



Quality Report

2023/24

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 except for organ transplantation.

Throughout 2023/24, LHCH provided:

1. Procedures used to visualise the coronary arteries and treat narrowings 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 narrowings, replacing the valves of the heart or dealing with other problems with major vessels in the chest (cardiac surgery) that includes a transcatheter aortic valve replacement (TAVR) or transcatheter aortic valve implantation (TAVI). Enhanced technology with the use of robotic surgery for cardiac surgery and provision of cardiac surgery for those patients with congenital heart disease (CHD).
4. Surgical procedures used to treat all major diseases that can affect the normal function of the lungs (thoracic surgery). Enhanced technology with the use of robotic surgery for thoracic surgery.
5. Drug management of asthma, chronic obstructive pulmonary disease and cystic fibrosis (respiratory medicine).
6. Community cardiovascular, respiratory and chronic obstructive pulmonary care for the residents of Knowsley. 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.

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 2023/2024 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 2023/2024 LHCH continued to provide elective, urgent and emergency services which included, cancer surgical procedures, emergency and urgent operations and

procedures. All Primary Percutaneous Coronary Intervention (PPCI) services were maintained.

Developments for 2023-24

A major programme of works to upgrade the Trust's catheter laboratories has continued during 2023/2024 with the delivery of 6 new state of the art catheter laboratories that will deliver high quality care for years to come. A further development of an additional lab is planned for 2024/2025.

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

Digital Excellence

Throughout 2023/2024, the team has continued to work through the Trust's 'Digital Excellence' strategy, which sets out the digital ambitions and deliverables for LHCH. The Digital Excellence Committee, chaired by the Chief Executive, is used to govern the programmes within the strategy.

Over the past year, the team has supported many projects including implementation of electronic prescribing within the community which has contributed to a reduction in safety errors and efficiencies for prescribing staff. The prescribing interface has also gone live in pharmacy, supporting a reduction in dispensing errors and automating workflows that were previously manual processes.

A new Digital Dictation has been introduced across LHCH, enhancing transcription software and reducing admin inefficiencies. The Trust's risk and incident management system has also been replaced, improving the assurance capability within the organisation.

The Trust has continued to innovate using remote monitoring technologies to safely care for patients outside of the hospital environment. Remote monitoring supports keeping patients at home where possible and a proactive approach to care where intervention may need to be brought forward. The digital and communications team have worked closely to design and introduce a new website and intranet at LHCH, improving experience for staff and patients.

Several technical projects have also been completed during 2023/2024 including the launch of the 'Tech Bar' at LHCH, a drop-in service for staff to allow staff to resolve any technical or system issues. The device refresh has also continued to ensure staff have the right tools to support them.

The Trust achieved EMRAM Level 7 from the Healthcare Information and Management Systems Society (HIMSS) in 2024, an external accreditation used to assess digital maturity.

Looking ahead, the team are working towards the implementation of an electronic Anaesthetic, Perfusion and Critical Care system, which aims to reduce safety incidents and improve staff and patient experience. The Trust is also looking to implement a single point of

access patient portal for all LHCH patients to manage their appointments, view test results and seek clinically led advice and guidance.

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 response rate was recorded at 63% compared to the national average of 40%. LHCH has been rated:

- top hospital in the northwest for overall care and
- second nationally in the National Inpatient survey 2022 reported in November 2023.

The Trust's vision is 'to be the best' and acknowledges that it will only achieve this by truly placing quality, safety and experience of patients and families at the heart of what is done. LHCH's 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.

Cheshire and Merseyside Acute and Specialist Trusts (CMAST)

The Trust has continued to be a supportive partner within the Cheshire and Merseyside Integrated Care system (ICS), through active engagement and leadership roles including the Cardiac Board and CVD Prevention Group. The Trust is an active contributor to our provider collaborative, CMAST and has contributed through CMAST governance, its Leadership Board and respective CMAST networks, where our Medical Director, Director of Nursing, Finance, Human Resources, Digital, Strategy and Company Secretaries play an active role in system approaches.

The Trust has continued to work in collaboration with Liverpool University Hospitals NHS Foundation Trust focusing on the 4 national cardiac pathways (acute coronary syndrome, heart failure, heart rhythm, and endocarditis). The purpose of which is to seek 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. A Broadgreen site-based committee was also established during the year to identify and jointly deliver workstreams that would support both patients and staff.

The Trust is engaged beyond Liverpool, 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, supporting groups that are particularly challenged with CVD and health inequalities.

Workforce / Education and Support

LHCH People Strategy has been created to complement the trust's strategic objectives, integrating culture and values. The People Strategy is underpinned by four distinct strategies:

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

Delivery of the LHCH People Strategy has demonstrated significant progress over the last 12 months, with specific emphasis on wellbeing, belonging and retention. Progress is evidenced through our staff survey results and through a downward trend in turnover over the last 6 months.

People Promise Theme	2021	↑ / ↓	2022	↑ / ↓	2023
We are Compassionate and inclusive	7.8	↑	7.9	↑	8.0
We are Recognised and rewarded	6.3	→	6.3	↑	6.6
We each have a voice that counts	7.3	↑	7.4	↑	7.5
We are safe and Healthy	6.5	↑	6.6	↑	6.85
We are always learning	5.9	↑	6.2	↑	6.3
We work flexibly	6.4	↑	6.5	↑	6.9
We are a team	7.1	↑	7.2	↑	7.4
Staff Engagement	7.5	↑	7.6	↑	7.7
Morale	6.3	↑	6.4	↑	6.6

The LHCH 'Be Civil Be Kind', has been embedded across the organisation which supports the importance of civility and kindness in our workplace. This culture campaigns support people to feel valued and appreciated as we understand that a culture of civility and kindness promotes a psychologically safe, harmonious, and highly performing teams and importantly civility can save the lives of patients.

There has been proactive recruitment over the last 12 months to recruit into hard to fill roles, for example, theatre scrub nurse role. The approach to recruitment has been successful with all areas being staffed to establishment level, supporting improved workforce stability.

LHCH Learning & Development Strategy provides a structured approach to the quality of both clinical and non-clinical education across the Trust. This is recognised in feedback from staff survey/GMC survey results and placement evaluation reports. The creation of a pathway to support leadership and management development across the Trust provides all staff with opportunity to develop their leadership capabilities, supported by quality leadership programmes. Significant progress has been made with the development of clinical competencies across medicine and surgery with the support of the Divisional Practice Educators and the ambition to further develop non-medical cardiothoracic expertise has seen the expansion of the academic portfolio in partnership with Edge Hill University. Schwartz

Rounds have been held regularly since March 2022 with the topics aligned to current themes or areas of concern. Feedback from staff attending Schwartz Rounds has been excellent.

There is a continued programme of expansion of apprenticeships across the Trust in both clinical and non-clinical roles.

Equality Delivery System

LHCH is committed to the Implementation of the Equality Delivery System (EDS) process, is a requirement on both NHS commissioners and NHS providers.

The EDS is an improvement tool for patients, staff, and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement, and insight.

