. This will include a detailed investigation of all suggested unexpected non-survivors, so that any areas of concern can be highlighted and measures for improvement initiated.
- Currently the survival to discharge rate is 48.1%
- This is based on 116 cardiac arrests per 13,436 admissions for this period.

### **Case Mix Programme (CMP) Adult critical care (ICNARC) Annual Quality Report 2018/19 for adult critical care (Published December 2019)**

Following the publication of the 2018-19 report which showed an increased number of readmissions within 48 hours of unit discharge, each readmission since the start of the last financial year has been reviewed to see if there are any learning points and to see if the readmission could have been avoided. A Multi-Disciplinary Team Readmission has been set up.

The reviews are undertaken by the multi-disciplinary team who provide feedback to the Critical Care Delivery Group. Collaborative working with the surgical division is planned to recommence post Pandemic to focus on any further improvements that could potentially be made within the ward area in order to prevent patient readmission.

### **National Comparative Audit of Blood Transfusion programme 2018 National Comparative Audit of the Management of Major Haemorrhage**

This is a national audit of major Haemorrhage and trauma. LHCH are not one of the major trauma centres. We do not have an A&E.

The sample in this audit for LHCH was small with only 4 cases included.

At LHCH, major haemorrhage when it does occur is anticipated. LHCH current process is to contact the laboratories who will facilitate all requests.

LHCH do not use the regional Major Haemorrhage Protocol with regards to massive haemorrhage packs.

### **Sentinel Stroke (SSNAP)**

A Sentinel stroke (SSNAP) Annual CCG Stroke Dashboard – Knowsley CCG is published each year. There are quarterly team reports available on the SSNAP website.

Actions:

- Number of Early Supported Discharge (ESD) patients in Knowsley has increased each year. Plan to continue to offer ESD input to all patients who are appropriate and to continue to input audit data for Sentinel stroke audit (SSNAP).
- Team are using electronic records - EMIS system. Plan in future to collect data for SSNAP directly from EMIS – still ongoing plan
- Team has two members of staff returning from leave during 2020 and 1 vacant post for rehab assistant with another assistant on long term sickness.

### **UK Cystic Fibrosis Registry Annual Report 2018 (Published August 2019)**

There has been no change in our performance compared to last year and the national picture. In the main measures of CF clinic performance (lung function and nutrition) the Trust is above the national average and frequently in the top centile, suggesting that the care offered is very good. The Trust has less than average use of mucolytic therapies (rhDnase and hypertonic saline), but these parameters are not evidence-based and are historical – given that LHCH patients are doing well, the Trust has no plans to increase the use of these therapies.

The Trust's chronic *Pseudomonas aeruginosa* infection level is higher than the national average, but such cases are nearly all inherited from the paediatric sector (who seem to have very high levels compared to other paediatric units) and what really matters are new infections (this would be a better measure) – the Trust has very few of these.

In summary this audit did not highlight any gaps in the LHCH service that need to be corrected. The Trust performs well and has a good national reputation.

### **National Audit of Care at the end of life (NACEL) (Published July 2019)**

The report findings demonstrate that the Trust is performing higher than National in 6 out of 9 key areas and similar in 2 areas. For one area it was not appropriate for the Trust to submit a Quality Survey as we utilise the Care of Dying Evaluation (CODE) bereavement questionnaire routinely throughout the year.

On review of the report, we can see that current trust service end of life improvement work streams align with the recommendations within this report.

We are working collaboratively with end of life services across the Liverpool and South Sefton in re-designing and improving services for all patients across Liverpool. .

Going forwards improvement work involves:

- Plans to develop ITU specific EOL documentation and flow sheets
- Development of AMBER for ITU working with the National team
- Continue to review and develop EOL training across all disciplines, with the focus on identifying the training needs for our senior medical staff.
- Continue to monitor our standards of care provision through the dashboard and local audit activity.

## **National Audit of Cardiac Rehabilitation Quality and Outcomes Report 2019 (Published December 2019)**

### **Phase 1**

Phase 1 cardiac rehab locally, is provided by Liverpool heart and chest Hospital team. The activity collected by this team is not routinely reported to NACR electronically, the hard copy format is as per usual practice annually; there is bulk upload of patient data and plans for future increase of quality information to be uploaded by the statistical team. Therefore this report at present is more for information regarding local services, and to highlight gaps for future intervention.

Liverpool Heart and Chest Hospital phase 1 cardiac rehab team is the biggest referring service in Cheshire and Merseyside, and is therefore essential that they are on board with information upload to a national level.

At phase 1 contact, the Trust Cardiac rehabilitation team are delivering more face to face contacts, mainly focusing on recruiting females to attend cardiac rehabilitation. The service has also implemented a new enhanced referral system pulling through more data and clinical information for providers, the feedback we have received about this is really positive.

### **Phase 2**

The Knowsley Community Cardiovascular rehabilitation services submit full patient data to the National audit of Cardiac rehabilitation (NACR), and in February 2020 we were delighted we had met all 7 minimum standards to be listed as a certified programme. This was published in the Quality and Outcomes Report 2019.

Knowsley commissioning services demand a high level of reporting data and these are monitored monthly through Key performance indicators (KPI) and within the last year we have met all the KPI with 100% compliance.

## **National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Pulmonary Embolism (Published Oct 2019)**

The Clinical lead for medicine intervention has reviewed the report recommendations. Further cross divisional discussion is in progress

## **National Smoking Cessation Audit 2019(Published Dec 2019)**

LHCH compares overall much better than national data.

We are constantly reviewing our processes at the Trust to ensure that we are meeting any national/local guidance and that our pathways and processes are effective and have positive impacts on patients/staff health

We are also working with our partners to ensure that we receive feedback outcomes on our referrals –there are plans within Public Health Liverpool for this to be implemented as part of Making Every Contact Count (MECC) locally to enable evaluation and effectiveness of the process in place.

### **Mandatory Surveillance of HCAI 2019/2020**

Information on all patients colonised, or infected with, specific “alert” organisms is collected and data is generated monthly and used by the Infection Prevention Committee to monitor performance and trends with regard to HCAIs.

Data is also collected on patients with certain bloodstream infections (bacteraemias) and reported to a healthcare associated infection (HCAI) national system.

## Participation in local clinical audits

The reports of 19 local clinical audits were reviewed by the provider in 2019/20 and Liverpool Heart and Chest Hospital intends to take the following actions to improve the quality of healthcare provided:

### Pharmacy audit programme

Audit	Improvement work
<b>Formulary Audit – Dual Antiplatelet &amp; PPI Audit</b>	<p>This audit looked at medical and surgical patients receiving dual antiplatelet therapy.</p> <p>The following points were noted:</p> <ul style="list-style-type: none"> <li>• 10% of medical patients were not co-prescribed PPI cover. This will be shared with the pharmacists and reviewed.</li> <li>• The cardiac order set should be changed to ongoing as it currently states 28 days. Danny will liaise with EPR to change the order set.</li> <li>• A decision should be made as to which antiplatelet patients should be kept on for a year and ensure this is clear as this is not always documented. The GP should also be informed how long the patient will be on the antiplatelet for.</li> </ul>
<b>Antibiotic Prescribing Audit</b>	<p>The audit shows improvement from the previous quarter as compliance with formulary has risen to 95%, exceeding the target of 90%.</p> <ul style="list-style-type: none"> <li>• It was agreed this should be highlighted at all Divisional meetings.</li> <li>• Action: to check the Prophylaxis Policy, it states to give cefuroxime if a patient's history is anything other than a severe reaction – the policy amended to state "significant allergy".</li> </ul>
<b>Epidural Audit</b>	<p>The following points were noted:</p> <ul style="list-style-type: none"> <li>• Policies and procedures are all compliant.</li> <li>• The audit was carried out for two patients and there were no issues.</li> <li>• There have been no incidents in the preceding year connected with epidurals.</li> <li>• Education and training has improved however Critical Care are still below target.</li> <li>• Low numbers of epidurals are being given in the Trust and audit raised the question whether arrangements are in place regarding competency of staff administering them as it is inadequate. It was agreed and this was added to the anaesthetic risk register.</li> </ul>
<b>Anticoagulation Audit</b>	<ul style="list-style-type: none"> <li>• Audit resulted in the change of warfarin administration time from 6pm to 2pm with effect from 1<sup>st</sup> Oct 2019.</li> <li>• Discussion highlighted the potential for delayed dosing due to the surgical ward rounds.</li> </ul>
<b>Enteral Medicines</b>	Recommendation: Medication should be given 30 minutes prior to

<b>Administration Audit</b>	<p>breakfast or 2 hours after breakfast</p> <ul style="list-style-type: none"> <li>Added to the Safety Bulletin to inform staff</li> </ul> <p>Action: To investigate further when to administer lansoprazole</p> <ul style="list-style-type: none"> <li>Reference checked and repeated doses of lansoprazole are not affected by food.</li> </ul>
<b>NPSA Injectable Audit</b>	<p>The following points were noted:</p> <ul style="list-style-type: none"> <li>Compliant for most areas around policy and procedures.</li> <li>Only partially compliant around staff competencies as unable to obtain a percentage figure for education. The group were happy that although figures are not available, they are assured that the level of competency is acceptable due to training on induction and also the medicines management package which is available on OLM.</li> <li>This audit is still required to be completed as it may be requested as part of the Aseptic Quality Audit.</li> </ul>
<b>PGD Audit</b>	<p>The audit is completed every 2 years</p> <ul style="list-style-type: none"> <li>All core PGDs have now been removed as they are now able to be administered via the Discretionary Medicines Policy.</li> <li>415 PGD doses were administered via EPR however there is still an issue around documentation for people being signed as competent.</li> <li>In relation to the Influenza Vaccine PGD, competency assessment forms have been completed however in terms of recording doses administered this information is entered onto the Team Prevent list therefore this data has now been lost. This requires improvement and evidence is required for who has given the PGD.</li> <li>Outpatients PGDs are largely for PCI patients however there was good compliance shown around supply and competency forms.</li> <li>In relation to the use of PGDs within the Knowsley Community, the results were good. 256 PGD supply forms were reviewed for Knowsley and 431 individual drugs issued.</li> <li>There are many actions on the audit action plan and these are largely around ensuring competency assessment forms are completed and recorded.</li> <li>One action is to review radiographer administration of medications without a PGD. Clarity is required around this and the Chief pharmacist would meet with radiology and the PGD pharmacist to establish how this can be improved.</li> <li>There is also an action to re-establish a PGD working group to include PGD specialist pharmacist), Education pharmacist, Divisional Head of Nursing and Quality and a D&amp;T clinical lead.</li> </ul>

