Quality Report

2022/23

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 2022/23, LHCH provided:

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 coronary artery narrowing's, 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. Respiratory virtual wards to enhance patient recovery and prevented hospital admission.
7. Targeted Lung Health Check inviting people who following a screening process are invited for CT scan to identify early lung cancer or lung disease.

Developments for 2022-23

A major programme of works to upgrade the Trust's catheter laboratories has continued during 22/23 with an expected completion in November 23. This will signal a significant achievement for the Trust with the delivery of 6 new state of the art catheter laboratories that will deliver high quality care for years to come.

Further significant investments have been made in the Trust's IT and Estates infrastructure.

Digital Excellence

Over the last year, the team have been working through the Trust's 'Digital Excellence' strategy, which sets out the digital ambitions and deliverables for LHCH. The strategy is grounded in delivering the basics well for staff and patients and is steeped in ambition and pioneering innovation. The Digital Excellence Committee chaired by the Chief Executive is used to govern the programmes within the strategy.

During 2022/2023, a number of digital initiatives have been implemented at LHCH allowing many benefits to be realised. Within the safety programme, closed loop medications has been introduced and has contributed to a reduction in medication errors across inpatient areas.

The Trust achieved EMRAM Level 6 from the Healthcare Information and Management Systems Society (HIMSS) in 2022, an external accreditation used to assess digital maturity. Electronic consent has also been introduced to support a safer consenting process and introduce efficiencies. Isla Care, a platform that supports the remote monitoring of patients has been rolled out to support the Community Stroke and Tissue Viability teams, allowing patients to be monitored without bringing them into clinic.

Digital Communications has been expanded across LHCH to replace paper correspondence, significantly reducing the administration requirements to prepare and send letters. Imprivata has also been introduced to support staff with faster sign in across all systems. LHCH became the first centre in the UK to implement CartoNet and the clinicians have fed back very positively following the deployment. The cloud-based storage solution allows teams to review, analyse & share cases stored remotely. Previously, any such case work would need to be completed using the systems within the on-site labs.

Several technical projects have also been completed to ensure the foundations were in place to support digital transformation work. This has included significant investment in Cyber Security, keeping information secure within the Trust. A complete device refresh was also completed to ensure staff had the right tools to support them.

Looking ahead, the team are working towards EMRAM Level 7 accreditation. The Trust has actively participated in the 'What Good Looks Like' frequent engagement with the national teams occurred to ensure digital programmes are aligned with national priorities. LHCH will continue to fully exploit remote monitoring technology and wider digital platforms to deliver effective and efficient care.

National Inpatient Survey

Patients were asked for their views on various aspects of their care, based on the proportion of patients who responded positively compared to the average.

LHCH has had the highest response rate from patients and overall LHCH has been rated the top hospital in the northwest for overall care and fourth nationally in the National Inpatient survey 2021. In addition, the Trust is listed as one of four trusts who have been rated as 'much better than expected' from the survey results.

Our vision is to be the best and we acknowledge that we will only achieve this by truly placing the quality, safety and experience of our patients and families at the heart of what we do. Our approach to care recognises each patient as part of a wider group including families, friends and carers and we embrace this with our patient and family centred approach to care.

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 2022/2023 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'.***

Throughout 2022/23 LHCH continued to provide elective, urgent and emergency services which included, cancer surgical procedures, emergency and urgent and operations and procedures. All Primary Percutaneous Coronary Intervention (PPCI) services were maintained.

LHCH continues to engage frequently with senior clinical leadership through internal command and control structures.

Cheshire and Merseyside Acute and Specialist Trust

The Trust has a leadership role within the integrated care system, with Jane Tomkinson, CEO of LHCH, being the Senior Responsible Officer for the Cardiac Board and the SRO for the Clinical Efficiency and Value workstream within the Cheshire and Merseyside Acute Specialist Trust Provider Collaborative (CMAST). Jonathan Develing, Director of Strategic Partnership, also chairs the Cheshire and Merseyside CVD Prevention Group and the long term conditions program, within the Liverpool Place system.

The Trust also plays an active role within respective CMAST networks, that of the Medical Directors, Directors of Nursing, Finance, HR and Strategy.

With the advent of provide collaboratives the Trust now has a formal committee in common with Liverpool University Hospitals focusing on the 4 national cardiac pathways (acute coronary syndrome, heart failure, heart rhythm, and endocarditis). This collaborative, Liverpool Cardiology Partnership, is seeking to streamline pathways, fast track patients and avoid duplication and delays. The partnership is working with other Trusts to onboard them into the pathways on a phased roll out basis.

The Trust is well engaged with other Place based systems in Knowsley and Sefton and with a wide range of new partnerships such as Liverpool and Everton Football Clubs, local school, Liverpool Philharmonic, and primary care groups that are particularly challenged with CVD and health inequalities.

Workforce / Education and Support

Investment in our workforce is essential – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care

LHCH has made significant investment in our workforce during 2022-2023, with focus on the health, wellbeing, and safety of our staff.

A successful local and international recruitment drive enabled the Trust to develop a pipeline of nurses with 130 internally educated nurses joining our workforce.

The ongoing work to support staff to improve the retention is key, we are currently in a strong position regarding band 5 nurse recruitment and retention enabling a safe nursing workforce.

The Trust has been examining new ways of working post-covid involving flexible working options to combat recruitment and retention challenges where possible. Pharmacy and Therapies are working towards a 7-day model, and we are also partnering with local universities to look at other opportunities for OPD's via the apprenticeship route.

Delivery of our workforce plan is supported through the development of the People Strategy 2022-25 which sets out a clear roadmap moving forward that focusses on 4 key pillars:

- Recruitment & Retention

- Learning & Development
- Culture & Wellbeing
- Equality, Diversity, Inclusion & Belonging (EDIB)

The impact of the pandemic reinforced the need for LHCH to develop a much bolder strategy on Equality, Diversity, Inclusion and Belonging (EDIB) to ensure that inclusion is felt authentically at a personal level. The team were instrumental in enhancing the visibility of EDIB activity across the organisation to encourage employee voice through our newly established LHCH Belong Inclusion Network. Listening to our people has helped shape our 2022-25 EDIB strategy and created a culture of belonging and trust.

With compassion, inclusivity and wellbeing in mind, the team led a trust wide, cultural transformation project named 'Be Civil Be Kind', embarking on a back-to-basics campaign to further embed the importance of civility and kindness on our workplace, this was achieved by placing engagement back in the hands of our people by reaching out and listening to their experiences. This provided the opportunity to make people feel valued and appreciated as we understand that a culture of civility and kindness promotes a psychologically safe, harmonious, and high performing teams and importantly civility saves the lives of patients.

We have also significantly enhanced our wellbeing offer, looking after the mental, physical and financial wellbeing of our staff.

The results and impact of our people centred initiatives show that resilience has improved, team working has improved, mental health absence has reduced, and morale and civility has become the heart of our behaviours, even during challenging and unprecedented times.

LHCH have led a very successful international recruitment programme with 70 nurses arriving in 2021, 40 in 2022 and 20 arriving in 2023. Our final cohort of international nurses arrived in April 2023.

All the international nurses who have undertaken their OSCEs examinations have passed either 1st or 2nd time and are well-established into LHCH clinical teams.

We have a successful pastoral care team who continue to offer support to all our international nurses.

LHCH have developed an accelerated development project with a first cohort who have started the Mary Seacole Leadership Programme, have shadowing opportunities arranged scenario-based learning sessions planned. We have received very positive feedback on the programme so far and look forward to expanding the programme later in the year.

Equality Delivery System

LHCH has completed EDS2 every year since 2013 and has demonstrated a wide number of achievements across the protected characteristics. EDS 2022 is aligned to NHS England's Long-Term Plan and its commitment to an inclusive NHS that is fair and accessible to all. The results for EDS 2022 demonstrate that LHCH is Achieving the requirements.

The trust reviewed two services, the targeted healthy lung project and Hypertension case finding in staff. The EDS provides a focus for organisations to assess the physical impact of discrimination, stress, and inequality, providing an opportunity for organisations to support a healthier and happier workforce, which will in turn increase the quality of care provided for patients and service users.

Infection Prevention and Control

Our infection prevention team was increased during the pandemic year of 2020 to ensure front line staff had support and specialist advice. The team continues to play a pivotal role in the Trusts gold command structure within the Trust to provide the assurance that all necessary infection and control measures are in place and are being monitored through the infection prevention and control Board Assurance Framework (BAF).

Elective Service

Throughout 2022/2023, LHCH enhanced its focus on recovering elective activity and reducing waiting times. As of March 2023, the Trust reached its target for no patients waiting over 78 weeks. The Trust will continue to look at reducing waiting times during 2023/2024 (in line with national targets)

To aid with prioritising the most clinically urgent patients for treatment, the Trust continued to use the national patients' classification to ensure there was clinical validation of patients on the waiting list and a clear position on the capacity required to treat urgent patients in priority order.

Diagnostic recovery and DM 01 compliance (6week targets) have been restored in 2022/2023 with continued work in C&M to look to increase capacity working in community diagnostic hubs.

Cancer services across outpatients, diagnostics and surgery have shown steady improvements post the pandemic, however a number of targets remain challenged and will need continued focus and capacity within 2023/2024.

The Trust has developed clear and stretching elective plans for 2023/2024 that will see the Trust exceed pre-Covid levels of activity across all points of delivery and support reducing elective waiting times further.

COVID19 Vaccination Programme and Trust Response to the Pandemic

The 2022 Flu/Covid vaccination campaigns commenced in October 2022 and concluded in February 2023.

A number of methods were deployed to ensure staff had full access to the vaccination, such as: peer vaccinators in each of the clinical areas; administration of the flu vaccine within the vaccination centre along with the Covid 19 vaccination; walk rounds to the areas and drop in at in occupational health.

A comprehensive communications strategy accompanied the campaign.

In the 2022 vaccination campaigns, LHCH achieved 51% for flu and 31% for covid vaccination of staff. While this is the lowest figure achieved for some years, LHCH were not an outlier as other healthcare organisations achieved similar percentages. In regional network meetings, this was attributed to vaccination fatigue as the request for staff to have several vaccinations per year for covid has been ongoing for two years.

The regional network meetings will continue to share learning and ideas for increasing the number of staff who are willing to receive the vaccinations.

The Trust adhered fully to national guidance in respect of infection control including requirements for PPE, testing and management of those testing positive for the virus. Open visiting was reinstated as soon as it was safe to do so recognising the importance of patients be able to see their family and friends.

Mutual Aid and System Working

As part of the Cheshire and Merseyside (C&M) response to Covid the Trust continued to work alongside partners in providing mutual aid across the system for the patients that needed access most. This included Echo, Critical Care support and Cancer diagnostics which ensured that patients within the region could continue to access services when their local Trusts were struggling with demand.

Preparedness and response to Industrial Action

The challenges of Industrial Action during 2022/23 have been managed through our emergency planning and preparedness arrangements, ensuring the priority remained on the safety of our services for our patients and our staff. Support was also provided to staff with an enhanced focus on wellbeing.

The impact of the industrial action is reviewed, and actions continue to be taken to prioritise the most clinically urgent patients on the waiting list first and then by waiting time.

Patient Engagement

Quality of care is at the heart of everything we do. Patients, families, and the public have a greater expectation than ever before about the degree to which they are involved in their care and in how NHS Trusts design and deliver services. At LHCH we recognise that a positive experience during care can lead to positive clinical outcomes. Engaging with our patients, families and carers, enables an understanding of their experiences and learning from them in order to improve service delivery, resulting in an environment where individual patients feel supported and cared for.

Our ambition is to create a culture of continuous improvement and empowerment that is both patient-centered and safety focused. Our Patient and Family Experience Vision is based on 6 steps to ensure quality and safety.

The Trust uses many ways of capturing patient experience, during 2022-2023 we continued to engage with our patients, their families and staff members to improve the quality of care we provide. In the last twelve months we have been able to resume our post covid patient engagement events which are supported by the Executive Team, Non-Executives, Governors and multi-disciplinary staff and Healthwatch have undertaken a Listening Event. This engagement has helped to shape our quality priorities for the year ahead.