The EDS Report is designed to give an overview of LHCH most recent EDS implementation and grade and is published in Feb on the trust website. This year we have focussed on the targeted Lung programme and Core 20 plus 5.

Infection Prevention and Control

The Trust recognises that the effective prevention and control of healthcare associated infections (HCAI) is essential to ensure that patients using our services receive safe and effective care. Effective prevention and control is an integral part of everyday practice and applied consistently to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

The Infection Prevention and Control Team have continued their commitment to improve performance in infection prevention practices across the Trust by working with all staff to ensure their forward plan for 2023/2024 was developed and progressed, with monitoring throughout the year of the plan through the Infection and Prevention Committee.

Elective Service

Throughout 2022/2023, LHCH enhanced its focus on recovering elective activity and reducing waiting times. As of March 2024, the Trust reached its target for no patients waiting over 104 weeks, with only 1 service line with patients over 78 weeks. The Trust will continue to look at reducing waiting times during 2024/2025 (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 Diagnostic Waiting Times (DM01) compliance (6week targets) in 2023/24 have been challenging given workforce pressures and increased demand. Ongoing work continues in partnership with Cheshire & Merseyside (C&M) to look to increased capacity working in community diagnostic hubs and recovery towards 95% compliance of diagnostic tests within 6 weeks.

Cancer services across outpatients, diagnostics and surgery have been significantly challenged within 2023/2024, with pressures on capacity due to industrial action as well as support for other C&M providers. Focus actions and capacity are being reviewed for the 2024/2025 financial year in line with national and regional guidance.

The Trust developed clear and stretching elective plans for 2023/2024 and was able to continue to exceed pre-Covid levels of activity across all points of delivery and support reducing elective waiting times further.

Mutual Aid and System Working

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

The use of virtual wards and psychology services was expanded in 2023/24 through national and regional funding. This continued to provide vital support to patients and facilitate early discharge and community-based treatment.

Preparedness and response to Industrial Action

The challenges of Industrial Action during 2023/2024 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 meant that the elective performance was approximately reduced by 4% in year. Actions continued 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 six steps to ensure quality and safety.

The Trust uses many ways of capturing patient experience, during 2023-2024 we continued to engage with our patients, their families and staff members to improve the quality of care we provide, and they receive. 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. This engagement has helped to shape our quality priorities for the year ahead.

The sixth step of the patient vision focuses on Discharge and Aftercare, to ensure that the patient and their family receive on-going support, throughout their stay and after discharge. 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 have also provided the opportunity to address specific patient concerns and escalate them to ward staff, ANP's or doctor which has 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 their stay with us.

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 over the year 2023/2024 we assessed each of the four divisions in its entirety, the assessments included:

- EECS assessment
- CQC Self-assessment
- Desk top review of Governance processes
- 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. These assessments will continue throughout 2024/2025

FTSU

LHCH is committed to an open, transparent and safe culture. During 2023/24 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 several 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 InPhase.
- 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.

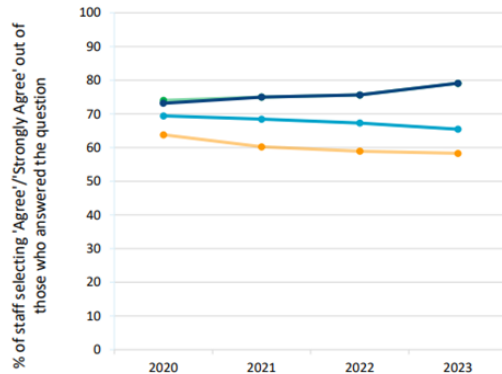
All staff who 'speak up' are given feedback in a timely manner by whoever they have spoken up to and there is a zero-tolerance policy for staff who may experience any detriment due to 'speaking up'. The process is overseen by the FTSU Guardians.

The national NHS Staff survey results 2023 show that LHCH is top in the country for being a place to work and staff engagement.

The following graphs are taken directly from the survey results and demonstrate that LHCH is the best Trust for staff feeling able to speak up about anything that concerns them. LHCH is the best Trust for Staff feeling confident that the organisation would address concerns being raised. This question has seen a 4% rise in the response in comparison with the 2022 results. LHCH is proud to work with the National Guardian Office and work with other organisations promoting the FTSU agenda.

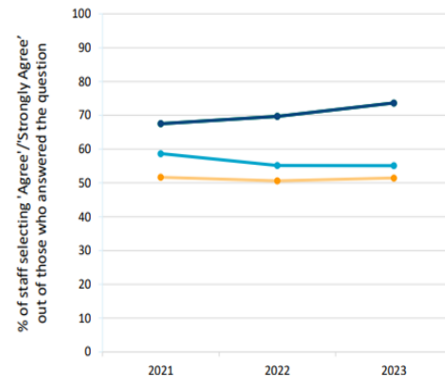


Q25e I feel safe to speak up about anything that concerns me in this organisation.



	2020	2021	2022	2023
Your org	73.16%	75.02%	75.63%	79.13%
Best result	74.04%	75.02%	75.63%	79.13%
Average result	69.41%	68.44%	67.30%	65.48%
Worst result	63.81%	60.23%	58.93%	58.29%
Responses	1099	1015	1236	1202

Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.



	2021	2022	2023
Your org	67.52%	69.68%	73.64%
Best result	67.52%	69.68%	73.64%
Average result	58.66%	55.15%	55.11%
Worst result	51.68%	50.61%	51.44%
Responses	1011	1235	1204

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.
- mandatory training for all staff groups,
- strengthening Trust policies and procedures supporting Duty of Candour,
- requirements within the incident reporting system to ensure duty of candour is considered and actioned.

Key achievements in 2023/24

- LHCH was rated one of the best hospitals in the country to receive care and to work according to the national NHS Adult Inpatient Survey, published in September 2023. It also showed LHCH was rated one of the top two trusts in the country for 'overall patient experience'.
- LHCH was rated the top Trust in the country for a 'place to work', 'care is our top priority', 'we are compassionate and inclusive', 'we each have a voice that counts', 'staff engagement', and 'morale' in the NHS Staff Survey 2023, published in March 2024.
- LHCH was rated top trust in the country in terms of the Freedom to Speak Up sub-score in the 2023 NHS staff survey results.
- LHCH joined an elite group of hospitals around the world who have been successfully validated against the HIMSS (Healthcare Information and Management Systems Society) international EMRAM Stage 7 standards, in March 2024. LHCH was the first trust in Europe to be assessed against the new and more extensive Stage 7 HIMSS standards.
- LHCH's 'Primary Care Heart Failure Project' was recognised as the 'Most Impactful Project Addressing Health Inequalities' at the HSJ Partnership Awards 2023, recognising their outstanding dedication to improving healthcare and effective collaboration with the NHS.
- LHCH was a shortlisted finalist in the HSJ Patient Safety Awards 2023, in the category Patient Safety Education and Training.
- LHCH announce the appointment of its new chief executive, Dr Liz Bishop in December 2023.
- LHCH formally opened its brand new multi-million-pound catheter laboratory suite in February 2024.
- LHCH was recognised with the Social Value Social Value Quality Mark Bronze Award in February 2024, demonstrating its commitment to creating, measuring and reporting social value.
- All minimum standards of care met or exceeded as defined by the Department of Health.
- On 21st March our ICB colleagues from Knowsley Place performed their quality walkabout of the Trust – no actions were identified for the Trust to consider following their initial verbal feedback.
- LHCH delivered strong performance against financial and operational targets for 2023/24.