<b>Clinical Intervention Audit</b>	<p>This is a quarterly audit for October to December and 144 interventions were made by a pharmacist.</p> <p>The following points were noted:</p> <ul style="list-style-type: none"> <li>• Interventions were actioned within 24 hours in total</li> <li>• Of the interventions made on the ward round, 96% of these were actioned within 24 hours.</li> <li>• 20% were actioned by pharmacists themselves via NMP or pharmacists amendment policy. This shows that pharmacists are able to address interventions themselves ASAP. These results should improve once more pharmacists are qualified as NMPs.</li> <li>• There were no major errors recorded for this quarter.</li> <li>• The author of the audit, contacts each prescriber who has made an error to inform them of it and will add prescriber errors in as appendix to the next quarterly audit in order to view any trends.</li> </ul>
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<b>Audit</b>	<b>Improvement work</b>
<b>Fasting audit compliance - Medicine</b>	<ul style="list-style-type: none"> <li>• Development of a Quality Improvement project with specific focus on Medicine Division fasting compliance to achieve proposed target.</li> <li>• Agree process for sharing cath lab data from Care Cube with audit team to ensure comprehensive data analysis.</li> <li>• Ensure fasting oversight from ward managers/ team leaders to consider that if patients have chosen not to eat or drink against guidance, this should then be encouraged on admission (as in Holly Suite).</li> <li>• Future capture of patients with rescheduled/ cancelled procedures due to inappropriate fasting, working with theatre team colleagues and with support from the Trust audit team.</li> <li>• Further review and approval of the fasting policy to include compliance targets.</li> <li>• Reinstate weekly review of fasting data addressing any issues as they arise and liaising with ward managers in 'real time'.</li> <li>• Strengthen recently commenced monthly reporting through Divisional Governance meetings.</li> <li>• Consider production of education and patient guidance for appropriate fasting.</li> </ul>
<b>Fasting audit compliance – Surgery</b>	<ul style="list-style-type: none"> <li>• Reinstate weekly review and actions of the fasting data.</li> <li>• Continue to reduce the impact of Day of Surgery Admission on fasting compliance by including follow up fasting advice on the day before telephone call to patients.</li> <li>• Further review and approval of the fasting policy to include compliance targets</li> <li>• This review should also be part of the Nutritional steering group and its on-going work plan.</li> </ul>

	<ul style="list-style-type: none"> <li>• Commence enhanced recovery project for surgery in line with Quality Priorities.</li> <li>• In conjunction with Diabetes Steering group actions review listing priorities of patients with diabetes.</li> </ul>
<b>NatSIPs and LocSSIPs</b>	<ul style="list-style-type: none"> <li>• Current audits demonstrate good compliance with LocSSIPs within the Cath labs and theatre departments. The clearly defined assurance framework with its recognised reporting committee's has now been populated with audit compliance, both quantitate and qualitative data</li> <li>• Priority to be given to the ward based LocSSIPs and audit process</li> <li>• LocSSIPs for radiology procedures to be developed by the Clinical Services Division</li> </ul>
<b>Evaluation of the ICD patient information day -survey</b>	<p>Review of services aimed to improve patient understanding of devices and to develop self-management strategies to improve physical, emotional &amp; psychological health.</p> <p>13 sessions so far with 129 patients evaluated. Overwhelmingly positive feedback. Future plans:</p> <ul style="list-style-type: none"> <li>• Wider team involvement- ACHD &amp; ICC</li> <li>• Psychologist involvement</li> <li>• Consider timing of event with respect to implant</li> </ul>
<b>Initial experience with Paxman cooling device - audit summary</b>	<p>PAXMAN cooling technology was a new innovation for the trust and this is not used nationally under current guidance, this is used for chemotherapy patients.</p> <p>Since introduction we have no adverse outcomes for patients and high satisfaction from consultant staff. This will be published later once further data captured.</p>



## Transfusion service

Audit	Improvement work
<b>Re-audits of the local Transfusion Policy</b>	<p>These audits are carried out on a yearly basis or more frequently if necessary and are reported via the;</p> <ul style="list-style-type: none"> <li>• Transfusion Link nurse</li> <li>• Hospital Transfusion Team</li> <li>• Hospital Transfusion Committee</li> <li>• Ward managers</li> </ul> <p><b>Re-audit of the completion of the Special Requirements on the Transfusion Request Forms.</b></p> <p>The new transfusion request form was introduced to the Trust in August 2019. Staff feedback actioned on font size.</p>
<b>Audit – Blood use in Cardiac Surgery</b>	<p>Our RBC transfusion rate in isolated CABG procedures for 2019 was 35.0% achieving the target of &lt;40%. There have been no significant increases in transfusion rate during the recorded time period.</p>

## Pain Service

Audit	Improvement work
<b>Acute Pain Service Audit and monitoring</b>	<p>Improvements planned for 2020:</p> <ul style="list-style-type: none"> <li>• Completion of post discharge analgesia audit</li> <li>• Service innovation to introduce telephone follow up service</li> <li>• Improved and responsible TTO analgesia</li> <li>• Band 6 pain nurse to commence clinical diagnostics and examination module.</li> <li>• Improved education around scoring pain</li> </ul>
<b>Pain satisfaction survey</b>	<p>Data is based on 73 responses from across the surgical directorate over a period of two months.</p> <p>Over 98% of patients were either satisfied or very satisfied with the pain control that they received.</p> <p>Areas that have improved since the last patient satisfaction audit in 2018</p> <ul style="list-style-type: none"> <li>• 100% of patients believed that staff did everything that they could to control pain compared with 94% in 2018 and 84% in 2015.</li> <li>• 67% of patients received written information about pain prior to surgery compared with 53% in 2018. Number expected to rise further follow this year's revision of written information for thoracic patients</li> </ul> <p>Areas for improvement</p>

	<ul style="list-style-type: none"> <li>Length of time to receive analgesia within 15 minutes was 85% in 2018 compared with 65% in 2019</li> <li>56% of patients had chronic pain before their procedure compared with 48% in 2018</li> </ul> <p>As chronic pain is rising in the UK, the acute pain team will endeavour to meet their needs by attending extra educational sessions and maintaining close links with chronic pain services.</p>
<b>Outcomes following addition of pain team member to thoracic multi-disciplinary team morning ward round</b>	<ul style="list-style-type: none"> <li>Pain team presence on our thoracic MDT ward round was well received with positive staff and patient feedback.</li> <li>Whilst multi-factorial, we observed a statistical significant decrease in strong opiate usage on discharge and a more coordinated strategy to post-operative analgesia.</li> <li>This has prompted further study into these outcomes.</li> </ul>
<b>Audit of Acute pain management after cardiac surgery</b>	<p>The audit demonstrated some recommendations for improvement.</p> <ul style="list-style-type: none"> <li>This was developed into an action plan to include a new Pain management protocol that was implemented Nov 2019. This new protocol is currently under audit.</li> </ul>

## Participation in clinical research

Research is an integral component of the Trust's core activities. It provides the opportunity to generate new knowledge and test new treatments or models of care to improve service quality across the board. The Trust's engagement with clinical research demonstrates its commitment to testing and offering the latest medical treatments and techniques.

It is well documented that trusts that are more research active have been shown to benefit from the 'research effect': they provide a better care experience, deliver improved outcomes for patients, and find it easier to recruit and retain staff (RCP, 2019). They also benefit from the competitive advantage gained through improved knowledge management and in particular, the ability to use and generate research knowledge (NHS Confederation, 2010).

As a specialist provider, LHCH is able to undertake the more complex clinical research trials, drawing from a much smaller group of patients compared to secondary care providers when offering participation in trials to our patients.

The total number of participants from 1<sup>st</sup> April 2019 – 31<sup>st</sup> March 2020 that were recruited to participate in NIHR clinical research was 821 this was to 41 NIHR portfolio studies, with a split of 47 participants to commercial research and 773 to non- commercial studies. The overall number of participants to all research studies was 853.

During 2019/20 Liverpool Heart and Chest Hospital was actively involved in 41 NIHR portfolio clinical research studies across the cardiovascular and respiratory specialties as summarised in table below.

Specialty	Numbers
Anaesthesia, Perioperative medicine & pain management	1
Cardiovascular disease	21
Critical care	1
Infection	1
Lung cancer	5 (+1 non NIHR)
Respiratory disorders	10
Surgery	2
<b>Total</b>	<b>41</b>

Liverpool Heart & Chest Hospital is part of wider regional infrastructure for the region and has many collaborators and partnerships to facilitate it achieving its research and innovation strategy.

### Applied Research Collaboration North West Coast (ARC NWC)

ARC NWC builds upon the applied research strengths of the existing Collaborations for Leadership in Applied Health Research and Care (CLAHRC) collaboration in the North West region. ARC NWC consists of health and social care providers, NHS commissioners, local authorities, universities, public advisers, the Innovation Agency (Academic Health Science Network), working together to learn more about these health inequalities, and overcome the

barriers around translating these discoveries in health research into practice which improves lives. The partnership has jointly chosen three research themes reflecting local needs. These are: 'Person-Centred Complex Care', 'Improving Population Health' and 'Equitable Place-based Health and Care'.