The sixth step of the patient vison focuses on Discharge and Aftercare, to ensure that the patient and their family receive on-going support. Since 2020, follow up calls have been made to patients following their discharge home. Patients who have had an overnight stay receive a follow up call post discharge home, to check on their well-being, levels of support at home and to answer any concerns or worries they may have. The response to the calls has been overwhelmingly positive and patients have expressed their gratitude for the call. Key themes for compliments have been that patients have received a high standard of safe care, delivered by a kind, caring and responsive team.

Some of the benefits of the follow up calls have been that the caller has access to staff within the Trust to escalate concerns as well as the ability to resolve issues at the time of the call. The calls provide have also provided the opportunity to address specific patient concerns and escalate them to ward staff, ANP’s or doctor which had helped to improve patient safety, offer advice and support and provided a focus for areas of improvement.

In addition, patient experience is gathered from patient and family shadowing and collecting patient stories. This has helped us to understand the patient and family experience and the key themes from the stories are excellent teamwork and recognition of the Trust has as a centre of excellence.

The Excellent, Efficient, Compassionate and Safe assessments (EECS)

The EECS assessments detail a comprehensive review of clinical/non-clinical standards in wards and departments. The document is located within Tendable which is a tool to collate the evidence in relation to the standards. The assessments are completed by senior leaders within the organisation, independent of the area being assessed. The purpose of the EECS is to ensure that care delivery across our wards, departments and clinical services are monitored as a minimum annually, with the aim of providing assurance of the Trusts standards, to the Board of Directors

During each quarter from October 2021 until September 2022 we assessed each of the four divisions in its entirety, the assessments included:

- EECS assessment
- CQC Self-assessment
- Desk top review of Governance processes
- X2 staff discussion sessions with Human Resources
- Well led interview – triumvirate

The results were outstanding in all areas. This gave us assurance of the quality standards within each division

Each division will have an EECS review meeting where all aspects of the assessment outcome are evaluated. Following this robust action plans are developed, which are progressed through divisional governance structures, until completed.

The focus of the EECS/CQC assessment ensures we gain a divisional overview of care delivery and services. These assessments have become part of the Trust's rolling programme for reviewing the standards expected for ensuring the delivery of high quality and safe care to patients and their families.

FTSU

Liverpool Heart and Chest Hospital is committed to an open, transparent and safe culture. During 2022/23 we have continued with our focus on a culture of openness, honesty and transparency with our patients and their families. The Trust has a Freedom to Speak Up (FTSU) Policy, two designated FTSU Guardians supported by a Deputy, a network of FTSU Champions and designated Non-Executive and Executive Director Leads. During the year the Trust continued to embed the 'Be Civil, Be Kind' work including the Culture Club and Civility Charter, both of which support staff to challenge behaviour and raise concerns to bring about positive change for all.

As Chief Executive, I have made a personal three-point pledge to all staff commencing employment within the Trust, 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 Guardians and Champions
- Daily Trust-wide Safety Huddle led by the Chief Executive and Director of Nursing, Quality and Safety
- 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
- Introduction of Patient Safety Champions across all areas

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 Guardians.

The National Staff Survey results 2022 provide strong assurance on the speak up culture within LHCH.

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 complies with the regulatory requirements by ensuring that where duty of candour is offered it is provided formally by letter, offering support and apology to patients and families.

The Trust has initiated several ways for ensuring consistent application of 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
- requirements within the Datix reporting system to ensure duty of candour is considered and actioned.

Key achievements in 2022/23

LHCH was rated as the top hospital in the north of England and one of the best hospitals in the country for 'overall patient experience' according to the NHS Inpatient Survey, published in September 2022.

- LHCH was rated the top Trust in the country for a 'place to work' and 'staff engagement' in the NHS Staff Survey 2022, published in March 2023.
- LHCH won the Excellence in Public Service HR Award at the Personnel Today Awards 2022 in November 2022.
- LHCH was a shortlisted finalist for Trust of the Year and the Staff Wellbeing Award at the HSJ Awards in November 2022.
- LHCH was a shortlisted finalist for Excellence in Employee Engagement at the HPMA Awards 2022.
- LHCH Consultant Cardiologist, Professor Greg Lip, was awarded the 2023 Distinguished Scientist Award-Clinical Domain by the American College of Cardiology in March 2023.
- LHCH was named winner of the Hospital Security Award in the 2022 Health Business Awards in December 2022.
- 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 2022/23.
- LHCH was awarded the NHS Pastoral Care Quality Award in January 2023.

Current Status

Provider:
Liverpool Heart and Chest Hospital NHS Foundation Trust

Overview and CQC inspection ratings

Overall Outstanding		
Read overall summary	Safe	Good
	Effective	Good
	Caring	Outstanding ☆
	Responsive	Outstanding ☆
	Well-led	Outstanding ☆

Latest inspection: 5th Feb to 7th Feb 2019
Report published: 3rd July 2019

Inspected and rated Outstanding ☆ CareQuality Commission

www.cqc.org.uk/provider/RBQ

Liverpool Heart and Chest Hospital Outstanding ☆
Thomas Drive, Liverpool, L14 3PE
Tel: 0151 600 1616

The CQC performed their relationship reviews on:

- 21st March 2022
- 11th July 2022
- 16th August 2022
- 1st February 2023

No actions for improvement identified following each event.

I am extremely proud of all achievements made during 2022-and into 2023, and we will continue to focus on ensuing 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, OBE
Chief Executive

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

Quality Priorities for improvement

The Quality Priorities looks at the year past and reflects upon the commitment the Trust has made to improve quality.

During 2021/2022 all Trusts were made aware that monitoring of the quality priorities would cease until further notice. Chosen Quality Priorities continue not to be externally audited, at LHCH we continued to monitor those quality priorities carried forward from 2021-2022 into 2022/2023.

Priority One: Sepsis Screening

All patients who trigger for a Sepsis Screening tool will receive an assessment immediately following this criterion-

Why: The fifth step of our Patient and Family Experience Vision focuses on Treatment, this quality priority would be to ensure that the patient receives safe, timely and effective treatment.

What is measured?

- Critical care- evidence of sofa score recorded and compared to baseline
- Ward Evidence of MEWS repeated after 1 hour if score of 3 or more
- Evidence of MEWS of 5 resulting in immediate screening
- Evidence of screening after patient triggers
- Evidence of escalation to doctor/ANP of a positive response.

Results

	Target	Outcome (mean)
• Blood cultures taken within 24hrs preceding first antibiotic given.	95%	94%
• Delivery of at least one sepsis antibiotic within one hour of prescription (LHCH target).	70%	88%
• Delivery of a sepsis antibiotic within three hours of prescription (National Standard)	96%	98%

Priority Two: Follow Up Calls

All in-patients who have an overnight stay in the hospital will receive a follow up call within 7-10 post discharge home.

Why: The 6th step of our Patient and Family Experience Vision focuses on Discharge and Aftercare -ensures that patients receive on-going support and share real time information of their experience.

What is measured? Number of patients who are contacted within 10 days.

Target: 95% of all patients within the criteria

Outcome:

- 95% achieved
- Directorate action plan for improvement.
- Patients feedback on how valuable the one-to-one call has been
- Quick resolve to patient queries and advice provided.
- Realtime mechanism to provide staff feedback on concerns and compliments.

Priority Three: Screening for Delirium

All patients are screened for delirium within 6 hours of admission and have a risk assessment once daily, or on change of ward or condition. If negative, continue to assess once daily.

Those patients who score positive on assessment will have a delirium assessment and management tool added and reviewed once per day.

Delirium Risk Assessment to be completed within 8 hours of Admission and once a day
Delirium Risk Assessment to be completed twice a day when patient has altered mental state.
Delirium Assessment and Management Tool to be completed once a day when patient has altered mental state

Why: The fifth step of our PFEV focuses on Treatment, our ambition is to create a safe environment for patients with delirium and provide interventions to resolve the delirium.

Outcome: Outcome 74% against a target of 90%.
Actions taken

- Information leaflets for patient and families about possibility of & recognising delirium
- Delirium e-learning compliance has remained stable and is above the 80% target and currently stands at 94%.
- Nice Guidance being reviewed

Priority Four: Pre-habilitation booklet for patients

Establish an enhanced recovery pathway which incorporates pre-op education to promote optimisation of patients undergoing cardiac surgery.

Why: The first step of our PFEV focuses on pre care to ensure that the patient and their family understand the care they will receive and are in optimum condition to receive cardiac surgery.

What is measured: The number of patients awaiting cardiac surgery who are provided with pre-operative information and offered interventions to improve wellbeing and outcomes.

Target: 80% of eligible patients

Outcome:

- The wards now provide pre-operative surgical information for non-elective patients (or elective patients who have not attended preassessment clinic).
- Pre-operative videos have been developed and are available online to all patients (ipads on wards)
- 82 % of patients in the current bed base, have received pre-op. information.
- Positive feedback from patients expressing how useful and informative the information has been.
- Reduced the variation in information given to patients depending on their pathway**.**

Quality Priorities for 2023-2024

The Trust held a number of internal and external consultation events which have successively refined its decision making over which priorities to select.

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. For the first time since the start of the Covid 19 pandemic the Trust held a face-to-face engagement event on Tuesday 21st February 2023 those invited were staff, Trust Governors, members of the public, previous patients, our Commissioners and Healthwatch.

At the end of the event all agreed the Quality Priorities to be taken forward into 2023/2024 would be:

Priority One - Discharge Medication
Why:
Our ambition is to create a culture of continuous improvement that is both patient centred and safety focused. The sixth step of our Patient and Family Experience Vision focuses on Discharge and Aftercare, to ensure that the patient and their family receive their medication and have a safe and timely discharge.

Priority Two – Availability and uptake of nutritional snacks
Why:
Our ambition is to create a culture of continuous improvement and empowerment that is both patient centred, and safety focused. The fourth step of our Patient and Family Experience Vision focuses on the patient's stay and ensuring that they receive the optimal nutritional support to enhance their recovery and wellbeing

Priority Three - Discharge equipment
Why:
Our ambition is to create a culture of continuous improvement that is both patient centred and safety focused. The fourth step of our Patient and Family Experience Vision focuses on the patients stay. The aim is to ensure that the patient receives a safe and timely discharge and is provided with the equipment they require at home

Priority Four - Smoking cessation
Why:
Our ambition is to create a culture of continuous improvement that is both patient centred and safety focused. The fourth and sixth step of our Patient and Family Experience Vision focuses on the patients stay and aftercare. The aim is to ensure that patients are offered support during their stay and signposted to community support upon discharge.

Part 2.1 Statements of assurance from the Board

Participation in Clinical Audits

During 2022/23, 20 National clinical audits and 0 National confidential enquiry covered relevant health services that Liverpool Heart and Chest Hospital provides.

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

The national clinical audits that Liverpool Heart and Chest Hospital were eligible to participate in during 2022/23 are as follows in Table 1.

The national clinical audits that Liverpool Heart and Chest Hospital participated in during 2022/23 are as follows in Table 1.

The national clinical audits that Liverpool Heart and Chest Hospital participated in, and for which data collection was completed during 2022/23, 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**
Acute			
1	Intensive Care National Audit and Research Centre (ICNARC)	Yes	The Trust is part of the ICNARC CMP and part of the Cardio-Thoracic sub-group. The data is submitted on a quarterly basis: For 2022/23 submitted data on 2191/2191 (100%) of patients admitted to Critical Care. Q4 is not fully complete yet but all the patients have had a partial submission of data and full submission is almost ready to go for external validation and reporting.