The CQC performed their relationship reviews on:

- LHCH Executive with CQC Executive Board Meeting 26th May 2023
- LHCH Engagement Event with CQC 2nd August 2023
- LHCH Engagement Event with CQC 7th March 2024

No actions for improvement were identified following each event.

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

www.cqc.org.uk/provider/RBQ

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

Inspected and rated
Outstanding ☆
Care Quality
Commission

I am extremely proud of all achievements made during 2023, and into 2024, and we will continue to focus on ensuring our patients and their families receive the very best in compassionate, quality driven safe care whilst with us.

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



Dr Liz Bishop
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 2023/2024 all Trusts were made aware that monitoring of the quality priorities would continue to cease until further notice. Chosen Quality Priorities continue not to be externally audited. Below are the results for our Quality Priorities from the previous year 2023-2024

Priority One: Discharge Medication

All in-patients who are being discharged home will have their medication dispensed within 60 minutes of the prescription being received in pharmacy.

Leads – Pharmacy Manager Ward Manager Medical Ward, Ward Manager Surgical Ward

Category:

Patient safety

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 receives their medication and has a safe and timely discharge.

What is measured?

From the TTO tracker the following information was the measure for Cedar and Birch wards.

1. Time the TTO is signed off awaiting PODs.
2. Time that PODs are received and the TTO is commenced.
3. Time that the TTO is complete.

How much:

Target - 85% of all patients within the criteria.

Results:

The target that all in-patients who were being discharged home would have their medication dispensed within 60 minutes of the prescription being received in pharmacy was achieved. Actions for improvement were identified.

Target	Birch	Cedar
PODs received, TTO being processed. (Target 60 mins)	0 hours 17 mins	0 hours 38 mins

Priority Two: Availability and uptake of nutritional snacks

All inpatients will be offered regular snacks and drinks daily.

Inclusions- all in-patient areas

Exclusions – Critical care and Theatres

Leads – Matron for Intensive Care Unit, Matron for Patient Experience

Category:

Patient experience

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 patient's stay and ensuring that they receive the optimal nutritional support to enhance their recovery and well-being.

What is measured?

From the FFT questionnaire the following information will be measured -

1. Was the patient offered regular snacks and drinks?
2. Was there a varied choice of snacks offered?

How much:

Target - 95% of all patients within the criteria.

Results

	Target	Outcome
Was the patient offered regular snacks and drinks?	95%	99% of patients were offered regular drinks and snacks throughout your stay
Was there a varied choice of snacks offered?	95%	98% said they were offered varied choices of snacks and drinks

In addition to achieving the above target, additional actions were implemented to improve the patient's experience of nutrition and hydration.

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

All inpatients referred to Occupational Therapy will have their needs assessed and any discharge equipment required on discharge will be provided before the patient is ready to be discharged.

Leads – Out of Hospital Therapy Lead/ Support Staff

Category:

Patient safety

What is measured?

The following information will be measured from EPR-

1. How many in-patients are referred to Occupational Therapies?
2. How many of those patients referred for assessment require equipment at home?
3. How many patents have their equipment in place when ready for discharge?

How much:

Target - 85% of all patients within the criteria.

Data Collection – information gathered from EPR and provided on a weekly/monthly basis.

Results:

	Target	Outcome
How many in-patients are referred to Occupational Therapies?	N/A	Between 16/11/23 and 02/01/24 there were 70 referrals to Occupational Therapy. 59 Patients did not require onward referral.
How many of those patients referred for assessment require equipment at home?		3 patients required an equipment service referral.

How many patients have their equipment in place when ready for discharge?	85%	Outcome 100% 3 patients had their discharge equipment in place ready for discharge. Therefore no discharges were delayed by awaiting OT equipment.
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Since sternal precautions post-surgery were reduced, the amount of discharge equipment required has too. The Therapies Team currently has its own stock of most used equipment to help prevent any delays in discharge.

Priority Four: Smoking cessation All in- patients will be offered regular support to stop smoking.

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.

Category:

Patient Experience

Lead: Knowsley Pharmacist Lead

Exclusions – Outpatients, Community patients, Staff.

Target – 95%

Data collection: Data taken from EPR Health Records

Results:

The aim is to ensure that patients are offered support during their stay and signposted to community support upon discharge.	Target 95%	Outcome Jan - Dec 2023
How many patients had a smoking assessment during their nursing admission?		13,821 patients were admitted of which 12,343 had a nursing documentation completed, 1143 there was no nursing document assigned. Outcome - =96%

Additional actions were implemented to improve the patient's experience.

Quality Priorities for 2024-2025

A Quality Priority Patient Engagement event was held in February 2024 the event was well attended by patients, relatives, public members, staff governors and trust staff. An update of the Quality Priorities for 2023-24 was presented and well received. Following discussion, all present took part in voting for what they considered to be a priority for the Trust in the next 12 months.

The following four were agreed for 2024 - 2025:

Quality Priority 1

To improve contact with elective cardiac surgical patients on the waiting list between referral and admission.

Why?

Patients referred to LHCH for cardiac surgery can wait several weeks for a date for surgery. During this period, they may have little or no contact from LHCH with regard to their referral being received. We would like to make sure we make contact to reassure patients that we have received their referral and to be able to manage their expectations in terms of wait time etc.

The first step of our Patient and Family Experience Vision focuses on pre-admission care, therefore our aim is to ensure there is clear communication and to reassure patients that we have received their referral.

Inclusions- all Cardiac Surgery patients

Exclusions – all other patients (initially)

Leads – Divisional Head of Operations for Surgery - Deputy Divisional Director of Operations, Surgery

Category:

Patient experience

What is measured?

The following will be measured:

1. Current contact with patients on the waiting list
2. Improved patient experience (FFT?)

How much:

Target – 100% of cardiac surgery patients on the waiting list (over 12 weeks) will be contacted.

Q	Month	Actions
Q1	April - June 24	Identify baseline in terms of numbers, waits, resource required to contact patients.
Q2	July- July 24	Identify resource to contact & SOP. Analyse data.
Q3	Aug - Nov 24	Start contacting patients and measure response rate & experience.
Q4	Nov – March 25	Monitor response rate & patient experience to determine whether to continue the service.

Quality Priority 2

All Cardiac / potentially to include Thoracic Surgical patients waiting for surgery on the TCI list to be offered pre-habilitation to improve their health in readiness for surgery.

Why?

Pre-habilitation is a service that supports patients to improve their fitness, health and overall wellbeing before any planned operation. Pre-habilitation provides an opportunity to give information, advice, and support and to set realistic expectations before admission. It is well documented that better health before surgery improves outcomes for patients and also reduces their length of stay.