ARC NWC's cross-cutting themes will provide expertise and guidance to support research theme activity: 'Care and Health Informatics', 'Methodological Innovation Development Adaptation and Support' and 'Health and Care across the Life-course'

LHCH is a partner organisation of ARC NWC continuing the relationship formed when it was CLAHRC NWC.

### **Liverpool Centre for Cardiovascular Science (LCCS)**

To address the regional heart related health needs the Liverpool Centre for Cardiovascular Science (LCCS) has been formed as a strategic research collaboration with LHCH, Liverpool John Moores University, Liverpool Health Partners and the University of Liverpool. LCCS is led by Professor Gregory Lip and is a virtual integrated academic NHS centre for the advancement of cardiovascular and stroke research

### **Liverpool Health Partners (LHP)**

LHCH is a member of Liverpool Health Partners, who it also hosts. LHP is an academic health science system formed of all the Liverpool NHS Trusts and 4 HEIs. The partnership facilitates collaboration and a system wide approach for the purpose of generating new knowledge that can be used to improve health and wealth for everybody.

LHCH also contributes to LHP's Single Point of Access to Research and Knowledge (**SPARK**); a unique collaboration delivering high quality research governance, costing, contracting and on- boarding of clinical trials and research projects.

### **NIHR Clinical Research Network North West Coast (CRN NWC)**

LHCH is a member of the local North West Coast National Institute for Health Research (NIHR) Clinical Research Network, a network that is comprised of 41 NHS partners. The network provides funding and support for research staff and clinicians at the Trust. The Trust contributes to targets and high level objectives set by the NIHR/DHSC, which inform the level of funding given to the NWC region to support access and involvement of our population to clinical research studies.

The following are some examples of the high quality research taking place at the Trust:

### **Cryoballoon Pulmonary Vein Isolation as First Line Treatment for Typical Atrial Flutter (CRAFT)**

People with atrial flutter are at increased risk of heart problems such as a heart attack. This is a study to assess which of two different options of treatment, targeting different tissues in the heart, results in better results.

One of the two treatments being investigated is the current accepted ('conventional') treatment, while the other is a treatment that has become accepted for another type of abnormal rhythm called atrial fibrillation. There are initial suggestions the second ('novel') type

of treatment may be better than the current accepted treatment, but it is not known if this will be the case. Therefore, this study will compare patients treated by the two different techniques, to assess which will lead to better control of this type of abnormal heart rhythm.

### **SMArTVIEW TRIAL - technology enabled remote monitoring and self-management: vision for patient empowerment following cardiac and vascular surgery**

Despite its numerous benefits and the resultant improvement in the quality of life, many patients, have certain complications after surgery such as undetected problems with blood circulation, surgical site infection, chronic pain and trouble adapting to everyday life after surgery. However if identified early, many of these complications can be treated before they impact a patient's health. Nurses on the ward routinely check vital signs such as: blood pressure, heart rate, temperature and surgical wound recovery to identify early signs of complications.

The Trust has entered into an exciting new research collaboration with McMaster University in Canada to deliver a new postoperative trial called SMarTVIEW for remote monitoring of vital signs for cardiac surgery patients at home after hospital discharge. This will be the first study of its kind and has the ability to radically transform care.

The purpose of this study is to establish whether the introduction of a remote automated monitoring system for vital signs within the hospital and at home improves recovery and wellbeing of patients recovering from cardiac or vascular surgery.

### **Cystic Fibrosis studies**

The Trust's collaboration with Vertex in the delivery of high quality clinical research for patients with Cystic Fibrosis (CF) continues. All eligible CF patients are invited to participate in several trials testing a number of new medicines. The Trust also achieved a first global patient to an Abbvie CF commercial study.

### **The SURE public and patients research advisory group**

The Service Users Research Endeavour (SURE) Group is an established public patient group that supports the research process within the Trust. The group is tasked with reviewing Consent Forms and Patient Information Sheets for clinical research studies conducted at the Trust. Feedback is then given to the Sponsor of the trial and suggestions provided to enhance the patient's understanding and experience of the trial.

## Innovation at LHCH

Liverpool Heart and Chest Hospital is developing a culture of innovation for improving the quality of care and patient experience which has led to a solid portfolio of innovation activity. The trust works closely with the Innovation Agency which is the Academic Health Science Network (AHSN) for the North West Coast. The Innovation Agency connects all partners across sectors: NHS and academia, local authorities, the third sector, industry and citizens. They support this trust by working collaboratively, identifying and supporting the successful development of innovations.

At the North West Coast Research and Innovation Awards 2020, held in February, Julie Tyrer and her team were shortlisted for a Patient Safety Innovation award.

Examples of ongoing innovations at the Trust in 2019/20 are summarised below:

Innovation	Description	Status
Minimise Moisture	Patient safety campaign to improve patient outcomes by reducing the incidence of moisture-associated skin damage	Promoted throughout the organisation
'Slippy' pillow	Pillow cover to reduce friction and heel ulcers in patients	Prototype development
RITMOCORE	Innovative procurement system for pacemakers and online monitoring systems	EU grant awarded and project is at the procurement bid stage.

During 2019/20 Liverpool Heart and Chest Hospital provided and/or sub-contracted the following 15 health services in cardiology, cardiac surgery, thoracic surgery, cystic fibrosis, respiratory medicine, critical care, adult congenital heart disease, cardio-respiratory and radiology diagnostics, physiotherapy, dietetics, speech and language therapy, psychology, palliative care and pathology.

Liverpool Heart and Chest Hospital has reviewed all the data available on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2019/20 represents 90% of the total income generated from the provision of relevant health services by Liverpool Heart and Chest Hospital for 2019/20

A proportion of Liverpool Heart and Chest Hospital's income in 2019/20, at a value of £0.8m (2018/19 £1.8m), was conditional on achieving quality improvement and innovation goals agreed between Liverpool Heart and Chest Hospital and any person or body they entered into a contract, agreement or arrangement with for the

provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Please see p35 for the number of patients receiving relevant health services provided or sub-contracted by Liverpool Heart and Chest Hospital in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee.

## Goals agreed with commissioners

In 2019/20, the Trust implemented the following CQUIN schemes as directed by the local and specialised commissioning contracts with commissioners:

### National schemes:

- Staff flu vaccinations
- Alcohol and tobacco screening
- Alcohol and tobacco – tobacco brief advice
- Alcohol and tobacco – alcohol brief advice
- Three high impact interventions to prevent falls

### Specialised Commissioning:

- Clinical Utilisation Review
- Rethinking conversations
- ACHD

Further details are available upon request from Susan Pemberton, Director of Nursing and Quality (e-mail [sue.pemberton@hch.nhs.uk](mailto:sue.pemberton@hch.nhs.uk) or telephone (0151 600 1007).

## What others say about the provider?

Liverpool Heart and Chest Hospital is required to register with the Care Quality Commission and its current registration status is 'registered without condition'.

The Care Quality Commission has not taken enforcement action against Liverpool Heart and Chest Hospital during 2019/20.

Liverpool Heart and Chest Hospital has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period 2019/20.

The Trust is rated as '**Outstanding**' by the Care Quality Commission.



## Data quality

Liverpool Heart and Chest Hospital submitted records during 2019/20 to the Secondary Uses service for inclusion in the Hospital Episode Statistics, which are reported below in the latest published data. The data quality of these submissions is monitored by NHS Digital and the statistics are made available, online, each month.

### Data Quality Maturity Index (DQMI)

This index is utilised by NHS Digital as a holistic assessment of an organisations data quality, for the year 2019/20 the Trust DQMI was **98.2**. In total 532 'data providers' are incorporated in the DQMI assessment and the Trust result was in the top 15% (n=78)

### Secondary Uses Data Quality

The statistics for the year 2019/20 are as follows:

#### (Outpatient care submission)

Data Item	Provider Total	Provider % Valid	Region % Valid	National % Valid
Attendance Indicator	100,210	100.0%	99.8%	99.6%
Attendance Outcome	69,406	100.0%	99.5%	97.0%
Commissioner	100,210	99.9%	99.9%	99.3%
Ethnic Category	100,210	100.0%	96.7%	93.9%
First Attendance	100,210	100.0%	99.8%	99.7%
HRG	100,210	100.0%	99.3%	99.2%
Main Specialty	100,210	100.0%	99.5%	99.6%
NHS Number	100,210	99.9%	99.9%	99.7%
Org of Residence	100,210	100.0%	99.9%	99.3%
Patient Pathway	97,181	100.0%	66.4%	68.2%
Postcode	100,210	100.0%	99.9%	99.9%
Primary Procedure	69,406	100.0%	100.0%	99.7%
Priority Type	100,210	100.0%	99.9%	96.3%
Referral Received Date	100,210	100.0%	99.9%	95.8%
Referral Source	100,210	99.9%	100.0%	98.9%
Registered GP Practice	100,210	99.4%	99.7%	99.6%
Site Code of Treatment	100,210	100.0%	98.2%	96.6%
Treatment Function	100,210	100.0%	100.0%	99.7%

#### (Inpatient care submission)

Data Item	Provider Total	Provider % Valid	Region % Valid	National % Valid
Commissioner	14,742	100.0%	99.8%	99.4%
Ethnic Category	14,742	100.0%	98.9%	95.9%
HRG	14,741	99.8%	97.6%	98.3%
Main Specialty	14,742	100.0%	99.9%	100.0%
NHS Number	14,742	99.8%	99.8%	99.5%
Org of Residence	14,742	100.0%	99.8%	99.6%
Patient Pathway	7,269	78.3%	65.0%	68.9%
Postcode	14,742	100.0%	99.9%	99.9%
Primary Diagnosis	14,741	99.9%	98.5%	98.6%
Primary Procedure	14,741	100.0%	100.0%	99.8%
Registered GP Practice	14,742	99.7%	99.9%	99.7%
Site Code of Treatment	14,742	100.0%	99.1%	96.3%
Treatment Function	14,742	100.0%	100.0%	99.9%

The Trust continues to maintain a very high level of data quality, across the majority of metrics the value is above the national and regional levels.