2	Lung cancer (NL CA)	Yes	Data for patients diagnosed in calendar year 2022 is submitted via the trust's monthly Cancer Outcomes and Services Dataset submissions to the National Cancer Registration System. Currently 1,066 (100%) records for suspected lung cancer have been submitted for patients diagnosed from January 2022 to December 2022
Heart			
3	Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Data validation ongoing Final data submission for Apr 2022 – Mar 2023 due 30/06/2023
4	Cardiac Rhythm Management (CRM)	Yes	1380/1684 (82%) cases submitted for pacing and implantable cardiac defibrillators for period April 22 – Jan 23. 1156/1402 (82%) cases submitted for EP for April 22 – Jan 23. Final data submission for Apr 2022 – Mar 2023 due 30/06/2023.
5	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	Yes	Total submission Apr 2022 -Mar 2023 = 429 cases (draft) 211 cases submitted for catheter or surgical procedures. 125 cases submitted for ICD & Pacing procedures 93 cases submitted for Other diagnostic procedures Final data submission for Apr 2022 – Mar 2023 due 02/05/2023
6	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Data validation ongoing Final data submission for Apr 2022 – Mar 2023 due 30/06/2023

7	National Adult Cardiac Surgery Audit	Yes	Data validation ongoing Final data submission for Apr 2022 – Mar 2023 due 30/06/2023 Q1 373 Cases Submitted (100%) Q2 397 Cases Submitted (100%) Q3 368 Cases Submitted (100%) Q4 372 (March Cases not yet Submitted)
8	National Cardiac Arrest Audit (NCAA)	Yes	Total cases 94 Q1 x 32 Cases Submitted (100%) Q2 x 27 Cases Submitted (100%) Q3 x 35 Cases Submitted (100%) Q4 data to be submitted Final data submission for Apr 2022 – Mar 2023 due 31/05/2023
9	National Heart Failure Audit	Yes	Data validation ongoing Final data submission for Apr 2022 – Mar 2023 due 08/06/2023
Long term conditions			
10	National Audit of Cardiac rehabilitation	Yes	Phase 1 cardiac rehabilitation (CR) locally, is provided by Liverpool Heart and Chest Hospital team Trust working on electronic upload from EPR. Referrals from LHCH 1/4/22 to 31/3/23 is 5950 Phase 2 The Knowsley cardiac rehabilitation for community cardiovascular service Referral to Knowsley CR service 1/4/22 to 31/3/23 is 414 with 391 accepting and 360/391 (92%) fully completing the programme

11	Sentinel Stroke National Audit programme (SSNAP) - Post-acute provider organisational audit	Yes	Knowsley service provider 2022/23 Early Supported Discharge & Community Stroke Rehabilitation Data provided from 1st April 2022 to 31st March 2023 <u>Transferred to team</u> Early Supported Discharge: 74 of 116 (64%) of patients referred for ESD have been transferred to the team on SSNAP by acute providers. Some of these patients have completed rehabilitation and some are still on-going with the team <u>Data submitted by team</u> 56 ESD patients had data submitted into SSNAP who were discharged from ESD between 1.4.22 and 31.3.23 47 of these ESD patient have transferred within the service to Knowsley CRT on SSNAP. <u>Transferred to team</u> Community Stroke Rehabilitation (CRT): 62 of 89 (70%) of patients referred for CSR have been eligible to enter onto SSNAP. 40 additional patients have been transferred to CRT within the service from the ESD element. Some of these have completed rehabilitation and some are still on-going with the team. <u>Data entered by team</u> 94 CRT patients had data submitted who were discharged from team between 1.4.22 and 31.3.23

12	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. Liverpool service 1st March 2022 and 28th Feb 2023 Total number referrals accepted and patient's assessed n467 Of these 186 /467 (40%) patients assessed and consented. 186/186 (100%) patients submitted Knowsley service 01/04/22 – 31/03/23 135 patients submitted
13	UK Cystic Fibrosis Registry	Yes	365 /365 (100%) submitted for calendar year 01/01/2022 -31/12/2022 as per the UK CF Registry.
14	Serious Hazards of Transfusion (SHOT)	Yes	The Trust participates with SHOT by reporting transfusion incidents and completing their investigation process. 7 incidents during 2022-23 were reported.
15	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. 0 submitted cases to report as no harms as per the audit criteria.
16	National Audit of Inpatient Falls (NAIF)	Yes	The trust falls lead submitted the Facilities Audit 2022 in March 2022. 0 submitted cases to report as no hip fractures.
17	Learning Disabilities Mortality Review Programme (LeDeR)	Yes	1 submitted case to the Learning Disabilities Mortality Review Programme
18	NHS Blood and Transplant: 2022 National Comparative Audit of Blood Sample Collection and Labelling	Yes	1034 submitted cases from LHCH. The data was completed by Broadgreen Labs and as the data included both Trusts on this site, the LHCH Transfusion Practitioner asked the National Audit lead to acknowledge LHCH had contributed to this audit. This was 100% of the sample size required.

19	National Audit of Care at the End of Life (NACEL)	Yes	19 cases identified, 3 in exclusion criteria, leaving 16/16 (100%) submitted cases as per the audit criteria
20	National Vascular Registry	Yes	Data validation ongoing Final data submission for Apr 2022 – Mar 2023 due 5th May 2023
	Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	N/A	No studies were relevant for LHCH to participate in during the reporting year.
	Total = 20	**Yes = 20**	

The reports of 17 national clinical audits were reviewed by the provider in 2022/23 and Liverpool Heart and Chest Hospital intends to take the following actions to improve the quality of healthcare provided.

Heart - National Cardiac Audit Programme (NCAP) Annual Report 2022 (Published June 2022)
The National Cardiac Audit Programme (NCAP) comprises of the six cardiovascular specialities. The Clinical leads for each area have reviewed their speciality reports.

The National Audit of Percutaneous Coronary Interventions (NAPCI) (Angioplasty audit British Cardiovascular Intervention Society (BCIS)
Similar to MINAP findings below.

Myocardial Ischaemia National Audit Project (MINAP) ('Heart Attack' audit / British Cardiovascular Society (BCS)
Our internally controlled performance measures e.g. Quality Metrics: reviewed by cardiologist, performance of an angiogram, discharged on appropriate medications, referral to cardiac rehab, performance of an echo, remain consistently high.

Problem areas:

1. ST-elevation myocardial infarction (STEMI) – There has been a progressive lengthening of median Call-To-Balloon (CTB) time (150min target) leading to fewer patients receiving PPCI within recommended time (CTB150 53%)
   This reflects the national picture, with progressive delays in ambulance times transferring the patient to the door.
   Cheshire & Merseyside (C&M) are further compromised by having a higher than UK average number of interhospital transfers – so worsening CTB.
   This requires a network approach – and close working with North West Ambulance Service (NWAS).

The PPCI policy was rewritten to emphasise discussion with LHCH for all patients identified as STEMI at a peripheral hospital (aim to reduce unnecessary activation of PPCI pathway). We will also need to re-emphasise consideration of thrombolysis as an alternative to delayed transfer but: it is difficult for referring A&E departments to determine how long a category 2 ambulance will be; there is a lack of familiarity with thrombolysis within those departments which may lead to reluctance; this is a national issue and needs to be addressed comprehensively by NHSE and national AS.

2. Non-STEMI / Acute Coronary Syndrome (ACS) – We continue to fail the target of admission to angiography within 72hrs. This is again a national picture, and one that has not changed for over decade but as a region C&M has the worst UK performance, quantified in this report as 19% achieving the 72hr target.
   We have introduced an accelerated pathway with RLUH, which has reduced length of stay, and are now looking to see how we can widen this to other Trusts.
   The ICS structure should allow us to standardise ACS pathways and streamline diagnosis and referral. Internally we are working on lab capacity via organisational change. Bed capacity remains a huge issue for the division and needs executive recognition. Ultimately the ACS service is a regional issue which cannot be solved by LHCH in its entirety, and a networked approach is required. The regional NSTEMI guidelines are due to be reviewed.

National Heart Failure Audit

- Dedicated HF clinicians including Consultant Cardiologists and HF Specialist nurses within trust. In-reach services to surgical and non-cardiology wards to ensure all patients are considered for appropriate therapies during admission and relevant follow up; often not captured within NICOR data. This due to the Primary reason for admission being a non-Heart Failure procedure or diagnosis (Audit criteria)
- There is a weekly Heart Failure MDT established, offering opportunity to discuss patients to provide timely and evidenced based care. Community Heart Failure teams can dial into this weekly meeting. This allows them to present any cases, and gain treatment guidance and expert consensus on treatment options. There is a Regional Heart Failure MDT Once a month. We can attend this as required.
- We run 2 full day Dedicated Heart Failure Specialist Nurse clinics, offering latest evidence-based therapies. This allows for timely prescribing and follow up as per national Heart Failure guidelines, with support from community teams for patients post discharge.
- In-patient Electronic clinical documents and referral orders prompt appropriate assessments and initiation of therapies during admission.
- These electronic Patient Records allow the team to carry out robust data collection for Audit and service improvement purposes.
- Close links with cardiac rehabilitation and other Specialist Nurse services such as Inherited Cardiac Conditions, Diabetes, Adult congenital and Arrhythmia teams; promoting collaborate care and ensuring appropriate referral on discharge if indicated.
- Benchmarking the LHCH Heart Failure service and comparing our scores this year against the previous 12 months, we are above the National Average. As a service we have also been able to evidence improvement in our score from last year’s figures.

National Audit of Cardiac Rhythm Management
CRM Devices:
LHCH performed >500 PPMs and > 600 complex devices (ICDs+ CRTs)
An 8% drop-in pacing activity and 24% drop-in complex pacing activity was noted.
This was in keeping with trends across the UK during the peak of the pandemic.

CRM Electrophysiology (EP): Catheter Ablation
LHCH performed 395 simple ablations and 434 complex ablations in 2020-2021, this represents a 20% and 37 % fall in activity respectively. Again, this was in keeping with trends during COVID which had a large impact on EP procedures nationally.

National Congenital Heart Disease (NCHDA)
The report shows Actual vs Predicted Survival for the 12 centres in the UK for ACHD. The survival ratio (Actual/Predicted) for LHCH surgery was better than predicted. LHCH was not an outlier and within the acceptable norm with regards to like-for-like centres.
The DQI is an assessment of quality of the data across 4 domains (Demographics/pre-procedure /Procedure/Post Procedure) and gives an indication of the quality of the data submitted by each centre against expected NCHDA Standard.
Good quality = >90%   Excellent quality = >98%

The 20/21 External Validation rated the LHCH DQI was 98.75% which was an improvement from 94.75% in 2019/20. In 2021/22 the DQI has further improved to 99.25% placing LHCH as one of the best adult only hospitals in the UK for data quality. *Scores <90 % are considered a cause for concern.*

National Adult Cardiac Surgery (NACSA)
Patients in the Cheshire, Mersey, North Wales and Isle of Man areas continue to have access to the full range of services at Liverpool Heart and Chest Hospital, despite one of the largest and most deprived catchment areas in the country, and services that continue to draw referrals from around the country.

For many services we are performing at or better than the national average. In other areas, we have some additional work to do to bring us back to the high-quality service that we were offering before COVID, or to streamline our services for patients' benefit.
We have higher than average rates of minimally invasive cardiac surgery, lower than average use of dual consultant exclusion operating, higher rates of mitral valve repair and lower in hospital length of stay.

We seek to improve patient flow from referral to treatment, following the national recovery plan for cardiac surgery with enhancements such as day of surgery admission, telehealth monitoring, and enhanced recovery after surgery.

National Diabetes Inpatient Safety Audit (NDISA) 2018-2021 (published July 2022)
LHCH takes part in the NaDIA Harms audit on a monthly basis. This is led by our Diabetes Nurse Specialist. LHCH has reported no NaDIA Harms since commencing participation in this audit. It is monitored monthly.

The Governance structure surrounding Diabetes in LHCH is Bi-monthly meeting of the Diabetes Steering Group, with clear Terms of Reference, and attendance including, pharmacy, DNS's, Heads of Nursing, Matrons, Clinical Lead for Diabetes, Anaesthesia and Consultant diabetologist. This provides assurance to Divisional Governance and then to the Trusts Governance Committee.

Case Mix Programme (CMP) Adult critical care (ICNARC)

The trust is part of the ICNARC CMP and part of Cardio -thoracic subgroup.
This data is submitted on a quarterly basis
The data shows the unit performing well in the quality indicator dashboard with Unplanned Readmissions the only area of the dashboard in amber. This has been improved over previous years being amber alert rather than as opposed to a red alert.
The expected percentage is calculated using data from all critical care units participating in the case mix programme.

The Trust has a Readmissions to ITU group who meet quarterly, and all readmissions are reviewed by the Trust Clinical lead, Critical Care Matron and Advanced Nurse Practitioner (ANP).
Recent themes show Respiratory FailureType1/2 requiring High Flow Oxygen, Continuous Positive Airway Pressure (CPAP) Support and management of cardiac arrhythmia (including post cardiac arrest).