The first step of our Patient and Family Experience Vision focuses on pre-admission care. Our aim is that while surgical patients are waiting for admission their condition could be optimised, which would improve outcomes, experience and length of stay.

Leads – Divisional Director of Nursing Clinical Services - Consultant Cardiologist (Imaging & Cardio-Oncology) - Anaesthetic Consultant - Therapy Lead

Category:

Patient Safety / Experience

What is measured?

The following will be measured:

1. Current Length of Stay of Cardiac Surgical patients
2. Post-Operative outcomes
3. Cancelled operations due to ill health /not medically fit for surgery.
4. Patient experience

How much:

Target – Reduction in Length of Stay of cardiac patients; improvement in post-op outcomes; reduction in cancelled ops due to ill health/not medically fit for surgery.

Q	Month	Actions
Q1	April - June 24	Identify baseline for: 1. Length of Stay 2. Post-Operative Outcomes 3. Cancelled Operations
Q2	July - Sept 24	Analyse data. Propose/make recommendations for Pre-Habilitation service format. Pilot the test of change.
Q3	Oct – Dec 24	Implement Pre-Habilitation service for cardiac surgery patients.
Q4	Jan – March 25	Roll out service & monitor to ensure compliance.

Quality Priority 3

To improve psychological support for patient, families and responders to Out of Hospital Cardiac Arrests (OOHCA).

Why?

The sudden and unexpected cardiac arrest of a family member can be a grief-filled and life-altering event and often it is a family member who is involved. The after-effects of a cardiac arrest can have a long emotional and psychological impact, regardless of outcome and family members can experience PTSD. Current psychological support is ad hoc and not formalised and the entire pathway for psychological care for OOHCA's could be improved. The sixth step of our Patient and Family Experience Vision focuses on Discharge and Aftercare, our aim is to provide a clear pathway of support for patients and families who have experienced seeing or being involved in a cardiac arrest of patients brought to the hospital for treatment.

Leads – Divisional Directors of Nursing Clinical Services and Medicine

Category:

Patient/Family experience

What is measured?

The following will be measured:

4. Number of OOHCA's where resus is given at the point of collapse.
5. Pathway and referral guidelines in place
6. Psychological support in place (for appropriate patients)

How much:

Target – 100% of OOHCA's that require resuscitation and are referred to LHCH have the opportunity to receive psychological support.

Q	Months	Actions
Q1	April - June 24	Identify baseline of number (current status), and current pathway.
Q2	July- Sept 24	Analyse data / current state – make recommendations for future state. Establish psychological support requirements.
Q3	Oct – Dec 24	Implement improvements identified in analysis.
Q4	Jan – March 25	Receive data weekly. Monitor and report compliance.

Quality Priority 4

To improve the discharge experience for patients and families. This may be the introduction of a Discharge Lounge but will make reference to the whole discharge process (including TTOs).

Leads – Matrons for Medicine and Surgery

Why?

A delayed discharge occurs when a patient is medically fit to leave hospital but is not discharged in a timely way. It can be caused by many factors including –

- poor discharge planning
- or not involving patients and families early enough in the discharge process.
- This may lead to complications, a risk of functional decline and adverse events. This is a poor experience for the patient and their family.

There are many aspects to the discharge process that can possibly be improved – this Quality Priority makes specific reference to a Discharge Lounge (and a continuation of the work we did last year on TTOs).

The sixth step of our Patient and Family Experience Vision focuses on Discharge and Aftercare, our aim is to provide a timely discharge and improve the patient experience by continuation of Quality Priority 1 from 2023/24.

Category:

Patient safety

What is measured?

The following will be measured:

1. Length of stay (LoS) on ward (Cedar Ward initially).
2. Patients identified as suitable for the Discharge Lounge before discharge are transferred to the lounge within 2 hours.
3. Time from patient being told they can go home to actually leaving the hospital.
4. Patient experience of discharge through follow up calls.

How much:

Target – To reduce LoS and time from the patient being told they can go home to the time they actually leave hospital, (Cedar Ward initially).

Data Collection – information gathered from EPR and provided on a weekly/monthly basis.

Q	Month	Actions
Q1	April - June 23	Identify baseline data for Cedar Ward <ol style="list-style-type: none">1. Time of admissions2. Time of discharge (Comparing the difference in the number of discharges on Cedar ward between and the weekends).
Q2	July-Sept 23	Analyse data & potential solutions to issues
Q3	Oct – Dec 23	Implement improvements identified in analysis.
Q4	Jan – March 24	Receive data weekly. Monitor and report compliance.

Part 2.1 Statements of assurance from the Board

Participation in Clinical Audits

During 2023/24, 20 National clinical audits and 2 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 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			
	Intensive Care National Audit and Research Centre (ICNARC)	Yes	<p>The Trust is part of the ICNARC CMP and part of the Cardio-Thoracic sub-group. The data is submitted on a quarterly basis:</p> <p>For 2023/24 submitted data on 2109/2109 (100%) of patients admitted to Critical Care.</p>
	Lung cancer (NL CA)	Yes	<p>Data for patients diagnosed in calendar year 2023 is submitted via the trust's monthly Cancer Outcomes and Services Dataset submissions to the National Cancer Registration System.</p> <p>Currently 1,123 (100%) records for suspected lung cancer have been submitted for patients diagnosed from January 2023 to December 2023</p>

Heart			
3	Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Data validation ongoing Final data submission for Apr 2023 – Mar 2024 due 31/05/2024
	Cardiac Rhythm Management (CRM)	Yes	1731/1731 (100%) cases submitted for pacing and implantable cardiac defibrillators for period April 23 – March 24. 1509/1509 (100%) cases submitted for EP for April 23 – March 24.
	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	Yes	Total submission Apr 2022 - Mar 2023: 463 cases (draft) - 173 EP catheter procedures - 79 Bypass surgical procedures - 181 Catheter interventions - 28 diagnostic catheter - 2 not otherwise specified.
6	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Data validation ongoing Final data submission for Apr 2023 – Mar 2024 due 31/05/2024
	National Adult Cardiac Surgery Audit	Yes	Cases Submitted: Q1 - 359 (100%) Q2 - 357 (100%) Q3 - 403 (100%) Q4 - 371 (100%)

8	National Cardiac Arrest Audit (NCAA)	Yes	<p>Q1 x 30 Cases Submitted Q2 x 34 Cases Submitted</p> <p>Final data submission for Apr 2023 – Mar 2024 due 31/05/2024</p>
9	National Heart Failure Audit	Yes	<p>Data validation ongoing Final data submission for Apr 2023 – Mar 2024 due 31/05/2023.</p>
Long term conditions			
	National Audit of Cardiac rehabilitation	Yes	<p>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 01/04/23 to 31/03/24 is 6080.</p> <p>Phase 2 The Knowsley cardiac rehabilitation for community cardiovascular service Referral to Knowsley CR 01/04/23 to 31/03/24 is 326 with 237 (296 completed).</p>