### NHS Number and General Medical Practice Code Validity

As highlighted in the above statistics, the validity of NHS number and General Practice code across Outpatient and Inpatient care settings was as follows:

	For admitted patient care	For outpatient care
Valid NHS number	99.8%	99.9%
Valid General Medical Practice Code	99.7%	99.4%

### Data Security and Protection Toolkit Assessment Report Attainment Levels\*

Liverpool Heart and Chest Hospital's Data Security and Protection Toolkit Assessment for 2018/19 was submitted with all mandatory standards met within all assertions.

The Trust received independent assurance from Mersey Internal Audit Agency obtaining a 'substantial' assurance opinion demonstrating the Trust has a good system of internal control and the controls are applied consistently.

*\*2019/20 assessment will be available in Autumn 2020.*

### Clinical Coding Error Rate

On an annual basis Liverpool Heart and Chest Hospital participates in an External Clinical Coding Audit by an approved NHS Digital Clinical Coding Auditor.

The External Clinical Coding Audit is commissioned by the Trust and is also used as evidence as part of the Data Security Protection Toolkit (DSPT).

The clinical coding accuracy scores are provided by the Terminology and Classifications Delivery Service to support the Data Security Protection Toolkit is as follows:

	Mandatory	Advisory
Primary Diagnosis	>=90%	>=95%
Secondary Diagnosis	>=80%	>=90%
Primary Procedure	>=90%	>=95%
Secondary Procedure	>=80%	>=90%

Trusts must meet or exceed the required percentages across all four areas above in order to meet mandatory or advisory levels.

The results of Clinical Coding Audit 2019/2020 for LHCH found the following level of coding accuracy:

	Audit Result
Primary Diagnosis	99.0%
Secondary Diagnosis	97.12%
Primary Procedure	98.89%
Secondary Procedure	99.42%

The audit results demonstrate that the Trust maintains a high level coding accuracy and exceeds the level required for Advisory Level set by the Terminology and Classifications Delivery Service.

## **Data Quality**

Liverpool Heart and Chest Hospital will be taking the following actions to improve data quality:

- Continuation of delivering the Trust's data quality strategy that is aimed at improving the collection, storage, analysis, reporting and validation of information. A refresh of the Trust Data Quality policy has recently been completed to align to the strategy.
- Producing data that is fit for purpose should be an integral part of an organisation's operational performance management and governance arrangements.
- Continuation of the Trust's Data Quality Group, which reports to the Audit Committee, to identify, understand and discuss potential data quality issues which need to be addressed and actioned accordingly.
- Progress the Trust Data Quality App to production, meaning tailored data quality alerting is available on users desktop – negating the need for email volume and also providing trend reporting and hotspot identification.
- Implementation of the national data out-out process.

The group is established to review and tackle issues identified through external (e.g. SUS Data Quality Dashboard, Commissioner Challenge packs, and Care Quality Commissions reports) and internal sources with a primary focus on pushing the issues through the Data Quality App. A key focus has been to understand how data quality issues arise from the perspective of system users and system owners and the course of action to address.

Through 2019/20 the PAS programme came to completion which yielded a number of outputs, including the following:

- Ensuring system patches are applied with the full engagement of all stakeholders
- Ensuring SOPs are embedded regarding system data collection and that these are adhered to.
- Review and cleanse of historic data and lists
- Improving Patient Demographics data held in PAS, specifically patient address, GP address, next of kin, ethnicity, and mobile numbers.
- Improving detail on PAS regarding Consultant Responsible.
- Improving detail on PAS regarding patient ward movements.
- Addressing inefficient processes
- Addressing the use of EPRs Problem List.

Figures You Can Trust: A Briefing on Data Quality in the NHS (Audit Commission, 2009) presents the six dimensions of data quality.

Dimension	Description
<b>Accuracy</b>	Data should be sufficiently accurate for its intended purposes, representing clearly and in sufficient detail the interaction provided at the point of activity. Data should be captured only once, although it may have multiple uses. Accuracy is most likely to be secured if data is captured as close to the point of activity as possible. Reported information that is based on accurate data provides a fair picture of performance and should enable decision making at all levels. The need for accuracy must be balanced with the importance of the uses of the data, and the costs and efforts of collection. For example, it may be appropriate to accept some degree of inaccuracy where timeliness is important. Where compromises have to be made on accuracy, the resulting limitations of the data should be clear to its users.
<b>Validity</b>	Data should be recorded and used in compliance with relevant requirements, including correct application of any rules or definitions. This will ensure consistency between periods and with similar organisations. Where proxy data is used for an absence of actual data, organisations must consider how well this data is able to satisfy the intended purpose.
<b>Reliability</b>	Data should reflect stable and consistent data collection processes across collection points and over time, whether using manual or computer based systems or a combination. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection approaches or methods.
<b>Timeliness</b>	Data should be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable time period. Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.
<b>Relevance</b>	Data captured should be relevant to the purposes for which it is used. This entails periodic review of requirements to reflect changing needs. It may be necessary to capture data at the point of activity which is relevant only for other purposes, rather than current intervention. Quality assurance and feedback processes are intended to ensure the quality of such data.
<b>Completeness</b>	Data requirements should be clearly specified based on the information needs of the organisation and data collection processes matched to those requirements. Monitoring missing, incomplete, or invalid records can provide an indication of data quality and can also point to problems in the recording of certain data items.

## Learning from deaths

**27.1** During 2019/20, 189 LHCH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 50 in the first quarter;
- 50 in the second quarter;
- 45 in the third quarter;
- 44 in the fourth quarter

**27.2** By 31/03/2020, 146 case record reviews and 39 investigations have been carried out in relation to the 189 deaths included in Note 1.

In 39 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 50 in the first quarter;
- 50 in the second quarter;
- 45 in the third quarter;
- 40 in the fourth quarter

**27.3** 8 deaths representing 4.2% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 2 representing 4% for the first quarter;
- 1 representing 2% for the second quarter;
- 3 representing 6.7% for the third quarter;
- 2 representing 4.4% for the fourth quarter

These numbers have been estimated using the Trust's Mortality Review Policy, based upon national guidance on learning from deaths issued by the National Quality Board (March 2017) and implementation of the structured judgement review methodology issued by the Royal College of Physicians (2016).

**27.4** A summary of what Liverpool Heart and Chest Hospital has learnt from case record reviews and investigations conducted in relation to the deaths identified in Note 3.

- Review ward location of patients with memory or learning difficulties – side rooms to enhance calm
- Improve infection prevention procedures during suction and endoscopy
- Programme of education for stakeholders referring primary PCI heart attack patients to ensure inappropriate transfers avoided
- Out of hospital cardiac arrest pathway revised to ensure head injuries are assessed and exclude cerebral bleeding as a cause of collapse

- Heightened awareness of cardiac tamponade as a cause of hypotension after complex PCI
- Ensure appropriate MDT discussions are carried out for patients with multiple co-morbidities and anaesthetist input considered
- Ensure reducing delays in patients lost to follow up

**27.5** A description of the actions which Liverpool Heart and Chest Hospital has taken in the reporting period, and proposes to take following the reporting period, in consequence of what LHCH has learnt during the reporting period (see Note 4).

All of the above issues have been addressed or are being addressed.

- Delirium policy recirculated and patient location reviewed
- Endoscopy IPC processes recirculated
- OOHCA pathway amended
- Education on PPCI pathway delivered
- MDT processes have been updated and attendees list widened. Meetings delayed unless quorate
- Priority on waiting lists given to those previously delayed due to being lost to follow up

**27.6** An assessment of the impact of the actions described in item Note 5 which were taken by Liverpool Heart and Chest Hospital during the reporting period.

It is not possible to comment on the effect of most these actions in the time period under consideration however the change in the cardiac arrest pathway has avoided two inappropriate transfers since inception

**27.7** 29 case record reviews and 14 investigations completed after 31/01/2019 which related to deaths which took place before the start of the reporting period.

**27.8** 0 deaths representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

**27.9** 5 deaths representing 2.76% of the patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

## Part 2.3 Reporting against Core Indicators

### Hospital Standardised Mortality Ratio (HSMR)

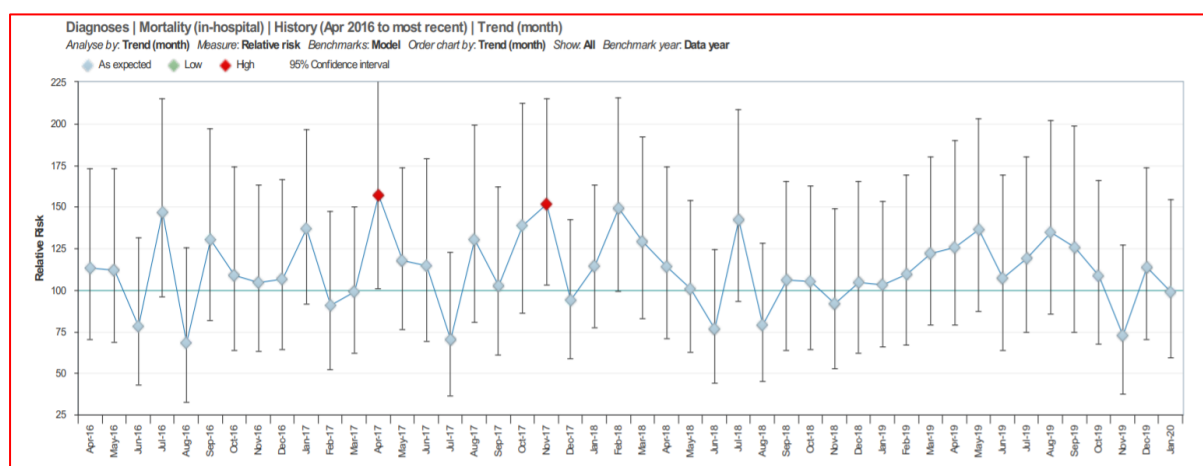
Liverpool Heart and Chest Hospital considers that this data is as described for the following reasons:

- Specialist acute trusts do not calculate their mortality rates using the summary hospital-level mortality indicator (SHMI); instead, Liverpool Heart and Chest Hospital uses information provided by Dr Foster Intelligence in the form of Hospital Standardised Mortality Ratio (HSMR) that is updated each month as part of its performance management arrangements and reported to the Trust's Quality Committee.