National Cardiac Arrest Audit (NCAA)
LHCH NCAA Annual Report (published 19/07/2022)

LHCH Q3 NCAA Report 01/04/2022 – 31/12/2022 (published 23/03/2023)

The National Cardiac Arrest Audit (NCAA) is the national clinical audit of in-hospital cardiac arrests in the UK and Ireland. It is a joint initiative between the Resuscitation Council (UK) and ICNARC.

Over 150 acute hospitals in England, Wales, Northern Ireland, Scotland and Ireland actively participate in this audit.
NCAA data are collected for any resuscitation event, commencing in-hospital, where an individual receives chest compressions and / or defibrillation and is attended by the hospital-based resuscitation team (or equivalent) in response to a 2222 call
The LHCH Q3 NCAA Report covering 1st April to 31st December 2022 also specifically by risk adjusted comparative analyses compared the LHCH with four other cardiothoracic hospitals. In this audit period the report details that on average and in all categories especially on 28-day in-patient hospital survival to discharge from Cardiac Arrest, our survival rates are above average compared with all other hospitals including similar Cardio-Thoracic Hospitals to ours. This is

also true for in-patient survival to hospital discharge by both shockable and non-shockable presenting / first documented rhythm.

The SHOT Annual Report 2021 (published July 2022)
On review of the report, the Trust has updated the Transfusion Associated Circulatory Overload (TACO) checklist on the Electronic Patient Record (EPR) system to reflect the updated checklist recommendations as per the annual report.

LHCH have not had any ABO-incompatible red cell transfusions.

Training information and presentations have been updated to include the latest data from the SHOT report.

Sentinel stroke (SSNAP) Post-acute Organisational Audit
A Sentinel stroke (SSNAP) Annual CCG Stroke Dashboard – Knowsley CCG is published each year alongside 6 monthly team reports available on the SSNAP website (Jan-June and July to Dec).

Actions

- Number of Early Supported Discharge (ESD) patients in Knowsley (116) continues to increase each year (2020/21- 102 / 2021/22 - 112). Plan to continue to offer ESD input to all patients who are appropriate and as capacity allows and team to continue to input audit data for Sentinel stroke audit (SSNAP).
- Number of non ESD rehab patients (CRT) patients in Knowsley (89) continues to increase each year (2020/21- 84 / 2021/22 - 74).
- Team are using electronic records - EMIS system. Team access data from EMIS and enter into SSNAP.
- Team are entering data into the new data fields that are now required within SSNAP.
- From 1st April 2023 – on SSNAP the team will be classed as combined ESD-CRT team – this means the team will only have 1 code – C384 and will no longer need to transfer patients within the service to CRT.
- Team attend Cheshire and Mersey Stroke Network ISDN meetings regarding developing stroke services in the region. Team have identified that service development (7-day rehabilitation and access to all disciplines) will involve increased staffing and increased skill mix including addition of Nurse and Psychologist. To progress this the service needs engagement from commissioners – at present Knowsley CVD service is out of contract - with advice from commissioners to continue service at present level. However, it has been advised that further funding is highly unlikely.
- Team to continue to explore use of technology for virtual groups. Virtual Upper Limb group has been ongoing, and a pilot virtual Emotional Adjustment group has been completed. Team are exploring feasibility further groups that may be achievable and beneficial.
- Team have completed and pilot and are now using ISLA care – a secure platform that allows clinicians and patients to securely upload and store photos, videos and forms. Links can be sent requesting patient upload relevant documents and to share resources with patients.

- Team continue to explore development of a vocational rehab pathway as per post-acute audit.
- Team are currently exploring delivery of a walking group for patients – to meet holistic needs – physical, emotional wellbeing, communication and cognition.
- Team to continue to explore relevant patient related outcome measure tools and standardised and formal tools for mood as per post-acute organisational recommendations.
- Team to continue to attend Stroke Network meetings / training sessions.
- Team to utilise stroke specific education framework and any relevant stroke training to identify courses / areas of training

UK Cystic Fibrosis Registry Annual Report 2021 (Published September 2022)
Once again, the Trust's CF Unit performs well above the national average in terms of lung health and nutritional state.

The death rate is very low and the number of people with CF attending the service continues to grow.

The audit did not highlight any gaps in the service which need correcting.
The Trust performs well and has a good national reputation.

National Audit of Care at the end of life (NACEL) (published July 2022)
The report findings provide reassurance that EOL care provision has been consistent and of a high standard with summary scores greater than the national average in the majority of areas. It also highlights the differences in deaths, demographics between a Specialist Trust and nationally. The staff survey has highlighted some concerns in relation to training and being confident in delivering care at the EOL.

Recommendations

- Undertake a gap analysis of EOL training needs may highlight areas for focus in relation to training.
- Develop multi modal mandatory approach with accessible training being essential but also staff require the time to attend training.
- SPCT and ward link nurses require support to assist in the development of confident, competent staff through release of staff for training.

National Audit of Cardiac Rehabilitation Quality and Outcomes Report 2022
Part 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 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 the wider CR network is therefore essential that they are on board with information upload to a national level.

At phase 1 the Trust Cardiac rehabilitation team are delivering more face-to-face contacts at bedside, and endeavour to see all patients that are in the eligible criteria for referral. This consultation provides risk factor and lifestyle advice, referrals to appropriate external agencies and information provision for patients and families. Our primary focus for this year is to support the Cheshire and Merseyside Network to encourage all groups of patients to be referred equitably across the patch – not dependant on post code. Also, to support individual services to offer rehabilitation to wider groups in their services by sharing good practice. We will closely monitor population and stakeholder delver to ensure all our patients are receiving the correct phase of CR recovery and support. We will escalate gaps in service provision and monitor on our risk register.

Part 2

The Knowsley Community Cardiovascular Rehabilitation services submit full patient data to the National audit of Cardiac rehabilitation (NACR). The most recent Quality Outcomes Report published in 2022 shows we have maintained our status of a ‘certified green’ site. Knowsley CVD contract has recently been reviewed and updated to meet the Key performance indicators (KPI) set by PLACE commissioned service provider. We have successfully met all the targets. The borough of Knowsley is one of the most deprived wards in the country. We endeavour to offer the choice of service to our hard-to-reach localities.

The service has multiple facets that encompass titration of medications, lifestyle modification and offer a menu of choice for patients so they can take ownership over their own care. We are offering a choice of home based, centre based, manual led and a hybrid approach to all components of rehabilitation, in order to ensure that all elements of the BACPR standards are met.

Royal College of Physicians Falls and Fragility Fracture - National Audit of In-patient falls (NAIF). (published November 2022)
Any patient who sustains a hip fracture at LHCH should be transferred to the local acute trust A&E department for management of the hip fracture and the receiving trust will submit this admission into the National Hip Fracture Database (NHFD).

It requires the service provider hospital to assign a new fall record to our trust, it is assigned automatically by e-mail from the National Hip Fracture Database (NHFD).

LHCH would then submit data into the National Audit of Inpatient Falls (NAIF) database workstream. The trust falls lead submitted data to the Facilities Audit 2022.

In this report, no LHCH cases are included in the Hip Fracture (NHFD) data. However, the LHCH Falls lead reviewed the NAIF report recommendations for any learning for improvement. LHCH are included in the Facilities Audit 2022.

The report recommended that trusts use the NAIF data to identify areas where their falls prevention activity or post fall management could be improved. They strongly recommended that trusts focus on process measures including NAIF KPIS and the recommendations in the report. They also recommend rapid reflection and learning from fall incidents.

Following review of this report, LHCH are meeting the relevant recommendations. We already have Multi-factorial risk assessments (MFRAs) available. An MDT Falls Steering group in place and every fall is fully investigated through a 72-hour review.
For next financial year, we will use the NAIF KPIs/recommendations and audit our own local falls data to focus on quality improvements for our patients.

Medical and Surgical Clinical Outcome Review Programme:
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
Remeasuring the Units: An update on the organisation of alcohol-related liver disease services
The report was reviewed; however, it is fairly specific to acute general trusts that receive patients with decompensated alcohol related liver disease, which is not relevant to our practise.

The main area of learning for LHCH would be around ensuring an accurate alcohol history is taken for every patient on admission (including pre surgical patients) and those at risk of alcohol withdrawal are identified. This is part of the nursing admission.

The reports of 12 local clinical audits were reviewed by the provider in 2022-23 and Liverpool Heart and Chest Hospital intends to take the following actions to improve the quality of healthcare provided:

Pharmacy audits

Audit	Findings / Improvement work
Oxygen audit	Oxygen prescription and monitoring at LHCH remains sub-optimal and appears to have slipped compared to previous audits (although limitation is small sample size). Following a Multidisciplinary team (MDT) meeting to review the audit findings, an action plan has been developed to improve the picture. This has been partially implemented to date. Oxygen prescribing remains a challenge for most Trusts. LHCH is not an outlier. **Actions:** • Dedicated Oxygen related education at Induction for new doctors/nurses - Respiratory nurse has reviewed induction and preceptorship training and feels it is adequate. Oxygen video needs to be reviewed and updated. ANP training is being constructed and delivered. • Respiratory nurse will do regular spot checks and also identify ward champions • Remind all prescribers about oxygen discontinuation to prevent continuous prescription of oxygen to patients already weaned off. • Conduct audit yearly (added to pharmacy audit planner) • Creation of oxygen alert inside the Ward Round notes • Create modifiable oxygen prescriptions so that prescribers can ensure patients prescriptions match their actual oxygen requirements. Introduction of a new complex deliver option to assist step down from critical care to ward oxygen requirements.
Surgical Prophylaxis Audit	This audit demonstrates good compliance with the trust antimicrobial policy to prevent surgical site infections. 99.78% across the anaesthetist department was achieved. Any non-compliance is visible across the anaesthetic department and in comparison, to previous data, antimicrobial surgical prophylaxis prescribing has overall improved. **Actions** • Continue rolling compliance monitoring • The next surgical prophylaxis audit will include MRSA status of patients, patients undergoing thoracic surgery and a comparison with the results of this audit
Antimicrobial Prescribing audit	This audit is conducted to demonstrate evidence of good antimicrobial stewardship practice and compliance with the Trust Antimicrobial Policy.

	Recommendations include
	Recommendations include • Feedback of results to: - Relevant committees, including antimicrobial stewardship, drug and therapeutics, infection prevention - Prescribers and pharmacists leading within various clinical ward areas via pharmacy bulletin - Junior doctors and ANPs via educational lead pharmacist. During the feedback of these results, a focus on documentation of clinical indications for antimicrobial prescribing must be emphasised. • Other recommendations include the promotion of the recently published National Antimicrobial Intravenous-to-oral switch (IVOS) Criteria for Early Switch guidance. This guidance encourages prompt review within 48-hours of antimicrobial initiation, and this should be incorporated into education and training to prescribers and pharmacists. In turn, the arrangement of teaching to prescribers and pharmacists by the microbiology team on this topic is recommended. • For complicated patient cases where specialist input is appropriate, referral to the microbiology ward round team should be promoted

Infection Prevention and control

An audit programme is in place for the infection prevention nurses to ensure compliance with policies and standards. Results and actions/recommendations have presented to the Infection Prevention Committee and also given to individual areas where relevant. Audits include:

Audit	Improvement work
Surveillance - Cleanliness	A new audit tool and programme to monitor cleanliness across the Trust has been developed in line with the National Standards for Cleanliness. A multi-disciplinary group including infection prevention nurses, matrons and Hygiene service supervisors have performed the audits ensuring a collaborative and standardised approach to monitoring cleanliness. There has been demonstrable improvement in both audit completion across the Trust and the scores obtained.
Patient compliance and satisfaction with decolonisation treatment	The Infection Prevention Nurses (IPNs) undertook a survey and feedback exercise on patient involvement with the decolonisation programme for patients who are given the treatments to use at home pre-operatively. Patients were interviewed, 97% understood the rationale for the intervention and had undertaken the decolonisation regime as instructed, some feedback was received, which will be used to improve the information provided

Infection prevention audits	Infection prevention audits are performed in all clinical areas within the Trust by the IPNs in conjunction with members of ward staff. The audits cover different aspects of infection prevention including decontamination and cleanliness, equipment, waste disposal, sharps handling and linen handling, screening for resistant organisms and isolation precautions. Overall compliance across the Trust was good and where issues were identified feedback and action plans were given to each area.
Surgical site Infection prevention bundle: Hair removal Skin prep Surgical prophylaxis Dressing removal	Aspects of the SSI prevention bundle were audited for patients undergoing cardiac surgery and compliance was usually good for each individual intervention i.e. 90- 100%. For one intervention (adequate hair removal) compliance was relatively low, additional work has been undertaken to improve this and this will continue to be monitored.