	Sentinel Stroke National Audit programme (SSNAP) - Post-acute provider organisational audit	Yes	<p>Knowsley service provider 2023/24 Early Supported Discharge & Community Stroke Rehabilitation</p> <p>Data provided from 1st April 2023 to 31st March 2024</p> <p><u>Transferred to team</u> Early Supported Discharge: 124 of 206 (60%) of patients referred for ESD have been transferred to the team on SSNAP by acute providers.</p> <p><u>Data submitted</u> 124 ESD patients had data submitted into SSNAP who were discharged from ESD between 01/04/23 and 31/03/24.</p> <p><u>Transferred to team</u> Community Stroke Rehabilitation (CRT): 82 of 124 (66%) 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.</p> <p><u>Data entered</u> 82 CRT patients had data submitted who were discharged from team between 01/04/23 and 31/03/24.</p>
	UK Cystic Fibrosis Registry	Yes	<p>356/356 (100%) submitted for calendar year 01/01/2023 -31/12/2024 as per the UK CF Registry.</p> <p>.</p>
	NaDIA-Harms - reporting on diabetic inpatient harms in England	Yes	<p>The National Diabetes Inpatient Audit - Harms (NaDIA-Harms) is a continuous collection of four diabetic harms which can occur during an inpatient stay.</p> <p>0 submitted cases to report as no harms as per the audit criteria.</p>
	National Audit of Inpatient Falls (NAIF)	Yes	<p>The trust falls lead submitted the Facilities Audit 2023 in March 2024.</p> <p>0 submitted cases to report as no hip fractures.</p>

	Learning Disabilities Mortality Review Programme (LeDeR)	Yes	0 submitted case to the Learning Disabilities Mortality Review Programme.
	NHS Blood and Transplant: 2022 National Comparative Audit of Blood Sample Collection and Labelling	Yes	?? 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.
	National Audit of Care at the End of Life (NACEL)	Yes	14 cases identified (100%) submitted cases as per the audit criteria.
	National Vascular Registry	Yes	43 cases submitted for the period Apr 2023 – Mar 2024.
	The UK Transcatheter Aortic Valve Implantation (UK TAVI) Registry	Yes	Cases Submitted: Q1 – 97 Q2 – 118 Q3 – 100 Q4 – 112 (not all cases validated and submitted.) Final data submission for Apr 2023 – Mar 2024 due 31/05/2023.
	End of Life Care (NCEPOD)	Yes	88 cases submitted for sampling to NCEPOD.
	ICU Rehabilitation (NCEPOD)	Yes	196 cases submitted for sampling to NCEPOD.

The reports of 20 national clinical audits were reviewed by the provider in 2023/24 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)

The trust continues to exceed the national average in the majority of KQIs including:

- Percentage of ST-elevation myocardial infarction (STEMI) and non-ST-elevation myocardial infarction (NSTEMI) patients undergoing an echocardiogram during admission.
- Percentage of NSTEMI patients undergoing an angiogram during admission.
- Percentage of patients admitted to a cardiac ward.

Furthermore, the trust has achieved 100% compliance with the following:

- Percentage of patients seen by a cardiologist.
- Percentage of patients prescribed the correct medication on discharge.

Areas to monitor:

- The call-to-balloon within 150 minutes (CTB150) time for patients presenting with a STEMI has reduced from 53% to 44%; moreover, the median CTB time has increased from 132 to 149 minutes. This is reflected in the data stratified by ambulance trust, where the CTB 150 and CTB 120 for the North-West Ambulance Service (NWAS) are lower than the national average. However, the NWAS reported the highest number of patients receiving a Primary Percutaneous Coronary Intervention (PPCI) in the country; despite this, the median CTB was around the national average, and the call-to-door (CTD) time was lower than the national average.
- "NSTEMI (ACS) – The Trusts has failed the target of admission to angiography within 72hrs. This is again a national picture, and one that has not changed over time - quantified in this report as 11% for the past financial year."

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.

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 in the following key standards:

1. Received echocardiogram.
2. Input from consultant cardiologist.
3. Input from specialist.

National Audit of Cardiac Rhythm Management CRM Devices:

LHCH performed 570 PPMs and 824 complex CIEDs in 2021-2022, this represents a 11% increase in pacemakers and nearly 30% increase in complex CIEDs (ICDs and CRTs) compared to 2020-2021. This is in keeping with recovery trend following COVID. Furthermore, the reintervention rates for all CIED activity remains reassuringly low.

CRM Electrophysiology (EP): Catheter Ablation

LHCH performed 498 simple ablations and 711 complex ablations in 2021-2022, this represents a 26% and 64 % increase in activity respectively as compared to 2020-2021. This was in keeping with recovery trends following 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 22/23 External Validation rated the LHCH DQI was 98.5% - a small decrease from 99.25% in 2021/22. However, the DQI remains within the excellent threshold, 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.

Our cardiac surgery audit results demonstrate significant improvements across key metrics compared to national averages:

- Elective CABG wait times reduced from 135 to 118 days, only marginally above the national average of 114 days.
- No change observed in urgent CABG wait times, aligning with the national average of 13 days.
- Decrease in CVA/TIA incidences from 2.82% to 1.36%, against the national average of 0.92%. The trust has a specialist stroke MDT, which identifies and treats CVAs aggressively. This likely inflates the pick-up rate for CVA and TIA.
- Kidney failure rates lowered from 2.22% to 0.81%, below the national average of 1.14%.

These outcomes underscore our commitment to delivering high-quality cardiac surgical care, with notable advancements in patient safety and outcomes.

National Diabetes Inpatient Safety Audit (NDISA)

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)

There was a full year number of 2,191 admissions in total. The unit-acquired infections in blood observed rate was higher in Q4 than the expected figure but was still within the 95% predicted range. This is something that is closely monitored by the Critical Care infection specialist Nurse and Critical Care Matron.

The data shows the unit performed well in the quality indicator dashboard with the unplanned readmissions the only area of the dashboard in red. Q1 and Q2 reports resulted in an amber warning however Q3 and Q4 were both green resulting in a red full year end stat. The expected percentage is calculated using data from all critical care units participating in the case mix programme. The expected full year percentage is 1.0 and our observed was 2.1. The predicted 95% range is (0.6-1.5) for the full year.

- All unit acquired infections undertake a review by the Critical care infection specialist nurse and a mini-RCA is completed whereby the MDT team meet and discuss and any learning outcomes are identified and worked through.
- Unplanned readmissions within 48 hours- MDT group meet quarterly all 48-hour readmissions are reviewed by the clinical team. Most current reoccurring themes are Type 1 respiratory failure who require high flow, management post cardiac arrest or renal failure.
- An enhanced care unit potentially would reduce the 48-hour readmissions as at present there is no other area between Critical care and the ward area.

National Cardiac Arrest Audit (NCAA)

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 NCAA report for the first half of 2023-24 provides a risk-adjusted comparative analysis against 5 other cardio-thoracic trusts. The data shows that the trust exceeds the standards set out, reflecting an above average survival rate in 24 hour and 28-day survival rate.

The SHOT Annual Report 2022 (published July 2023)

The following actions are in place to improve compliance:

- Continue with the training programs on Corporate & Clinical Inductions, plus 2 yearly administration competency sessions.
- Provide posters for each ward and department.
- Share the audit finding at the link nurse meetings which provide feedback to each area, highlighting an area of good practice and encouraging all areas to adopt good practice.