To achieve statistical significance using confidence intervals:

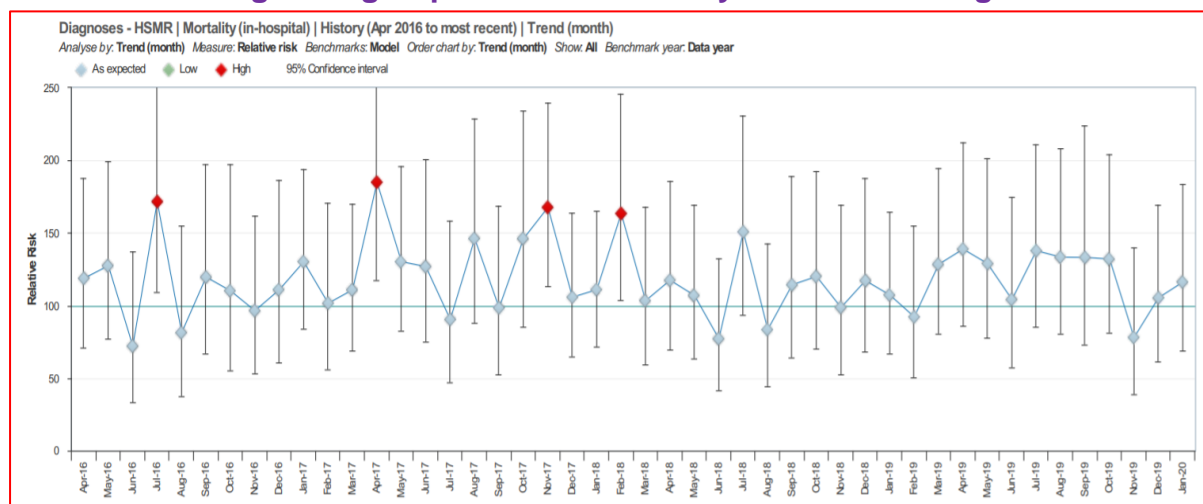
- To be high, a hospital must have HSMR and the lower confidence interval above 100. A hospital above 100 but with lower confidence interval below 100 is classed as 'within the expected range'.

### HSMR for all diagnoses





## HSMR for 56-diagnosis groups as determined by Dr Foster Intelligence



Liverpool Heart and Chest Hospital intends to take the following actions to continue to improve this rate and so the quality of its services by:

- continuing to support the broadened remit of the mortality review group and ensuring all deaths in the hospital are subject to a mortality review screening process and any lessons learnt shared accordingly.

## Readmission Within 28 days of Discharge

Liverpool Heart and Chest Hospital considers that this data is as described for the following reasons:

The percentage of readmissions refers to those coming back directly to the Trust.

	Performance 18/19	Performance 19/20
Percentage of patients aged 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period	Elective: 6.8% (RR: 107.5)  Non-Elective: 11.6% (RR: 84.9)  Total: 8.6% (RR: 94.89)	Elective: 6.4% (RR: 100.9)  Non-Elective: 11.5% (RR: 82.8)  Total: 8.2% (RR: 90.8)

. \*18/19 Performance Information will be available from September 2019.

NB. The Trust monitors readmission rates up to 30 days post-discharge, not 28.

Liverpool Heart and Chest Hospital has taken the following actions to improve this rate, and so the quality of its services by:

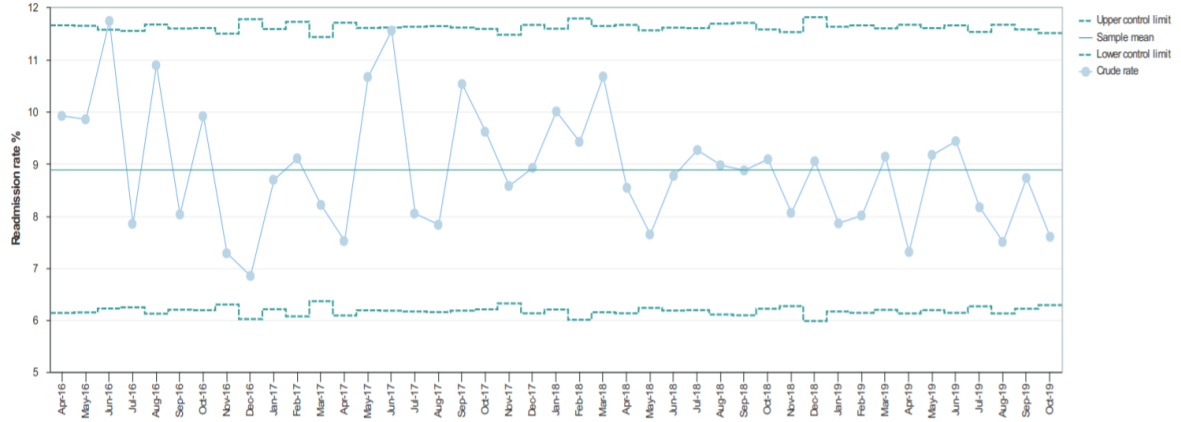
- providing contact details for the ward from which patients are discharge.



Diagnoses | Readmission (28 days) | History (Apr 2016 to most recent) | Trend (month)

Admission type: Non-elective, Elective | Age (adult/child): Child, Adult

Period: Month



## Responsiveness to personal needs

Liverpool Heart and Chest Hospital considers that this data is as described for the following reasons:

- Personal needs are a composite of a number of aspects of care, including the provision of advice on medication following discharge. This year, the Trust has improved its performance markedly on this part of the indicator from last year through the embedding of teach back – asking the patients to repeat back what they had been told about taking their medications.

	Performance 17/18	Performance 18/19
Trust's responsiveness to the personal needs of its patients during the reporting period	8.0	7.9

*NB 19/20 Performance Information will be available from July 2020*

Liverpool Heart and Chest Hospital has taken the following actions to improve this percentage, and so the quality of its services by:

- ensuring the systematic training of teach back to all new personnel appointed to a role that involves discharging patients
- making the 6Cs culture business as usual.

## Staff recommending the Trust to family and friends

Liverpool Heart and Chest Hospital consider that this data is as described for the following reasons:

	Target 18/19	Performance 18/19	Target 19/20	Performance 19/20
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	94%	95%	94%	93%

The continued high levels of advocacy from staff highlights the ongoing commitment to delivering safe, compassionate care to patients and their families.

Liverpool Heart and Chest Hospital has taken the following actions to improve this percentage, and so the quality of its services by:

- increasing communication of results through internal systems, such as directorate meetings, team briefs, listening events and Executive walkabouts.

### Venous thromboembolism (VTE) assessment

Liverpool Heart and Chest Hospital considers that this data is as described for the following reasons:

- The rate of assessment of patients at admission has been consistently high this year and is an improvement on last year's performance. The data is taken directly from each patient's electronic record of care.

	Target 18/19	Performance 18/19	Target 19/20	Performance 19/20
The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period	95.0%	96.92%	95.0%	96.0%

Liverpool Heart and Chest Hospital has taken the following actions to improve this percentage, and so the quality of its services by:

- learning from each and every VTE through root cause analysis and feedback of lessons learned.

### Clostridium difficile infection

Liverpool Heart and Chest Hospital considers that this data is as described for the following reasons:

The Trust's infection rates are consistently low; the number of Clostridium difficile cases in 2019/20 eight corrective measure were put in place if identified

	Target 18/19	Performance 18/19	Target 19/20	Performance 19/20
The rate per 100,000 bed days of cases of C. difficile infection reported within the trust among patients aged 2 or over during the reporting period	<=16.9	3.39	<=16.9	13.51

Liverpool Heart and Chest Hospital has taken the following actions to improve this number, and so the quality of its services by:

- ensuring samples are sent appropriately when an infection is suspected
- ensuring appropriate precautions are taken when an infection is suspected or confirmed
- ensuring a robust surveillance system is in place.

### Patient safety incidents

	Target 18/19	Performance 18/19	Target 19/20	Performance 19/20
The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	TBC	1551 patient incidents  11.55 per 100 admissions (13,424 admissions)  1 (0.6%) resulted in severe harm or death	TBC	1645 patient incidents  12.06 per 100 admissions (13,641 admissions)  0 (0%) resulted in severe harm or death

Liverpool Heart and Chest Hospital considers that this data is as described for the following reasons:

Liverpool Heart and Chest Hospital intends to take the following actions to improve this number and so the quality of its services by:

- implementing the Trust's vision for safety – Safe from Harm
- implementing the Speak up Safely campaign
- developing the new Quality Strategy which is patient focused.

Please note that there is no national comparison, however the Trust receives a comparative report by the NRLS (National Reporting and Learning System).

## Part 3 other information

### Performance Review

This section of the Quality Account presents an overview of performance in areas not selected as priorities for 2019/20.

**Presented are:**

- Quantitative metrics, that is, aspects of safety, effectiveness and patient experience which the Trust measures routinely to prove the quality of care it provides.