Audit	Improvement work
Transfusion Service and Committee Annual Report: Compilation of internal audits undertaken during 2022 relating to compliance with the Trust Transfusion policy	The Hospital transfusion team & committee improvement plan based on audit results 2022-23: • Implementation of a new special requirements process is in progress, and we are now looking at the use of an electronic transfusion request form with special requirements being a mandatory field. • We are participating in the Trust's closed loop system which will introduce electronic bed side checking. • Based on the rejected samples audit and the increase in duplicate samples, it has been highlighted the need for greater staff awareness. Therefore, a poster guideline has been introduced to all wards and departments. • All transfusion training sessions have been updated to capture the learning from audits.
National Safety Standards for Invasive Procedures (NatSSIP). Local Safety Standard for Invasive Procedures (LocSSIP)	**Catheter labs** Regular audits demonstrate good compliance with LocSSIPs • To continue to monitor NatSSIPs and LocSSIPs in all divisional governance work plans • Ensure robust processes are in place to share outcomes and learnings from NatSSIPs and LocSSIP audits – both within the department and Trust wide. • To improve areas of lower compliance of mandatory training regarding NatSSIPs. • To continue to monitor and improve the debrief process and recording within the catheter labs, with structured questions within Carecube.

	• Continue to identify non-compliance with sign out and engage with individual staff. • Improve clinician engagement with debrief- working with clinical leads. Theatres Current audits demonstrate overall good compliance with NatSSIPs within the theatre departments with key areas requiring improvement identified with clear actions in place to improve this. • An increased frequency of full reporting to divisional board – in addition to monthly reporting will be commenced alongside staff education and feedback. Monthly compliance is shared in various forums within theatre. • The division is also reviewing the Care Cube system and whether this system would be beneficial to the theatre department. • The planned peer review of NatSSIPs will support further assurance on compliance for both divisions. • Work is ongoing to implement NatSSIPs 2 which have been published in January 2023.
Fasting Compliance – Surgery	The audit demonstrates improvements in fluid fasting to 95% compliance, supporting the evidence that sips to send (patients allowed to drink sips of water until the point of transfer to theatre) had been embedded in the Trust for patients undergoing a surgical procedure. This will have a positive impact on the comfort of our patients prior to surgery. Food fasting compliance has been demonstrated to be delivering a static positive performance between 78-80 % compliance. This is similar to the previous year. • A plan to reintroduce monthly interrogation of the data through divisional board, will enable the division to target the areas where compliance could be improved.
Fasting Compliance – Medicine	Fasting compliance within medicine remains poor and continues to be an area of focus for improvement **Recommendations** • Ensure one source of audit information to allow consistency. To obtain the required data for cardiology patients undergoing a procedure in catheter labs that requires a general anaesthetic, the cath lab's integrated digital workflow system Care Cube is interrogated by the cath lab matron. Work is ongoing to correlate this with data taken from EPR following changes to key

	documents as there was no consistent way of recording this. • New band 4 roles have been established within cath labs to support improved communication and flow between the wards and labs and these staff should also be able to communicate any changes to lists, an ongoing challenge when timing fasting for medicine patients. • Patient choice continues to affect compliance as patients attending on the same day for the same procedure with the same information and TCI letter present with very different fasting compliance. The 'Perfect Ward' matron's audit has recently been updated to include patient questions regarding knowledge of fasting plans and will be used to support the ongoing improvement work.

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 especially the ability to use and generate research knowledge (NHS Confederation, 2010).

As a specialist provider, LHCH can undertake 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.

LHCH is dedicated to improving access to research for all patients across the organisation. It therefore has a good research portfolio for respiratory and cardiology research. These are outlined below.

Research Achievements

In 2022/23 LHCH recruited 927 participants across 5 Specialities. While this is less than some previous years, a decrease was expected. The decline is partly because in some previous years LHCH were sponsoring a very high recruiting trial (ARCH – 2000 participants), which raised recruitment numbers significantly. Additionally, some of the studies that were thought to be relatively high recruiting studies LHCH were unable to recruit as expected.

28 *new* studies were opened in 2022/23; 17 for Cardiovascular, 4 for Respiratory, 3 for Cancer, 3 for Surgery, and 1 for Stroke. In total we had 53 studies open in 22/23, either in recruiting or follow-up phase. This is a large number of studies for the size of the Trust, and the size of the research team.

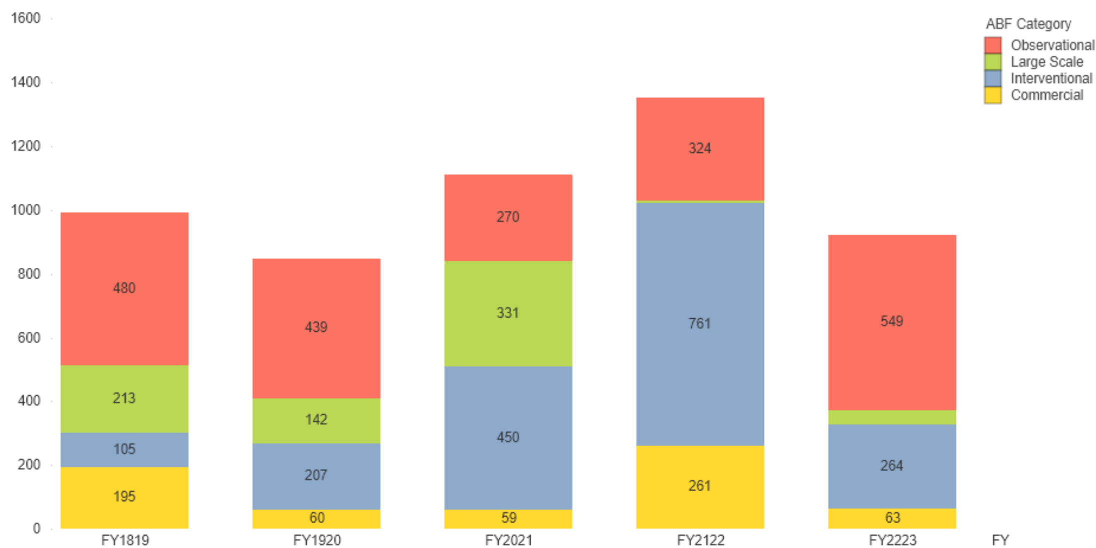


Chart 1: Recruitment per financial year for LHCH, split according to study category.

Liverpool Clinical Research Facility (CRF)

In September 2022, Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH), Liverpool University Hospitals NHS Foundation Trust (LUHFT), and The Clatterbridge Cancer Centre NHS Foundation Trust (Clatterbridge) formally commenced their NIHR Clinical Research Facilities collaboration (after being one of the winners of the CRF competition in 2021).

The partners have long standing relationship with both academia and industry, and as LUHFT holds one of only two MHRA Phase 1 accredited units in England and Wales, this partnership allows for early phase studies in cancer, heart disease and infection, with leading clinical researchers at the top of their specialist field. The true aim of the collaboration is to address the collective needs of our local population and provide better, safer medicines. The combined facilities will allow us to attract cardiothoracic and cancer research up north – in line with health and population needs, and increased benefits to patients and staff.

We are well on our way to achieve our first-year objectives, despite only being 6 months in. Since September we have hired key staff members, made significant headway with a governance structure that promotes cross- working and less organisational bureaucracy, set up operational and oversight meetings and committees, and are in the process of opening our first (Phase 1) cross-site Trial.

Strategic R&I committee

The first meeting of the Strategic R&I committee was held in March 2023. The Committee will advise on, contribute, and direct the Trust's Research and Innovation Strategy, integrated with the University of Liverpool, Liverpool John Moore's University and other key Higher Education Institutes and partners, and aligned to system priorities.
The Committee will provide assurance onto the Board on the effective implementation of the Trust's Research and Innovation strategy to deliver world-class translational and clinical research in conjunction with partners. In our first meeting we reviewed and accepted the Terms of Reference for the committee, reviewed the Research Strategy, ongoing and planned research projects, the CRF, and other partners and relationships.

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. Acknowledging the importance of innovation, it has been incorporated into the Trusts five-year strategy and forms one of the six core strategic objectives: Advancing Quality and Innovation, sitting within the portfolio of the Innovation and Strategic Partnerships team.

Goals agreed with commissioners

LHCH delivered strong performance against financial and operational targets for 2022/23.

As the NHS continued to manage the response to the COVID-19 pandemic, the financial arrangements with commissioners were simplified. Payment by Results (PbR) continued to be suspended and English and Welsh commissioners paid the Trust block contract payments reflective of their average 2019/20 spend, with additional payments for high-cost drugs above a specific baseline. The Isle of Man was the only commissioner who maintained a full PbR contract in 2022/23. CQUIN payments are included within these block payments and guidance stated that assessment of performance would be made at the end of the financial year with possible payment variations being enacted for non-achievement. It has been agreed that this will not be transacted for providers within the Cheshire & Mersey ICB or through the NHSE specialised services contract.

Additional payments were received to support elective recovery and address the increase in waiting lists that have built up during the pandemic.

Further details are available upon request from Susan Pemberton, Director of Nursing and Quality (e-mail 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 2022/23.

Liverpool Heart and Chest Hospital has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period 2022/23.

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

Data quality

Liverpool Heart and Chest Hospital submitted records during 2022/2023 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.

Liverpool Heart and Chest has taken the following actions to improve data quality governance:

- A new DQ strategy has been developed and signed off for 2022-2025
- The DQ Policy has been updated in 2022
- The Trust has formed a Data Quality Steering Group to oversee the DQ Programme delivery

The Trust will continue to work with commissioners through issues identified in the challenge packs and other sources and places a continued and growing importance on Data Quality.

Data Quality Maturity Index (DQMI)

This index is utilised by NHS Digital as a holistic assessment of an organisation's data quality; for the year 2022/23 the Trust DQMI was 98.7. In total 612 'data providers' are incorporated in the DQMI assessment, and the Trust result was positioned in the top 10% (n=38)

Secondary Uses Data Quality
The statistics for the year 2022/2023 are as follows:

(Outpatient Care submission)

Data Item	Provider Total	Provider % Valid	ICB* % Valid	Region* % Valid	National % Valid
Admin Category	104,478	100.0%	99.9%	98.4%	99.0%
Attendance Indicator	104,478	99.5%	99.9%	99.6%	99.6%
Attendance Outcome	77,157	100.0%	98.9%	98.6%	97.6%
Commissioner	104,478	100.0%	99.9%	97.8%	97.8%
Consultant	104,478	100.0%	98.6%	99.2%	94.6%
Ethnic Category	104,478	100.0%	95.0%	94.7%	93.0%
First Attendance	104,478	100.0%	100.0%	99.9%	99.7%
Main Specialty	104,478	100.0%	99.9%	99.8%	98.8%
NHS No Status Indicator	104,478	99.9%	100.0%	100.0%	99.9%
NHS Number	104,478	99.9%	99.9%	99.9%	99.8%
Org of Residence	104,478	99.5%	99.9%	99.5%	94.1%
Patient Pathway	102,832	100.0%	77.7%	66.9%	66.8%
Person Birth Date	104,478	100.0%	99.6%	99.8%	99.8%
Person Gender Current	104,478	100.0%	100.0%	100.0%	100.0%
Postcode	104,478	99.9%	99.9%	99.9%	99.9%
Primary Procedure	77,157	100.0%	99.8%	99.8%	99.5%
Priority Type	104,478	100.0%	99.7%	94.1%	95.2%
Referral Received Date	104,478	100.0%	99.8%	95.9%	95.1%
Referral Source	104,478	100.0%	100.0%	98.3%	97.9%
Registered GP Practice	104,478	99.8%	97.9%	99.0%	99.5%
Site Code of Treatment	104,478	99.8%	93.2%	96.3%	97.4%
Treatment Function	104,478	100.0%	100.0%	98.9%	99.0%
Overall	**2,242,228**	99.9%	**98.2%**	**97.2%**	**96.6%**

(Inpatient care Submission)