Since last audit EPR changes have been implemented. The 'Transfusion Alert' has replaced 'Patient transfusion directive' and 'Irradiated units' has been added to the list for the patient banner. Staff have been directed to the Transfusion Practitioners desk to collect any information leaflets required for patients.

The Hospital Transfusion Team are currently working with EPR with a view to an electronic request form. When the electronic request form is completed there will be a mandatory requirement to complete the special requirements section on the form which should improve compliance.

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

- Exemplifying excellence, we have achieved full adherence to all Key Performance Indicators (KPIs) for the preceding financial year. This accomplishment reflects our commitment to the highest standards of performance to provide care.
- As of 1st April 2023 – on SSNAP the team is classed as combined ESD-CRT team – this means the team will only have 1 code 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 (5-day rehabilitation and access to all disciplines) will involve increased staffing and increased skill mix including addition of Nurse and Psychologist - this is currently under review.
- 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 is 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 continues to explore development of a vocational rehab pathway as per post-acute audit.
- Team is currently delivering 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.
- As a new integrated approach, the team now work in collaboration with an MDT approach with cardiac rehab and heart failure teams to improve patient outcome and experience.

UK Cystic Fibrosis Registry Annual Report 2022 (Published December 2023)

The adult centre remains among the top units for lung function and BMI, key markers for CF care. Moreover, this is on a background of lower use of IVs and high-cost treatments.

- Lower than national average proportion of patients with chronic *Pseudomonas aeruginosa* by adult centre/clinic, which is good. This might have been impacted by newer treatments and surveillance.
- Lower than national average Intravenous (IV) antibiotic use by adult centre/clinic, which is good and cost-effective.
- Higher than national average Inhaled antibiotic use for patients with chronic *pseudomonas aeruginosa* by adult centre/clinic, which is good and reflects lower prevalence of PsA.

National Audit of Care at the end of life (NACEL)

Overall, the audit findings provide reassurance that EOL care provision has been consistent and of a good standard, with summary scores greater than the national average in some areas. It also highlights the differences in deaths, demographics between a Specialist Trust and nationally.

The staff survey highlighted some concerns in relation to training and being confident in delivering care at the EOL. Staff who completed the survey reflected a relatively junior workforce which may have had an impact on their confidence in caring for patients at the end of life. Work has been ongoing to support staff in their clinical areas.

An early alert was received from the audited data which identified the Trust as an outlier for a higher proportion of category 2 patients than the National mean average. This led to a meeting with no concerns being raised but recognition of the differences between deaths in a specialist Trust. The team will form part of a pilot to shape the next NACEL audit.

Recommendations

- Continue with ward-based training.
- Develop shadowing for trained staff across areas.
- Monitor numbers of EOL e-learning packages undertaken
- Undertake pilot for NACEL and team to be active members of any group for the development of questionnaire.
- Audit care provision for key areas and monitor through EOL dashboard or identify areas of concern.

National Audit of Cardiac Rehabilitation Quality and Outcomes Report 2022

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, because they have changed the requirements.

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 deliver 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.

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 2023 shows the service has achieved an 'amber' status. Preliminary data for the 2024 report indicates that the service is on target to achieve a 'certified green' status.

Knowsley CVD contract has recently been reviewed and updated to meet the Key performance indicators (KPI) set by the Knowsley Place Integrated Care Board. We have successfully met all the targets for 2023. 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, CVD risk management and psychosocial support and delivered via 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, 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 January 2024)

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 National Audit of Inpatient Falls clinical audit data from 1st January to 31st December 2022, reports that 2,033 people sustained a femoral fracture as an inpatient; 1,669 (82%) were due to a fall.

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. Following review of this report, LHCH are meeting the relevant recommendations with some additional work planned.

Participation in local clinical audits

The reports of local clinical audits were reviewed by the provider in 2023-24 and Liverpool Heart and Chest Hospital intends to take the following actions to improve the quality of healthcare provided:

Infection Prevention and control audits

A robust surveillance system to obtain accurate information is now in place. The SSI group oversee an audit programme and ongoing action plan and will consider new initiatives to reduce SSI rates.

Audits include:

Audit	Improvement work
Surveillance - Cleanliness	<p>The audit tool and program implemented last year continue to yield positive results:</p> <ul style="list-style-type: none"> • The audit tool and program developed in the previous year remain in active use. • Continued collaboration among infection prevention nurses, matrons, and hygiene service supervisors ensures a standardized approach to monitoring cleanliness. • Average cleanliness scores have remained consistently high, ranging between 97% and 100%.
Infection prevention audits	<p>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:</p> <ul style="list-style-type: none"> • Decontamination and cleanliness • Equipment • Waste disposal • Sharps handling • Linen handling. <p>Overall compliance across the Trust ranged from 89% to 98%. Feedback and an action plans were given to each area.</p>
Surgical site Infection prevention bundle:	<p>Aspects of the SSI prevention bundle were audited for patients undergoing cardiac surgery:</p> <ul style="list-style-type: none"> • Hair removal • Appropriate skin prep is applied prior to surgery. • Surgical prophylaxis • Dressing removal • Pre-op screen prior to surgery <p>Compliance was usually very good i.e. 95- 100% apart from one intervention, which was appropriate hair removal. Compliance</p>

	remained low, despite some improvement. Work is going to ensure the standard is met.
Risk adjusted Surgical Site Infection rates	The implementation of risk-adjusted surgical site infection rates. This new approach allows us to more accurately assess and compare infection rates across different surgical procedures, taking into account patient-specific risk factors. By incorporating this advanced methodology, we aim to further enhance patient safety and quality of care in our surgical services.

Audit	Improvement work
National Safety Standards for Invasive Procedures (NatSSIP). Local Safety Standard for Invasive Procedures (LocSSIP)	<p>Steady progress can be identified regarding the implementation of NatSSIPs 2. A robust action plan has been developed and steering group to drive the implementation. Cross divisional including corporate services will all have an integral role in the successful implementation of NatSSIPs 2.</p> <ul style="list-style-type: none"> The Clinical Audit and Effectiveness Team has worked to automate trust wide reporting of LocSSIP compliance. <p><u>Catheter labs</u> Regular audits demonstrate good compliance with LocSSIPs</p> <ul style="list-style-type: none"> To continue to monitor NatSSIPS and LocSSIPS in all divisional governance work plans. To improve areas of lower compliance of mandatory training regarding NatSSIP. 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. Priority to be given to the ward based LocSSIPs and audit process including Holly Suite endoscopy and chest drain insertion/removal. Trust-wide chest drain LocSSIP compliance improvements required. <p><u>Theatres</u> 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.</p>