Performance against relevant indicators which are present in both the Risk Assessment Framework and Single Oversight Framework.

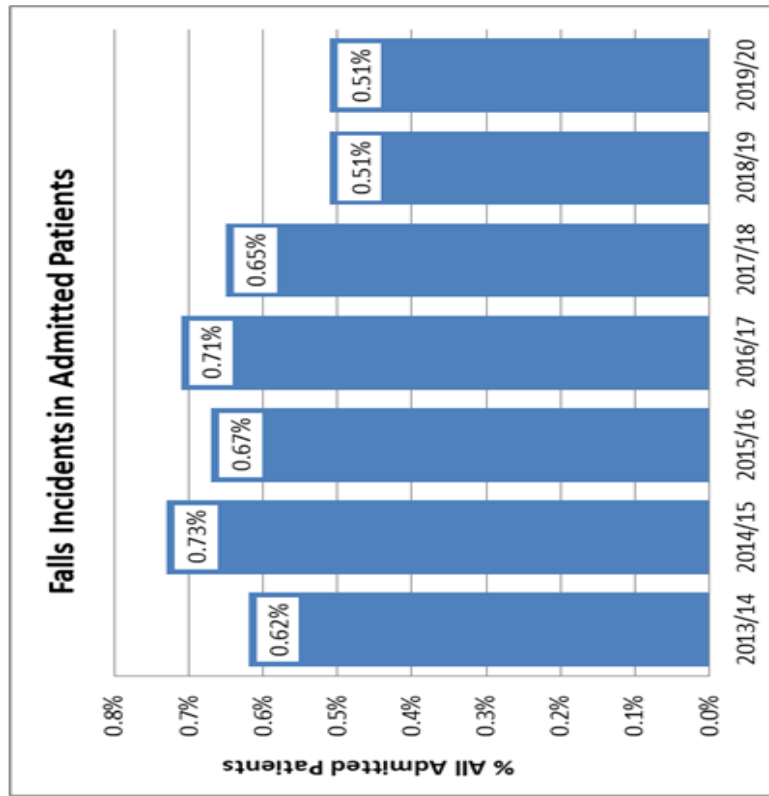


## Quantitative Metrics

Safety				
Metric	Pressure ulcer incidence	Organisation Wide or Service Specific	Organisation Wide	
Derived From	Referrals to the Tissue Viability Specialist Nurse	Why metric chosen	Pressure ulcers are painful for patients and contribute to a negative patient experience. Nursing high impact action	<p><b>Annual Pressure Ulcers Incidence Rate</b></p> <p>Pressure Ulcers per 1,000 Beddays</p> <p>Grade 2</p> <p>Grade 3 or 4</p>
How is data collected	Staff who observe a pressure ulcer report this to the Trust's Tissue Viability Service for treatment	Improvements planned	Continued staff education Establishment of the Pressure Ulcer Bundle with a focus on pressure ulcer prevention	
LHCH Performance 2019/20	Grade 2 = 0.10 (< 1 ulcers per month) Grade 3+ = 0 (= 0 ulcers per year)	LHCH Performance 2018/19	Grade 2 = 0.09 (< 1 ulcers per month) Grade 3+ = 0 (= 0 ulcers per year)	
Interpretation of Results	A large reduction in pressure ulcers occurring in our patients has been observed during 2019/20. The number of Grade 3 and above pressure ulcers is reported as none for our patients. The Tissue Viability Team have worked closely with all ward teams with the development of scoping meetings, changes to mechanical devices that previously had identified to be the causation of grade 2 pressure ulcers.			

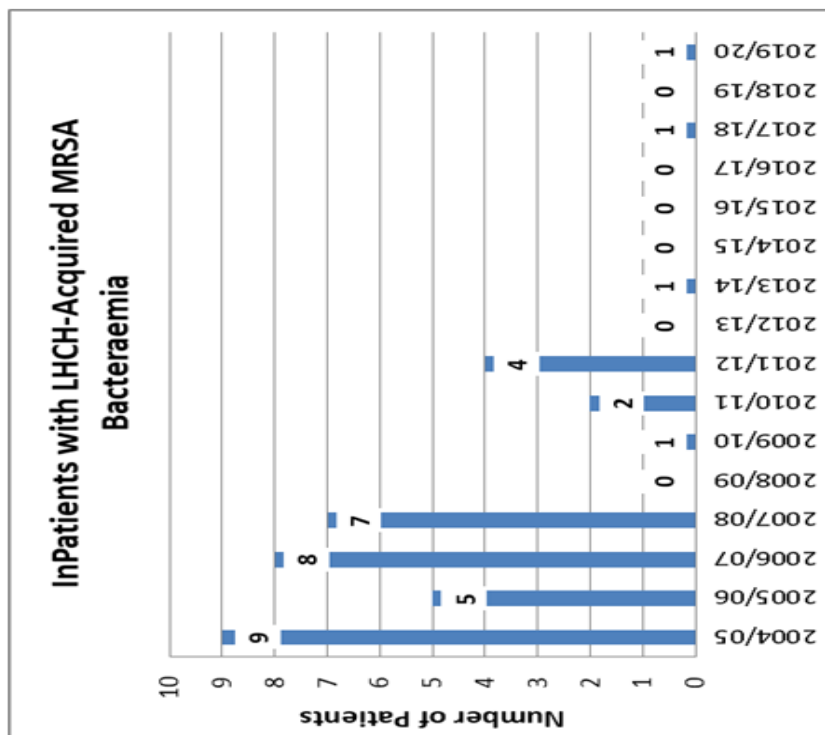


Safety				
Metric	Number of in patient falls	Organisation Wide or Service Specific	Organisation wide	
Derived From	Incident reporting	Why metric chosen	Falls have the potential to cause significant harm. Nursing high impact action	
How is data collected	Staff who witness or become aware of a fall report this via the Trust's risk management processes	Improvements planned	Embedding of Comfort Checks in wards- Call don't fail initiative, scoping meetings to prevent falls RCA for all sever harm falls-	
LHCH Performance 2019/20	0.51% (69 falls in 13641 admissions)	LHCH Performance 2018/19	0.51% (68 falls in 13,436 admissions)	
Interpretation of Results	The rate of falls occurring in 2019/20 is slightly higher than last year. The risk profile of our inpatients continues to become more challenging. We will continue to strive to reduce the number of falls.			

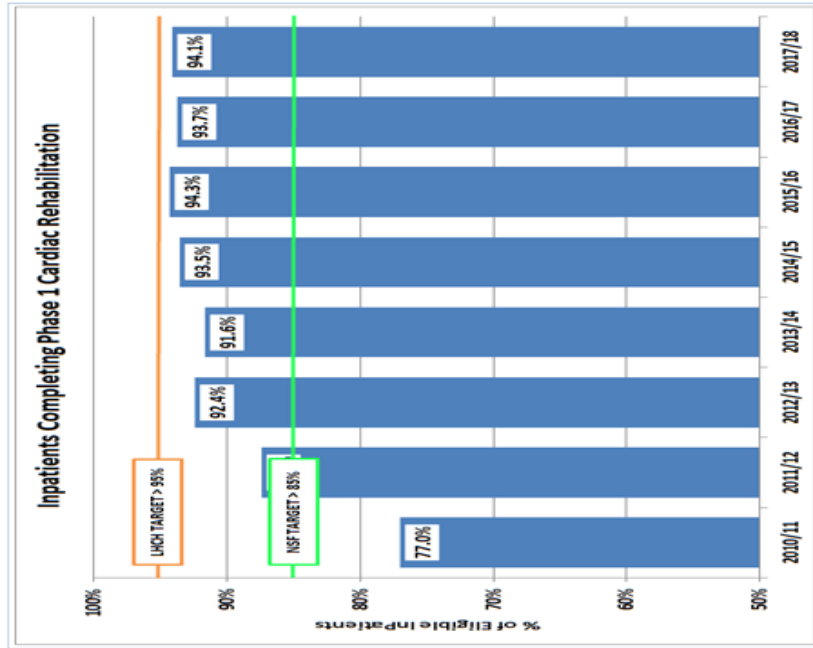




Safety				
Metric	Number of patients acquiring MRSA whilst in hospital	Organisation Wide or Service Specific	Organisation wide	
Derived From	Infection prevention team	Why metric chosen	Major concern of patients; Department of Health priority	
How is data collected	Monthly surveillance reported to health protection agency. National definitions of bacteraemia applied.	Improvements planned	We'll continue with the processes out in place last year. Surgical site infection check MRSA screening audits Central lines bundle	
LHCH Performance 2019/20	1 patients	LHCH Performance 2018/19	0 patients	
Interpretation of Results	The Trust has achieved an excellent result with 1 case of MRSA in 2019/2020. Patient transferred from another hospital and due to reporting criteria attributable to LHCH.			