Data Item	Provider Total	Provider % Valid	ICB* % Valid	Region* % Valid	National % Valid
Admin Category (On Admiss)	13,302	100.0%	99.7%	99.9%	99.9%
Admin Method (Hosp Prov Spell)	13,302	100.0%	100.0%	100.0%	100.0%
Commissioner	13,302	100.0%	99.8%	98.5%	98.6%
Consultant	13,302	100.0%	100.0%	99.3%	98.1%
Discharge Dest (Hosp Prov Spell)	12,318	100.0%	100.0%	100.0%	100.0%
Discharge Meth (Hosp Prov Spell)	12,318	100.0%	100.0%	100.0%	100.0%
Ethnic Category	13,302	100.0%	97.6%	97.0%	94.8%
Main Specialty	13,302	100.0%	100.0%	100.0%	99.9%
NHS No Status Indicator	13,302	99.9%	100.0%	100.0%	99.7%
NHS Number	13,302	99.9%	99.9%	99.8%	99.6%
Org of Residence	13,302	99.4%	99.8%	99.7%	95.8%
Patient Classification	13,302	100.0%	100.0%	100.0%	100.0%
Patient Pathway	7,686	71.1%	75.6%	75.3%	69.2%
Person Birth Date	13,302	100.0%	99.5%	99.8%	99.9%
Person Gender Current	13,302	100.0%	100.0%	100.0%	100.0%
Postcode	13,302	99.9%	100.0%	99.9%	99.9%
Primary Diagnosis	13,300	100.0%	97.2%	97.7%	96.6%
Primary Procedure	13,300	100.0%	100.0%	100.0%	99.8%
Registered GP Practice	13,302	99.9%	99.9%	99.9%	99.7%
Site Code of Treatment	13,302	100.0%	100.0%	99.8%	97.6%
Treatment Function	13,302	100.0%	100.0%	100.0%	99.9%
Overall	**271,754**	**99.1%**	**99.3%**	**99.2%**	**98.5%**

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:

	Admitted Patient Care	Outpatient Care
Valid NHS Number	99.9%	99.9%
Valid General Medical Practice Code	99.8%	99.9%

Data Security and Protection Toolkit Assessment Report Attainment Levels*

	Audit Result
Primary Diagnosis	98%
Secondary Diagnosis	96.60%
Primary Procedure	98.35%
Secondary Procedure	97.50%

The DSPT baseline assessment was submitted in February 2023, with the final submission to be completed in June 2023. The submission process is supported by an independent 2-phase audit process with Mersey Internal Audit Agency with an assurance opinion provided regarding robustness of evidence and information risk management. It is anticipated the Trust will submit a fully compliant return.

The information governance function continues to work collaboratively in partnership with Alder Hey to further strengthen and enhance processes and controls across all areas of information governance. Outputs and delivery of the information governance work programme are monitored through the Trusts governance and committee structures. There have been no reportable data security incidents during 2022/23.

Clinical Coding Error Rate

The annual external Clinical Coding Audit which 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 to meet mandatory or advisory levels.

The results of Clinical Coding Audit 2022/2023 for LHCH found the following level of coding accuracy:

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.

Part 2.2 Statements of assurance from the Board

During 2022/23, 182 LHCH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 50 in the first quarter;
- 48 in the second quarter;
- 34 in the third quarter;
- 50 in the fourth quarter

By 31/03/2023, 175 case record reviews and 36 investigations have been carried out in relation to the 182 deaths included in Note 1.

In 36 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;
- 48 in the second quarter;
- 34 in the third quarter;
- 43 in the fourth quarter

6 deaths representing 3% 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;
- 2 representing 4% for the second quarter;
- 1 representing 3% for the third quarter;
- 1 representing 2% 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).

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.

- Myocardial protection during surgery
- Post-operative tamponade management
- Delays in surgery and cardioplegia – review of waiting times/patient pathways/Harm reviews
- TOE use post cardiac surgery should be entered into the Anaesthetic and Critical Care Echocardiography Policy
- Development of acute inpatient cancer pathway

- Appointment of a Medical Clinical Lead for Cancer Services
- Improved internal processes for listing urgent surgical patients
- Encouragement of all cardiac surgeons to manage the OnBase referrals in a timely fashion and for cross referrals to be made early in the patient's journey.
- Management of waiting lists to allow a more equal distribution between surgeons, thereby ensuring shorter waiting times.
- Quality of referral investigations should be adequate, appropriate, and complete before the case is allocated for surgery.

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 the above issues have been actioned and education delivered or are being addressed.

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.

Three case record reviews completed after 31/03/2022 which related to deaths which took place before the start of the reporting period.

Nil 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.

Six deaths representing 3% of the patient deaths during 2022/23 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)

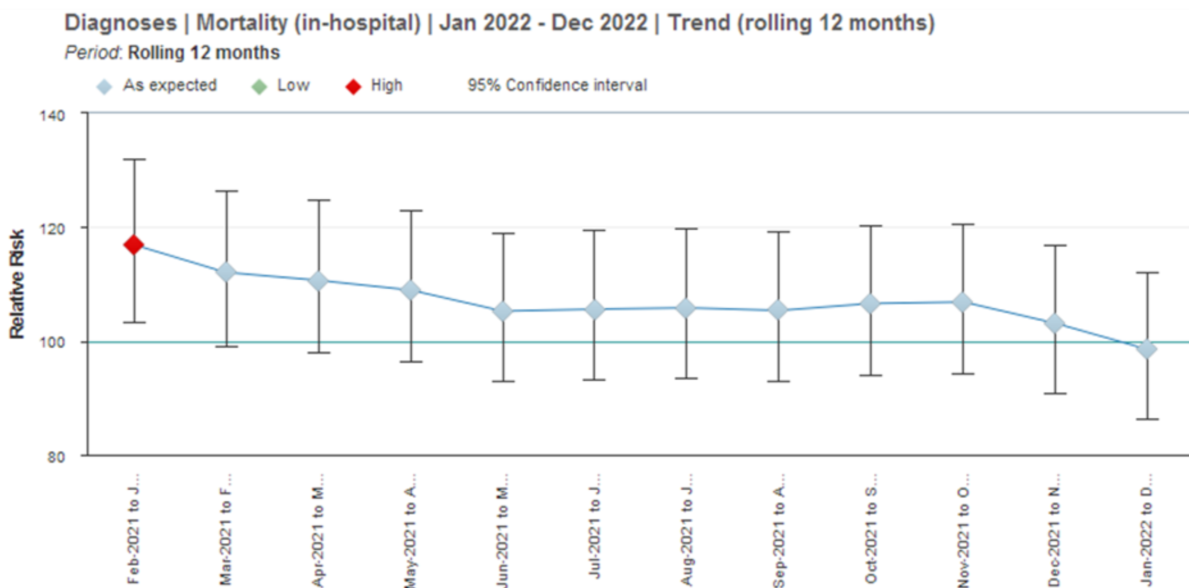
Liverpool Heart and Chest Hospital considers that this data is as described for the following reasons:

- 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.

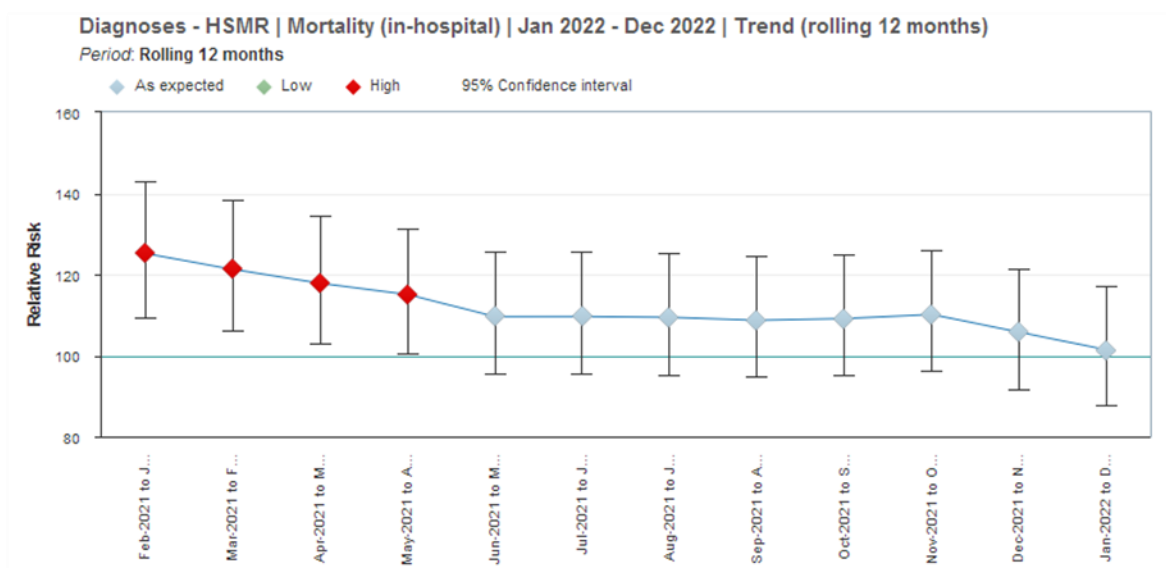
To achieve statistical significance using confidence intervals:

- 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'.

LHCH had alert for HSMR from February 2022. In response a multidisciplinary mortality improvement group was formed, and a divisional mortality action plan developed. The MIG focussed on wide ranging drivers of mortality and there has been a consistent improvement in the HSMR. The main drivers of mortality were due to acute transfer of sick patients/cardiac arrests on the PPCI pathway. Various measures have been put in place to ensure appropriate treatment pathways are followed.



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.
- Continue the focus on mortality through the MIG and deliver the divisional mortality improvement plans

Readmission Within 28 days of Discharge

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

	Performance 20/21	Performance 21/22	Performance 22/23
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 (Apr-Mar): 6.9% (RR: 109.8) Non-elective (Apr-Mar): 12.7% (RR:93.98) Total (Apr-Mar): 9.3% (RR: 101.5)	Elective (Apr-Mar): 5.9% (RR: 99.9) Non-elective (Apr-Mar): 10.3% (RR:81) Total (Apr-Mar): 7.6% (RR: 89.3)	Elective (Apr-Oct): 4.9% (RR: 84.8) Non-elective (Apr-Oct): 9.1% (RR:76.1) Total (Apr-Oct): 6.2% (RR: 80.5)

Responsiveness to personal needs

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 related to discharge and overall LHCH was second in the country for the question: "Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?"

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

- Question: "*Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?"*

	Performance 19/20	Performance 20/21	Performance 21/22
Trust's responsiveness to the personal needs of its patients during the reporting period	8.7	8.8	9.4

The results for 2021/2022 were much better than previous years as staff implemented

- systematic training of teach back to all new personnel appointed to a role that involves discharging patients
- ensuring patients had received all the information they required before being discharged

Staff recommending the Trust to family and friends

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

	Performance 20/21	Performance 21/22	Performance 22/23
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would be happy with the standard of care provided by this organisation	92%	91.6%	90.62%

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 by the learning and sharing of information pivotal in preventing harm and sharing good practice. Other mechanisms within the Trust are safety huddle, 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 remains high there is a slight increase in performance. The data is taken directly from each patient's electronic record of care.

	Target	Performance 20/21	Performance 21/22	Performance 22/23
The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period	95.0%	93.97%	95.65%	95.11%

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 VTE through root cause analysis and feedback of lessons learned.
- Identification of assessments not undertaken and reasons why
- Introduction of a more contemporaneous system of monitoring for compliance, with regular ward level feedback and targeted interventions for areas that are in need.

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 2022/23.

	Target	Performance 20/21	Performance 21/22	Performance 22/23
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	11.72	11.98	5.72

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, and isolation precautions adhered to
- ensuring a robust surveillance system is in place.