	<ul style="list-style-type: none"> • 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 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.
Duty of Candour Audit.	<p>The Organisation has maintained in its processes for compliance with Duty of Candour in the relevant cases:</p> <ol style="list-style-type: none"> 4. Duty of candour is included in induction and as an e-learning pack. <ul style="list-style-type: none"> • Currently 100% of eligible staff have received training regarding Duty of Candour.
BTS National Audit Report: Smoking Cessation	<p>The audit undertaken in November 2022 for the period of 01/01/21 to 31/12/21. Total number of hospital admissions was 12876 (100%). Nursing admission document was completed on 11792 (91.6%):</p> <p>Action points from the audit:</p> <ol style="list-style-type: none"> 1. Appointed 2 smoke free advisors – one for inpatients and one for Knowsley community services. 2. Identified Clinical Pharmacist Smoke Free Lead 3. Support from Executive Director of Strategic Partnerships 4. Worked with BI and QI Teams to identify action points including updating EPR, developing smoking dashboard, introduced automated referrals to stop smoking services, automated NRT order set policy for patients who are admitted to hospital. 5. Presenting findings at Learning and Sharing Meetings, sharing good practice and any areas for improvement 6. CVD Prevention Lead post is now on post, this postholder will work closely with the Smokefree Advisors giving patients VBA and ensure that Making Every Contact Counts (MECC) opportunities are taken. <p>The aim is to capture 100% smoking data, 100% pharmacotherapy and related smoking cessation referral and monitor by quarterly audit</p>

Pharmacy audits

Audit	Findings / Improvement work
Surgical Prophylaxis Audit	<p>This audit demonstrates good compliance with the trust antimicrobial policy to prevent surgical site infections. Any non-compliance is visible across the anaesthetic department and in comparison, to previous data, antimicrobial surgical prophylaxis prescribing has overall improved.</p> <p>Actions</p> <ul style="list-style-type: none"> • Continue rolling compliance monitoring. • The surgical prophylaxis audit is planned to commence in 2024/25 for thoracic surgery.
Antimicrobial Prescribing audit	<p>This audit is conducted to demonstrate evidence of good antimicrobial stewardship practice and compliance with the Trust Antimicrobial Policy.</p> <p>The trust monitors Intravenous-to-oral switch (IVOS) Criteria for Early Switch compliance in accordance to National Antimicrobial guidance. Over the past financial year, the trust has consistently achieved compliance well above the national target.</p> <p>Recommendations include</p> <ul style="list-style-type: none"> • 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. • For complicated patient cases where specialist input is appropriate, referral to the microbiology ward round team should be promoted
LV Thrombosis Audit	<p>We studied patients spanning a five-year period from 2016 to 2021, identifying them through their medical records for heart attack and left ventricular thrombus. Our focus was on how well discharge documents communicated the left ventricular thrombus diagnosis.</p> <ul style="list-style-type: none"> • We found that in 91% of cases, this diagnosis was clearly stated in the discharge paperwork. Additionally, 87% of discharge plans included details about anticoagulation management and follow-up care. This high level of documentation ensures that patients receive clear guidance and support for their ongoing treatment and recovery.

Participation in Clinical Research

Research is an integral component of the Trust's core activities and forms part of the trust strategy. 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. Therefore, it has a good research portfolio for respiratory and cardiology research. These are outlined below.

Research Achievements

In 2023/24 LHCH recruited 1345 participants to National Institute for Health Research (NIHR) portfolio studies across 5 specialities which is a significant increase in comparison to last year's recruitment (N=928). With 1087 patients recruited to cardiovascular badged studies, 128 to cancer, 63 to respiratory disorders, 41 to critical care and two to surgical studies. It is important to note that the main speciality often relates to the disease area and that surgical studies are recruited across the specialities. In total there were 43 actively recruiting within the year 23/24. Some of the highlights and achievements are outlined below.

- We were top of the Northwest Research Network leaderboard for the patient reported experience survey with 114 responses.
- Shortlisted for the HSJ 'Empowering Patients Through Digital' awards for our recruitment and innovative LHCH study call TICS – Telehealth in Cardiac Surgery
- Highest recruiter to a national study called SCOOT – a lung cancer study.
- Top UK recruiter to a study called Cryo Persistent PAS
- Exceeded recruitment to time and target by 6 months for AF big picture.
- Recruiting to time and target on 83% of our commercial research trials (National Target is 80%)
- Chief investigator for a national NIHR priority study and first recruit in the UK to ASPIRE

Collaboration

At LHCH we are focused on collaboration and have several key partnerships that we actively contribute to. These being Liverpool Health Partners (LHP), Liverpool Centre for Cardiac Science (LCCS) and the NIHR Liverpool Clinical Research Facility (CRF).

The Liverpool NIHR CRF is a joint collaboration with Liverpool University Hospitals NHS Foundation Trust (LUHFT), and The Clatterbridge Cancer Centre NHS Foundation Trust (CCC) and has been fundamental in driving forward early phase and first in man studies. We currently have two studies within the pipeline and are collaborating on a cancer vaccine study with Clatterbridge, all which will commence recruitment in 24/25. This is providing new and novel treatments to our patients with persistent health conditions.

The LCCS collaboration is a partnership with Liverpool John Moores University (LJMU) and University of Liverpool (UoL), this has enabled us to joint fund a PHD studentship for a pharmacist, this will increase the opportunity for pharmacy led research in the future at LHCH. It is further through this collaboration where we are developing and designing studies for grants that will address cardiovascular issues in our surviving CF patients, right through to helping to detect and prevent HF in the community.

Our partnership with LHP and joining up through the Joint Research Office (JRO) has enabled us to streamline our governance processes and therefore improve our set up time of commercial and NIHR funded trials.

Additionally, we are supporting the LJMU EDEPI project. A project with LJMU to increase applicants from minority ethnic groups into higher education.

Strategic R&I committee

The Committee advises 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 provides 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.

Patient and Public Involvement and Engagement (PPIE)

LHCH are dedicated to promoting and advocating the patient voice throughout. The LHCH patient research ambassador leads national guidance for research as well as collaborates and influences design of research with several partners and stakeholders. Additionally, LHCH are leading the development of the PPIE strategy and committee for the CRF.

Goals agreed with commissioners

“LHCH delivered strong financial performance in 2023/24.

There continued to be a focus nationally on addressing the waiting lists, with additional funding set aside to incentivise providers to maximise elective treatments. Providers were paid on a block basis for all emergency care, but most planned care was paid on a cost per case basis.

In addition to trying to maximise elective activity, the Trust continued to deliver savings and exercise strong fiscal discipline. Saving initiatives were reviewed by clinical managers to ensure there was no detrimental impact on service quality.”

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 2023/2024.