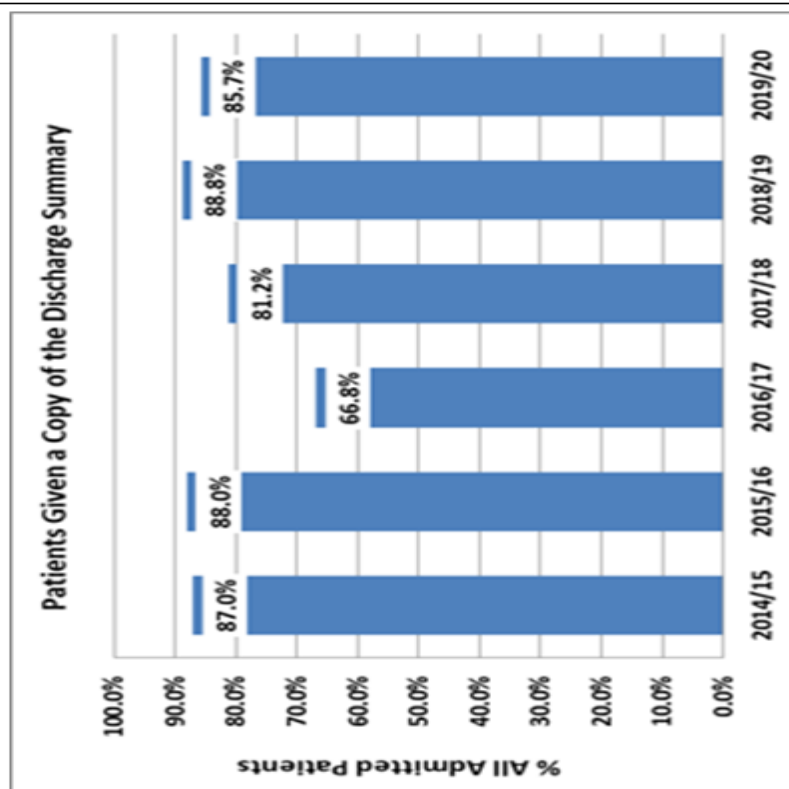
Effectiveness				
Metric	% patients completing phase one cardiac rehabilitation	Organisation Wide or Service Specific	Organisation wide – phase 1;	
Derived From	Local audit figures	Why metric chosen	Promotes lifestyle change and reduces future risk of cardiac events such as heart attacks	
How is data collected	When in hospital, Eligible patients for cardiac rehab receive a comprehensive educational session highlighting their personal lifestyle /medical risks and how they can make any changes to improve their health outcomes and prevent further disease and re-admissions to hospital This data is sent to the Clinical Quality	Improvements planned	Increase the number of staff with relevant competencies. Current training delivery methods by CR nurse and Knowsley CVD nurse ineffective due to increased competing initiatives for staff. Review and modify the competency tool agreed at CR steering group Jan 2016 that competencies will be delivered as E learning package. We are awaiting confirmation for mandatory status. This will form part of planned CR KPI for training /competency confirmed plans to redesign CR referral –start April 2016 have a PCB setting of service KPI's.	
LHCH Performance 2017/18	94.1%	LHCH Performance 2016/17	93.72%	
Interpretation of Results	We have exceeded 2017/18 NSF target of 85%, set for this indicator. We plan to set Trust target to 98% for 2018/19. We will continue the excellent service provided by having ward specific Cardiac Rehabilitation trainers with relevant competencies. Increasing number of staff competent is part of the work stream for 2018. We will now record activity on discharge flow sheets for future audit purposes			



Effectiveness																		
Metric	% patients with heart attack receiving treatment within 90 minutes of arrival (door to balloon time)	Organisation Wide or Service Specific	Service specific - Cardiology	<p>90 minute Door-to-Balloon Success in primary PCI for Acute Heart Attacks</p> <table><thead><tr><th>Year</th><th>Success Rate</th></tr></thead><tbody><tr><td>2014/15</td><td>98.7%</td></tr><tr><td>2015/16</td><td>98.9%</td></tr><tr><td>2016/17</td><td>98.0%</td></tr><tr><td>2017/18</td><td>96.8%</td></tr><tr><td>2018/19</td><td>97.7%</td></tr><tr><td>2019/20</td><td>97.5%</td></tr></tbody></table> <p>National Average 15-16, 89%</p>	Year	Success Rate	2014/15	98.7%	2015/16	98.9%	2016/17	98.0%	2017/18	96.8%	2018/19	97.7%	2019/20	97.5%
Year	Success Rate																	
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2016/17	98.0%																	
2017/18	96.8%																	
2018/19	97.7%																	
2019/20	97.5%																	
Derived From	Local audit figures	Why metric chosen	Service has expanded this year, so need to ensure good quality care has been maintained															
How is data collected	LHCH contribution to myocardial infarct national audit project (MINAP) collected into in house electronic database. National definition of performance measures used from MINAP.	Improvements planned	Performance is excellent so we aim to learn from each of the times performance is not perfect.															
LHCH Performance 2019/20	97.5%	LHCH Performance 2018/19	97.7%															
Interpretation of Results	The high standard set in previous years has been maintained this year. Our patients continue to benefit from this extremely efficient, gold-standard service.																	

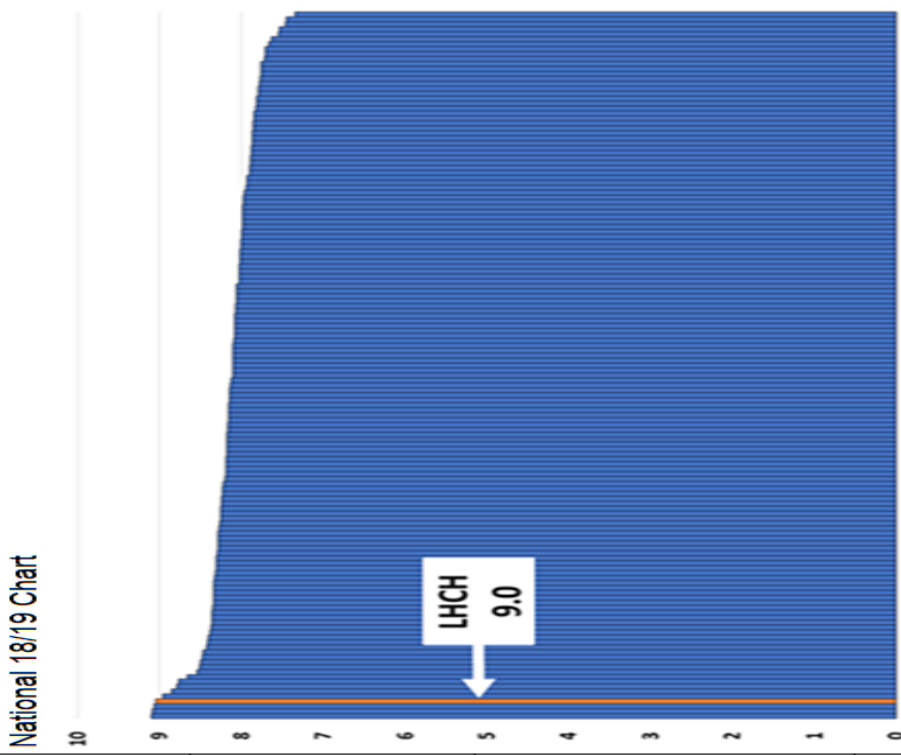
## Effectiveness

Metric	% of patients who received a copy of their discharge summary to the GP	Organisation Wide or Service Specific	Service specific – Support Services
Derived From	Nursing Discharge Checklist in the Electronic Patient Record	Why metric chosen	Patients should receive a copy of their discharge summary, so they are aware of and can convey to community services details pertinent to their stay at LHCH and on-going care.
How is data collected	Nursing staff confirm whether or not the patient has received a copy of their discharge summary at the point of discharge.	Improvements planned	Our Electronic Patient Record (EPR) system includes a module for generating patient correspondence. Development of standard documentation across the health economy
LHCH Performance 2019/20	85.7%	LHCH Performance 2018/19	88.8%
Interpretation of Results	The proportion of patients receiving a copy of the discharge summary has decreased slightly due to patients being recorded as not wanting a discharge summary. Improvement works continue regarding documentation		





Patient Experience																								
Metric	Dementia screening, assessment and referral	Organisation Wide or Service Specific	Organisation wide																					
Derived From	Data submitted to NHS England as part of national programme	Why metric chosen	Patients assessed and identified with dementia need to be referred for specialist care	<table><thead><tr><th></th><th>16/17</th><th>17/18</th><th>18/19</th><th>19/20</th></tr></thead><tbody><tr><td>Eligible Patients are asked the case finding question</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td></tr><tr><td>Patients Requiring Full Dementia Assessment are Assessed</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td></tr><tr><td>Patients Identified as possible Dementia are Referred to GP</td><td>95%</td><td>95%</td><td>95%</td><td>95%</td></tr></tbody></table> <p>■ Compliance — Target 90%</p>		16/17	17/18	18/19	19/20	Eligible Patients are asked the case finding question	95%	95%	95%	95%	Patients Requiring Full Dementia Assessment are Assessed	95%	95%	95%	95%	Patients Identified as possible Dementia are Referred to GP	95%	95%	95%	95%
	16/17	17/18	18/19		19/20																			
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Patients Identified as possible Dementia are Referred to GP	95%	95%	95%	95%																				
How is data collected	By nursing staff in ward at assessment and entered into Electronic Patient Record	Improvements planned	Dementia awareness training																					
LHCH 2019/20	94% of patients treated appropriately	LHCH 2018/19	97% of patients treated appropriately																					
Interpretation of Results	This process is now well embedded in the Trust. Patients with dementia and their carers can be assured that LHCH will help to ensure appropriate care is provided for this condition.																							