Patient Safety Incidents

	Target 20/21	Performance 20/21	Target 21/22	Performance 21/22	Target 22/23	Performance 22/23
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.	Slightly below target	1523 patient incidents 24.44 per 100 admissions (6,231 admissions) 7 (0.46%) resulted in severe harm or death	Target achieved	1573 patient incidents 11.97 per 100 admissions (13,133 admissions) 18 (1.14%) resulted in severe harm or death	Target achieved	1567 patient incidents 11.55 per 100 admissions (13,563 admissions) 17 (1.08%) 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:

- Development of a quality and safety strategy aligned to The NHS patient strategy
- Safety culture survey for 2022- 2023
- Appointment Medical Trust Safety Lead.
- Monitoring of the Trust's vision for safety – Safe from Harm
- Monitoring of the Speak up Safely campaign

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

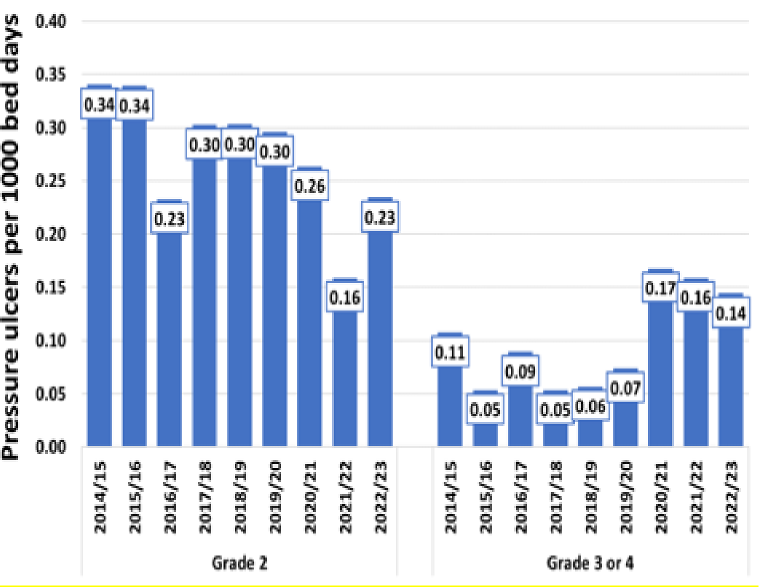
This section of the Quality Account presents an overview of performance in areas not selected as priorities for 2022/23.

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

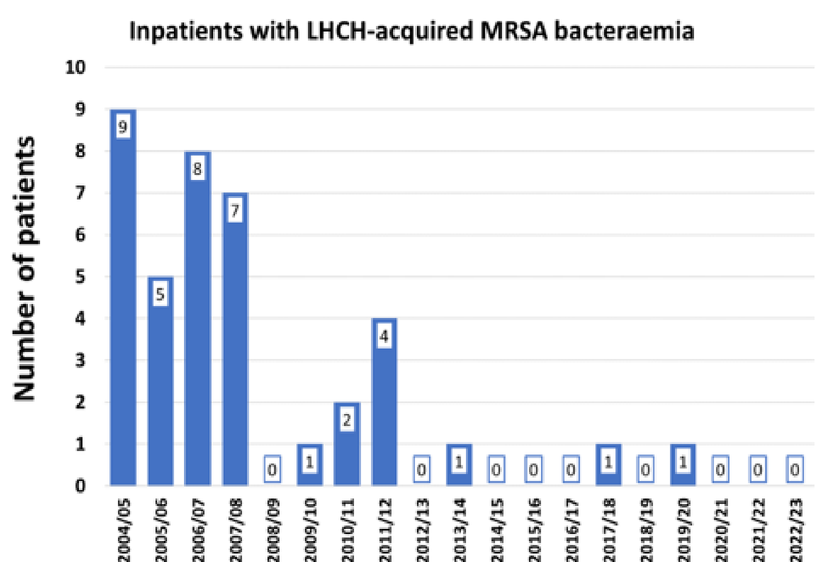
Safety				
Metric	Pressure ulcer incidence	**Organisation Wide or Service Specific**	Organisation Wide	
Derived From	Referrals to the Tissue Viability Specialist Nurse	**Why metric chosen**	Pressure ulcers are painful for patients and contribute to a negative patient experience. Nursing high impact action	
How is data collected	Staff who observe a pressure ulcer report this to the Trust's Tissue Viability Service for treatment	**Improvements planned**	1. Continued staff education 2. Establishment of the Pressure Ulcer Bundle with a focus on pressure ulcer prevention	
LHCH Performance 2022/23	Grade 2 = 0.23 (n = 13 in the year) Grade 3+ = 0.14 (n = 8 in the year)	**LHCH Performance 2021/22**	Grade 2 = 0.16 (n = 8 in the year) Grade 3+ = 0.16 (n = 8 in the year)	
Interpretation of Results	A large reduction in pressure ulcers occurring in our patients has been observed during 2019/20. The volume of Grade 3 and above pressure ulcers is reported similar performance from 2021/22 to 2022/23. 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.			

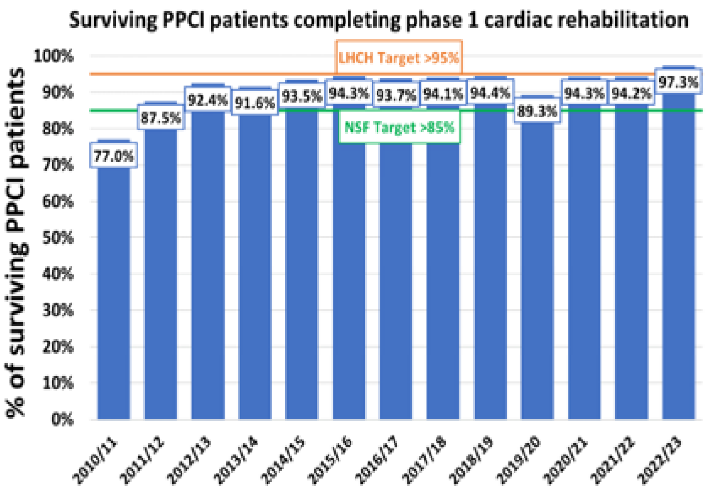
Safety				
Metric	Number of inpatient falls	**Organisation Wide or**	Organisation wide	
Derived From	Incident reporting	**Why metric chosen**	Falls have the potential to cause significant harm. Nursing high impact action	
How is data collected	Staff who witness or become aware of a fall report this via the Trust's risk management processes	**Improvements planned**	Embedding of Comfort Checks in wards- Call don't fall initiative, scoping meetings to prevent falls RCA for all sever harm falls-	
LHCH Performance 2022/23	0.96% (130 falls in 13,579 admissions)	**LHCH Performance 2021/22**	0.68% (90 falls in 13,139 admissions)	
Interpretation of Results	The rate of falls occurring in 2022/23 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.			

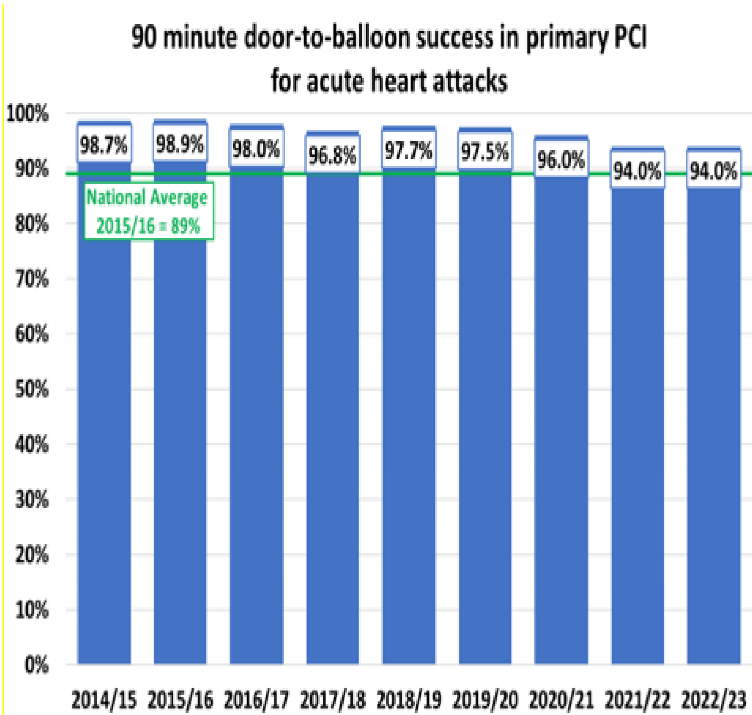
Falls incidents in admitted patients

Year	% All admitted patients
2013/14	0.62%
2014/15	0.73%
2015/16	0.67%
2016/17	0.71%
2017/18	0.65%
2018/19	0.51%
2019/20	0.51%
2020/21	0.66%
2021/22	0.68%
2022/23	0.96%

Safety			
Metric	Number of patients acquiring MRSA bacteraemia 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 will continue with the processes previously put in place: Surgical site infection check MRSA screening audits Central lines bundle
LHCH Performance 2022/23	0 patients	**LHCH Performance 2020/21**	0 patient
Interpretation of Results	The Trust has achieved an excellent result with no cases of MRSA in 2022/23		



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 KPIs.	
LHCH Performance 2022/23	97.3%	**LHCH Performance 2021/22**	94.2%	
Interpretation of Results	2022/23 sees performance exceed the target of 95% for the first time. Maintaining standards will be the aim moving forward.			

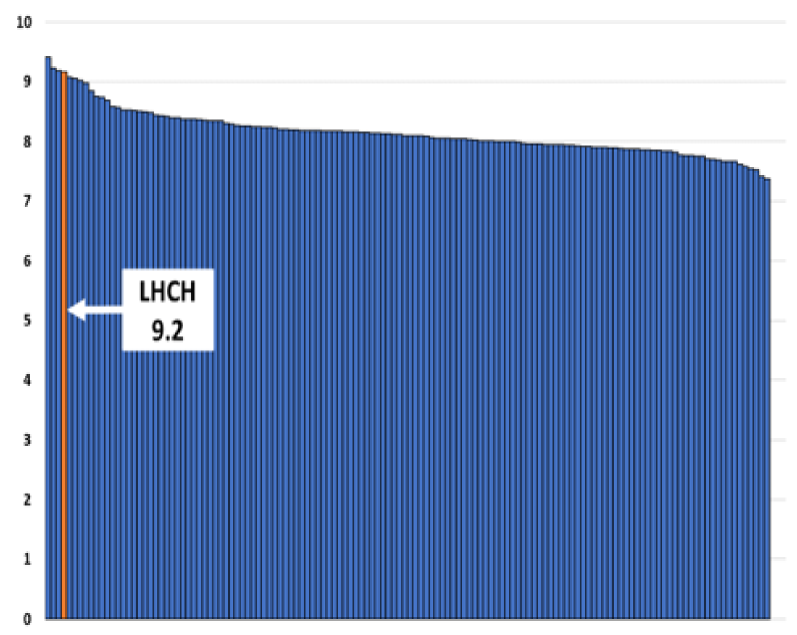
Effectiveness				
Metric	% patients with heart attack receiving treatment within 90 minutes of arrival (door to balloon time)	**Organisation Wide or Service Specific**	Service specific - Cardiology	
Derived From	Local audit figures	**Why metric chosen**	Service has expanded this year, so need to ensure 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 2022/23	94.0%	**LHCH Performance 2021/22**	94.0%	
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.			

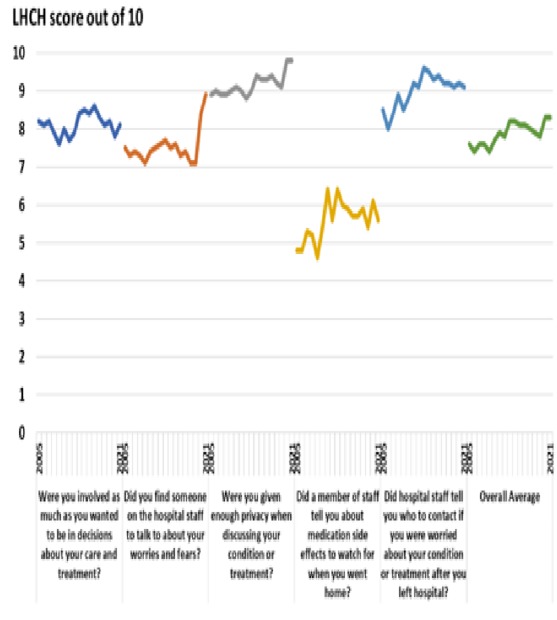
Effectiveness			
Metric	% of patients who received a copy of their discharge summary to the GP	**Organisation Wide or Service Specific**	Service specific – Support Services
Derived From	Nursing Discharge Checklist in the Electronic Patient Record	**Why metric chosen**	Patients should receive a copy of 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 2022/23	88.5%	**LHCH Performance 2021/22**	82.8%
Interpretation of Results	The proportion of patients receiving a copy of the discharge summary has increased slightly compared to the previous year, this was a targeted improvement regarding uptake of the discharge documentation.		