Patient Experience				
Metric	Mean of 'Overall patient experience' question. Inpatient care rated 0-10	Organisation Wide or Service Specific	Organisation wide	 <p>National 18/19 Chart</p>
Derived From	National patient survey results	Why metric chosen	This question is an overall measure of the patients experience	
How is data collected	1250 LHCH patients are invited to complete a questionnaire about their in-patient stay. Results are benchmarked with other Trusts in England.	Improvements planned	Continuing the Implementation of the Patient and Family centred care plan	
LHCH Performance 2019/20	Performance available July 2020	LHCH Performance 2018/19	9.0 (90%)	
Interpretation of Results	LHCH continues to have positive feedback from patients were actions are needed plans are put into place			

Patient Experience																																																																																														
Metric	Responsiveness to patients needs	Organisation Wide or Service Specific	Organisation wide	<div>National data not available until July 2020</div> <div>2018/19 graph below:</div> <div><table><thead><tr><th>2005</th><th>2006</th><th>2007</th><th>2008</th><th>2009</th><th>2010</th><th>2011</th><th>2012</th><th>2013</th><th>2014</th><th>2015</th><th>2016</th><th>2017</th><th>2018</th><th>Overall Average</th></tr></thead><tbody><tr><td>8.2</td><td>8.1</td><td>8.3</td><td>8.4</td><td>8.2</td><td>8.5</td><td>8.6</td><td>8.7</td><td>8.8</td><td>8.9</td><td>9.0</td><td>9.1</td><td>9.2</td><td>9.3</td><td>8.6</td></tr><tr><td>7.5</td><td>7.4</td><td>7.6</td><td>7.7</td><td>7.5</td><td>7.8</td><td>7.9</td><td>8.0</td><td>8.1</td><td>8.2</td><td>8.3</td><td>8.4</td><td>8.5</td><td>8.6</td><td>8.0</td></tr><tr><td>8.8</td><td>8.9</td><td>9.0</td><td>9.1</td><td>9.2</td><td>9.3</td><td>9.4</td><td>9.5</td><td>9.6</td><td>9.7</td><td>9.8</td><td>9.9</td><td>10.0</td><td>10.0</td><td>9.4</td></tr><tr><td>5.5</td><td>5.6</td><td>5.7</td><td>5.8</td><td>5.9</td><td>6.0</td><td>6.1</td><td>6.2</td><td>6.3</td><td>6.4</td><td>6.5</td><td>6.6</td><td>6.7</td><td>6.8</td><td>6.2</td></tr><tr><td>7.8</td><td>7.9</td><td>8.0</td><td>8.1</td><td>8.2</td><td>8.3</td><td>8.4</td><td>8.5</td><td>8.6</td><td>8.7</td><td>8.8</td><td>8.9</td><td>9.0</td><td>9.1</td><td>8.5</td></tr></tbody></table></div>	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Overall Average	8.2	8.1	8.3	8.4	8.2	8.5	8.6	8.7	8.8	8.9	9.0	9.1	9.2	9.3	8.6	7.5	7.4	7.6	7.7	7.5	7.8	7.9	8.0	8.1	8.2	8.3	8.4	8.5	8.6	8.0	8.8	8.9	9.0	9.1	9.2	9.3	9.4	9.5	9.6	9.7	9.8	9.9	10.0	10.0	9.4	5.5	5.6	5.7	5.8	5.9	6.0	6.1	6.2	6.3	6.4	6.5	6.6	6.7	6.8	6.2	7.8	7.9	8.0	8.1	8.2	8.3	8.4	8.5	8.6	8.7	8.8	8.9	9.0	9.1	8.5
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Derived From	Average of 5 key questions drawn from the national patient survey results	Why metric chosen	Summary of overall experience of care. National CQUIN indicator																																																																																											
How is data collected	1250 LHCH patients are invited to complete a questionnaire about their in-patient stay. Results are benchmarked with other Trusts in England.	Improvements planned	Embedding Teach back, to make sure patients know exactly what their discharge summary means, and what to expect from their medication  Embed a generic discharge summary with clear instructions and information																																																																																											
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## Developments in the Single Oversight Framework(SOF) to M12

Liverpool Heart and Chest Hospital considers that this data is described from Indicators arising from appendices 1 and 3 of the Single Oversight Framework to M12.

Indicator	Target	Performance 2018/19	Performance 2019/20
Maximum time of 18 weeks from point of referral to treatment in aggregate- patients on an incomplete pathway	92%	92.31%	91.79%
All cancers: 62 day wait for first treatment from urgent GP referral for suspected cancer	85%	95.32%	94.79%
All cancers: 62 day wait for first treatment from NHS cancer screening service referral	90%	N/A	N/A
C. Difficile variance from plan	4	2	8
Hospital Standardised Mortality Ratio (HSMR)	<=100	104.8 (all diagnoses)  110.0 (HSMR diagnoses)	114.9 (all diagnoses Apr - Jan)  120.8 (HSMR diagnoses, Apr - Jan)
Maximum 6-week wait for diagnostic procedures	99%	81.78%	73.57%
Venous thromboembolism (VTE) risk assessment	95%	96.9%	96.0%



Liverpool Heart and Chest Hospital intends to take the following actions to improve this number and so the quality of its services by:

- implementing the Trust's vision for safety – Safe from Harm
- implementing the Speaking up Safely campaign
- developing the new Quality Strategy which is patient focused.

## **Annex 1: Statements of Commissioners, local Healthwatch, and Overview & Scrutiny Committees**

### **Statement from Healthwatch**

Healthwatch Liverpool welcomes the opportunity to comment on this 2019-20 Quality Account for the Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH).

We base our commentary on feedback and enquiries that we receive throughout the year, as well as our annual Listening Events that – prior to the Covid -19 pandemic - we carried out at each Liverpool Trust. We visited the Liverpool Heart and Chest Hospital in June 2019 and spoke to 63 patients and visitors. People we spoke to rated the hospital highly at 4.85 out of 5 stars, and we received many positive comments about the staff and the care provided.

The 2019-20 Quality Account highlights many successes; we would especially like to congratulate the Trust on receiving an ‘Outstanding’ rating from the Care Quality Commission (CQC) for the second time.

Patient satisfaction continues to be high for the Trust; although not covered in this Quality Account as results were not published until July 2020, we were pleased to see that the Trust came joint second for overall patient experience in the National Inpatient Survey, which covers patients discharged in July 2019.

Additionally, it was positive to note that the Trust remains highly recommended by its staff as a place for friends and family to receive treatment.

Details about the Trust’s performance show that good progress was made against the 2019-20 priorities, although not all targets were met. The target to carry out risk assessments and screen patients for delirium was narrowly missed again, and although this will not be a priority for 2020-21, we welcome that the Trust is looking to appoint a clinical lead for mental health to help improve care for patients experiencing a delirium.

That patients with additional hearing and/or vision needs can now expect to be given an individualised care plan and risk assessment is a positive step and will hopefully reduce potential health inequalities. We were pleased to note that the target to reduce medication errors was reached.

The target for discharging patients before 4pm from Elm and Cedar wards was not achieved, however improvements have been made. Hospital discharge is a system-wide issue, not just for LHCH.

We believe that this year’s introduction of a palliative care room with better facilities for patients and relatives should have an immediate impact, and help to improve patient experience during a particularly difficult time.

Apart from feeding back about last year’s priorities, the report also highlights new and ongoing work carried out with other Trusts, researchers and universities, and wider health networks. We particularly welcome the partnership work to develop single models of care for several conditions with Liverpool University Hospital Trust, and the launch of a cardio-

oncology service with the Clatterbridge Cancer Centre. We believe that these collaborations will spread good practice and bring better outcomes for the Liverpool population, as well as patients further afield.

Although for most of 2019-20 the Trust was able to operate as usual, the final quarter brought rapid changes to services due to the Covid-19 pandemic. We look forward to next year's Quality Account reflecting some of the changes introduced due to the pandemic, and the impact this has had on patient care and patient experience. We will be interested to learn the outcomes for the quality priorities that have been chosen for 2020-21.

Due to the pandemic we currently can't visit Trust sites and meet patients and visitors face to face to capture their feedback. We are working in different and new ways, for example by facilitating online focus groups. We look forward to working with the Liverpool Heart and Chest Hospital in 2020-21, helping to ensure that patients' voices continue to be central in celebrating good practice, and in feeding back if and where improvements could be made.

### **Statement from Commissioners**

*(not received)*

### **Statement from the Trust's Council of Governors**

I have reviewed the Quality Account for 2019/20 for the Trust and am confident they represent a true account of the performance of the Trust based on the audited figures presented. The Quality Account clearly demonstrates, in depth, the complexities involved in treating our patients and confirms the huge commitment to a safe caring environment for patients, their families and our staff.

The Annual Members Meeting on 23/09/19 was attended by Clinicians, Stakeholders, Foundation Trust Members & Staff, as well as public governors from Merseyside, Cheshire, and North Wales. Amongst many other presentations, this meeting received a review of the work of the Council of Governors including the Membership and Communications Committee.

Last year, I made the following statement - "On behalf of the Council of Governors, I am confident that this Hospital will respond, as it always has, in a very positive way, to the challenges of the year ahead". Little did any of us know that the current pandemic would hit the country so hard, but I am pleased to report that governors were kept fully informed through this period, with 'Team LHCH' responding magnificently to this unprecedented and unexpected challenge, without any adverse impact to the quality of care for our patients.

The Governors are totally supportive of the well led culture at LHCH and acknowledge the professionalism and enthusiasm demonstrated by every member of the team at all times, but especially during the Covid-19 pandemic.

**Trevor Wooding, Senior Governor**

22<sup>nd</sup> July 2020

## Annex 2: Statement of Directors Responsibilities for the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2019 to May 2020
  - papers relating to Quality reported to the board over the period April 2019 to May 2020
  - feedback from commissioners dated (not received)
  - feedback from governors dated 22/07/20
  - feedback from local Healthwatch organisation dated 2/11/20
  - feedback from Overview and Scrutiny Committee (not received)
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/04/20
  - the 2019 national patient survey – 02/07/20
  - the 2019 national staff survey - 18/02/20
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 22/06/20
  - CQC Inspection report dated 16/09/19
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

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

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

## How to provide feedback on the Quality Account

Liverpool Heart and Chest Hospital NHS Foundation Trust would be pleased to either answer questions or receive feedback on how the content and layout of this quality account can be improved. Additionally, should you wish to make any suggestions on the content of future reports or priorities for improvement we may wish to consider, or should any reader require the Quality Account in any additional more accessible format then please contact:

Mrs Sue Pemberton, Director of Nursing and Quality  
(E-mail [sue.pemberton@lhch.nhs.uk](mailto:sue.pemberton@lhch.nhs.uk) or telephone 0151 600 1339).