Patients given a copy of the discharge summary

Year	% all admitted patients
2014/15	87.0%
2015/16	88.0%
2016/17	66.8%
2017/18	81.2%
2018/19	88.8%
2019/20	85.7%
2020/21	82.9%
2021/22	82.8%
2022/23	88.5%

Patient Experience				
Metric	Dementia screening, assessment and	**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	
How is data Collected	By nursing staff in ward at assessment and entered into Electronic	**Improvements planned**	Dementia awareness training	
LHCH 2022/23	98.57%	**LHCH 2021/22**	98% 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	National 2022 data not available until later in 2023 2021 graph below: 
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 2022/23	Performance available later in 2023	**LHCH Performance 2021/22**	9.2 (92%)	
Interpretation of Results	LHCH continues to have positive feedback from patients, where actions are needed plans are put in place			

Patient Experience				
Metric	Responsiveness to patients needs	**Organisation Wide or Service Specific**	Organisation wide	National 2022 data not available until later in 2023 2021 graph below: 
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	
LHCH Performance 2022/23	Performance available later in 2023	**LHCH Performance 2021/22**	8.3 (83%)	
Interpretation of Results	LHCH continues to have positive feedback from patients, where actions are needed plans are put in place .			

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 2020/21	Performance 2021/22	Performance 2022/23
Maximum time of 18 weeks from point of referral to treatment in aggregate- patients on an incomplete pathway	92%	70.32%	79.59%	77.84 (YTD) 72.56% (*M12 position*)
All cancers: 62 day wait for first treatment from urgent GP referral for suspected cancer	85%	96.9%	95.1%	69.2%
All cancers: 62 day wait for first treatment from NHS cancer screening service referral	90%	N/A	N/A	N/A
C. Difficile variance from plan	4	5	6	3
Hospital Standardised Mortality Ratio (HSMR)	<=100	112.3 (All diagnoses Apr-Mar) 113.4 (HSMR diagnoses, Apr-Mar)	110.3 (All diagnoses Apr-Mar) 117.4 (HSMR diagnoses, Apr-Jan)	94.8 (All diagnoses Apr-Jan) 98.6 (HSMR diagnoses, Apr-Jan)
Maximum 6-week wait for diagnostic procedures	99%	60.69%	98%	98.69% (YTD) 99.45% (*M12 Position*)
Venous thromboembolism (VTE) risk assessment	95%	93.97%	95.65%	95.11%

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

- Continuous improvement of the Trust’s vision for safety – Safe from Harm
- re-enforcing the FTSU campaign
- Quality and Safety Strategy updates to reflect progress on safe care which is patient focused.

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

Statement from NHS Liverpool ICB

Cheshire & Merseyside (C&M) Integrated Care Board (ICB) Place representatives along with NHSE/I Specialist Commissioning welcome the opportunity to jointly comment on the Liverpool Heart & Chest Hospital NHS Foundation Trust Draft Quality Account for 2022/23.

C&M ICB Places were both impressed and assured with the Trust presentation at the Quality Accounts 2022/23 presentation event on Thursday 18th May 2023.

The Trusts continued CQC status as 'Outstanding' is commended by the C&M ICB, alongside its participation in National Clinical Audits and continued participation in Clinical Research Programmes.

Positive patient experience and staff experience continues with the Trust achieving some of the highest Patient Experience ratings in the country for both patient and staff categories. The number of Trust staff that have either won or been nominated for national awards is also noted by the C&M ICB.

The Trusts achievements regarding their Quality Priorities for 2022/23 are noted, with particulate reference to sepsis screening, follow up calls post-discharge, and pre-op rehabilitation education. The Trust was open and honest regarding compliance with the completion of the delirium and assessment management tool with recognition to further improve compliance and continue to focus on this area again in 2023/24.

The Trust provided assurance regarding its Freedom To Speak Up (FTSU) culture within the Trust which is commendable and another example of providing positive staff experience.

The focused quality priorities for 2023/24 demonstrate a holistic approach to improving patient experience, with a clear rationale as to why these priorities have been chosen and the desired outcome(s).

The C&M ICB will be monitoring the implementation of the national Patient Safety Incident Response Framework (PSIRF) by the Trust in 2023/24, with appropriate reference to this by the Trust in the 2023/24 Quality Account.

On behalf of the C&M ICB I would like to thank you for the Trusts work in 2022/23 and continued work to improve patient care in 2023/24.

Helen Meredith,
Associate Director of Quality & Safety Improvement C&M ICB @ Knowsley Place
6th June 2023

Statement from the Trust's Council of Governors

I have read and reviewed the LHCH Quality Report for 2022/23 and the complexities within the FT and the procedures carried out by 'Team LHCH' are incredible. The proactive collaborative support by the LHCH Board for C&M ICB is clearly demonstrated not only by our additional financial contribution to the ICS deficit, but also by the (part time) secondment of our CEO, Jane Tomkinson (and other directors), to assist in reinforcing "good practice" and leadership at The Countess of Chester Hospital, but without compromising the well-established effectiveness of LHCH.

With the main impact of Covid-19 behind us in 2022, LHCH planned to reduce "the backlog", as well as encompassing mutual aid programmes with other local hospitals, but latterly, industrial action frustrated this goal.

The LHCH Quality Report 2022/23 documents an extensive range of the hospital's practices and principles to ensure the safe care of patients and their families whilst importantly recognising the wellbeing of our staff. The vast majority of our practices meet or exceed national minimum standards, but where there is a shortfall, 'learning' is readily actioned to help restore standards. That said, Inpatient & Staff Surveys show the impeccable standards which LHCH consistently achieves in these critical feedback areas. Eliminating or reducing a range of inequalities in the community is also a priority for LHCH, along with actively promoting a proactive approach to Equality, Diversity, Inclusivity and Belonging (EDIB).

In April 2022, Val Davies assumed the role of Chair, succeeding Neil Large. Val has made an invaluable contribution in her first twelve months in post, despite a challenging year, especially promoting the identity of LHCH within the ICS, ICB, CMAST and other regional organisation's, whilst strongly fostering collaborative principles within Cheshire and Merseyside. The governance of the hospital is overseen by the Audit, Quality, People, Integrated Performance Committees as well as the newly created Research & Innovation Committee. All of these committees are chaired by our experienced NED's, who ensure independent oversight of the hospital policies and priorities.

With the reduced risk of Covid-19 it was deemed safe to begin to hold some LHCH Governor Meetings 'face to face', though some have remained virtual or hybrid. 'Walkabouts' to wards and departments have returned to the agenda for governors, as have PLACE, 'Friends & Family' events, and participation in LHCH Quality Priorities. Additionally, Community & Recruitment events are now mainly 'face to face', though some are still held virtually.

Importantly, 'Walkabouts' reinforce, firsthand, to governors the excellent care we offer to our patients every day. Conversely, 'Walkabouts' also demonstrate the visibility and commitment of our governors to our frontline staff.

The Annual Members Meeting was held 'face to face' on the 26th September 2022 and was attended by public governors, staff governors, LHCH members, the Board of Directors, LHCH staff and our external auditors, Grant Thornton LLP. The meeting received a review of the Council of Governors activities, including a resume from the Membership and Communications Committee, as well as the annual Audit Report from Grant Thornton.

The Council of Governors recognises the commitment and positive impact of 'Team LHCH' which makes the hospital so successful; this includes not only The Board, but Management, all front-line staff, administration & support staff as well as volunteers.

Trevor Wooding
Senior Governor, Liverpool Heart & Chest Hospital
16th May 2023

Statement from Healthwatch

Healthwatch Liverpool welcomes the opportunity to comment on this 2022-2023 Quality Account for the Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH). At Healthwatch Liverpool we recognise the challenges faced by LHCH during the past year from addressing post-covid backlogs and the increased needs for diagnosis and treatment whilst also dealing with repeated NHS strikes. We applaud the joint working across trusts utilising mutual aid to help with these backlogs and hope to see this cooperation continue. We base the information in our commentary from feedback and enquiries, reports from our Listening Events and information from the LHCH quality report.

Healthwatch Liverpool visited LHCH in December 2022 and spoke to 45 patients and visitors. Those we spoke to rate the hospital highly at 4.64 out of 5 stars, and we received many positive comments about staff and the care provided. The results included that 88% of patients felt that staff had enough time to spend with patients, 84% said they had been given enough information about their treatment and 80% specifically praised staff and the quality of care they received. We had more mixed responses regarding the food available with only 60% saying they were happy with the standard of food and drink and 27% of people struggled with the layout and signage of the buildings. Navigational difficulties are a continued theme over time, and we understand that due to the layout this is difficult to solve but hope efforts continue.

The 2022-23 Quality Account highlights many successes; That LHCH has been rated the top hospital in the northwest for overall care and fourth nationwide in the National Inpatient survey 2021 is an outstanding achievement to be commended. It also impressive that the Trust was rated top in the country for both 'place to work' and 'staff engagement' in the NHS Staff Survey 2022. This speaks to an environment where staff feel valued at work and is reflected in both awards and the increased patient experience that follows. Daily staff huddles including senior management staff and the use of multiple schemes for staff to speak up shows a desire to keep staff satisfaction high and the Trust a safe place for all. The international recruitment programme will hopefully lead to the employment of many more specialist nurses who will bring further skills and knowledge into the Trust.
The Trust's quality accounts performance show that good progress was made against the 2022-

2023 priorities, although not all targets were met. The target of providing 80% of patients awaiting cardiac surgery with pre-operative information was met and has been expanded further. Positive feedback has followed and hopefully more patients can benefit from this. The Sepsis Screening target was met across 2 of the 3 criteria with one missed by a single percentage point. These results reflect well on staff attitude and knowledge in identifying

Sepsis and keeping patients safe. The expertise of a dedicated Sepsis focused nurse working alongside the Microbial team shows commitment to expertise in managing Sepsis. The target for patient follow-up calls was also successful at 95%. Feedback was described as positive with multiple instances of quick resolutions to patient queries and medication issues. This can continue to provide positive results if the Trust utilises this feedback for improvements and maintaining good practice. The target of delirium screening had mixed results with the initial risk assessment target met at 99% and assessment of patients with an altered mental state twice daily missed by a percentage point at 89%. The completion of the assessment and management tool was missed heavily however at 45% with a target of 90%, the reason for this disparity was not provided.

LHCH has set challenging targets for the upcoming year, and we look forward to seeing how they benefit patients. The focus on discharge medication and equipment should help get people safely into their own homes sooner and free up beds. Post discharge medication was an issue brought to our attention by patients and it is positive the Trust recognises improvements can be made. The targets for smoking cessation and the availability and uptake of nutritional snacks are ambitious and to be applauded. Preventative health focus can benefit patients and the city if implemented well. The Trust already has had some success in providing smoking cessation materials to patients and the ripple effects could help whole families. Healthwatch Liverpool encourages the trust to act co-operatively with local partners already focused on stopping smoking such as the Life Rooms, Merseyside Fire and Rescue as well as local GPs and Pharmacists. It would also benefit from reaching out to groups that support communities for whom smoking, and obesity have a higher prevalence.

Healthwatch Liverpool would like to congratulate LHCH on its many achievements in 2022/2023 and are optimistic to see how much more the Trust can do in the upcoming year. Achieving high rates of staff and patient satisfaction is a commendable accomplishment and is to be applauded. As should always be the case we would like the final words to be from patients.

“[The staff are] fabulous, on call all of the time, there’s never anything too much for the staff.”
“Efficient, centre of excellence, staff are positive and cheerful when you arrive”.

Terry Ferguson
Information and Project Officer, Healthwatch Liverpool
7th June 2023

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 2021/22 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 2022 to May 2023
    - papers relating to Quality reported to the board over the period April 2022 to May 2023
    - feedback from commissioners dated 06/06/23
    - feedback from governors dated 16/05/23
    - feedback from local Healthwatch organisation 07/06/23
    - 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 26/07/22
    - the 2021 national patient survey - 30/09/22
    - the 2022 national staff survey - 09/03/23
    - the Head of Internal Audit's annual opinion over the Trust's control environment
    - 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

- 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 Susan Pemberton, Director of Nursing Safety and Quality
(E-mail or telephone 0151 600 3313).