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 2023/2024 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 Data Quality (DQ) strategy has been developed and signed off for 2022-2025
- The DQ Policy has been updated in 2022 and to be reviewed at the end of 2025.
- 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 2023/24 the Trust DQMI was 98.0 against a national average of 81.4. In total 666 '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 2023/2024 are as follows:

(Outpatient Care submission)

Data Item	Provider Total	Provider Missing	Provider Invalid	Provider % Valid	ICB* % Valid	Region* % Valid	National % Valid
Admin Category	131,683	0	0	100.0%	99.9%	99.1%	97.9%
Attendance Indicator	131,683	451	0	99.7%	99.9%	99.6%	99.6%
Attendance Outcome	95,722	0	0	100.0%	98.6%	97.0%	95.6%
Commissioner	131,683	0	4	100.0%	99.9%	98.9%	98.9%
Consultant	131,683	0	11,891	91.0%	98.3%	85.6%	86.6%
Ethnic Category	131,683	0	0	100.0%	95.7%	95.8%	91.2%
First Attendance	131,683	0	0	100.0%	100.0%	100.0%	99.8%
Main Specialty	131,683	0	0	100.0%	99.9%	99.1%	99.0%
NHS No Status Indicator	131,683	0	112	99.9%	100.0%	100.0%	99.9%
NHS Number	131,683	117	0	99.9%	99.9%	99.9%	99.7%
Org of Residence	131,683	0	648	99.5%	99.9%	99.5%	95.4%
Patient Pathway	122,994	0	0	100.0%	77.5%	65.8%	66.8%
Person Birth Date	131,683	0	7	100.0%	99.4%	99.7%	99.7%
Person Gender	131,683	0	2	100.0%	100.0%	100.0%	100.0%
Postcode	131,683	0	100	99.9%	100.0%	99.9%	99.9%
Primary Procedure	95,722	0	0	100.0%	99.7%	99.7%	99.5%
Priority Type	131,683	0	0	100.0%	99.2%	93.0%	93.1%
Referral Received Date	131,683	0	0	100.0%	99.4%	94.8%	94.0%
Referral Source	131,683	0	0	100.0%	99.9%	97.3%	96.3%
Registered GP Practice	131,683	0	200	99.8%	95.7%	98.1%	99.5%
Site Code of Treatment	131,683	240	0	99.8%	98.7%	96.9%	96.1%
Treatment Function	131,683	0	0	100.0%	99.9%	99.2%	99.0%
Overall	2,816,415	808	12,964	99.5%	98.3%	96.3%	95.8%

(Inpatient care Submission)

Data Item	Provider Total	Provider Missing	Provider Invalid	Provider % Valid	ICB* % Valid	Region* % Valid	National % Valid
Admin Category (On Admiss)	15,238	0	0	100.0%	99.9%	100.0%	99.9%
Admin Method (Hosp Prov Spell)	15,238	0	0	100.0%	100.0%	100.0%	100.0%
Commissioner	15,238	0	0	100.0%	99.8%	98.9%	99.4%
Consultant	15,238	0	2	100.0%	99.8%	99.1%	96.7%
Disch Ready Date (Hosp Prov Spell)	13,921	0	0	100.0%	18.9%	13.7%	19.3%
Discharge Dest (Hosp Prov Spell)	13,921	0	0	100.0%	100.0%	100.0%	100.0%
Discharge Meth (Hosp Prov Spell)	13,921	0	0	100.0%	100.0%	100.0%	100.0%
Ethnic Category	15,238	0	0	100.0%	98.1%	97.4%	94.9%
Main Specialty	15,238	0	0	100.0%	100.0%	99.8%	99.8%
NHS No Status Indicator	15,238	0	20	99.9%	100.0%	100.0%	99.7%
NHS Number	15,238	20	0	99.9%	99.9%	99.8%	99.7%
Org of Residence	15,238	0	77	99.5%	99.8%	99.7%	96.4%
Patient Classification	15,238	0	0	100.0%	100.0%	100.0%	100.0%
Patient Pathway	8,538	2,518	0	70.5%	75.5%	71.8%	70.1%
Person Birth Date	15,238	0	3	100.0%	99.4%	99.8%	99.8%
Person Gender	15,238	0	0	100.0%	100.0%	100.0%	100.0%
Postcode	15,238	0	8	99.9%	100.0%	99.9%	99.9%
Primary Diagnosis	15,213	2	0	100.0%	97.4%	96.2%	95.5%
Primary Procedure	15,213	0	0	100.0%	100.0%	100.0%	99.9%
Registered GP Practice	15,238	0	12	99.9%	99.9%	99.8%	99.7%
Site Code of Treatment	15,238	0	0	100.0%	100.0%	99.8%	96.9%
Treatment Function	15,238	0	0	100.0%	100.0%	99.8%	99.8%
Overall	324,535	2,540	122	99.2%	96.2%	95.7%	95.3%

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	99.87%	99.91%
Valid General Medical Practice Code	100%	100%

Data Security and Protection Toolkit Assessment Report Attainment Levels*

The Data Security and Protection Toolkit (DSPT) baseline assessment for 2023/24 was submitted in February 2024, with the final submission to be completed in June 2024. The submission process is supported by an independent two-phase audit process by 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 compliant return for 2023/24.

The information governance function continues to work collaboratively in partnership with Alder Hey Children's NHS Foundation Trust across all areas of data protection, information governance and cyber security. Outputs and delivery of the information governance work programme are monitored through the Trust's governance and committee structures. The information governance team were shortlisted as finalists for the National Health and Social Care Information Governance Annual Awards 2024.

During 2023/24, there were no data security incidents reported to the Information Commissioners Office (ICO).

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:

Category	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 2023/2024 for LHCH found the following level of coding accuracy:

Category	Audit Result
Primary Diagnosis	99%
Secondary Diagnosis	97.6%
Primary Diagnosis	99%
Secondary Diagnosis	98%

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 2023/24, 214 patients died at LHCH. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 41 in the first quarter
- 49 in the second quarter
- 60 in the third quarter
- 64 in the fourth quarter

By 10/05/2024, 201 patients had received a case record review (mortality screen) of which 28 received a full investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 41 in the first quarter
- 49 in the second quarter
- 58 in the third quarter
- 53 in the fourth quarter

1 death representing 0.5% 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:

- 0 representing 0% for the first quarter
- 0 representing 0% for the second quarter
- 1 representing 2% for the third quarter
- 0 representing 0% 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).

The MRG reviews have identified main contributors to death, some of which are:

- High Risk Procedures
- Left or Right ventricular failure
- Respiratory Failure
- Cerebrovascular Accident
- Technical procedure issues
- Post procedural bleeding and tamponade
- Unheralded arrhythmia
- Myocardial infarction

Actions from learning identified include (not exhaustive):

- High risk anaesthetic clinic in addition to the already existing robust High-Risk MDT.
- Further education and teaching regarding identification of tamponade and the role of imaging.
- Development of a postoperative bleeding management protocol.
- Further emphasis on appropriate use of Transit Time Flow measurements to intra-operatively evaluate coronary bypass grafts.
- A review of the use of Atriclips in cardiac surgery for management of chronic / paroxysmal atrial fibrillation, with a focus on potential complications.
- Emphasise the importance of appropriate escalation to Consultants to junior doctors and AHPs.
- A review of the management of post-infarct ventricular septal defects.
- Plans for appointing an urgent cardiac surgery coordinator to help improve pathways and flow of urgent patients and improve communication.
- Commencement of a Safer Waiting List Management group.

The Trust complies with national guidance and populates the mortality dashboard. There is a rigorous review process for all deaths within the Trust. Learning from these deaths is shared widely through Divisional Boards, clinical audit meetings and also by uploading relevant presentations to a mortality SharePoint page which can be accessed at any time.

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:

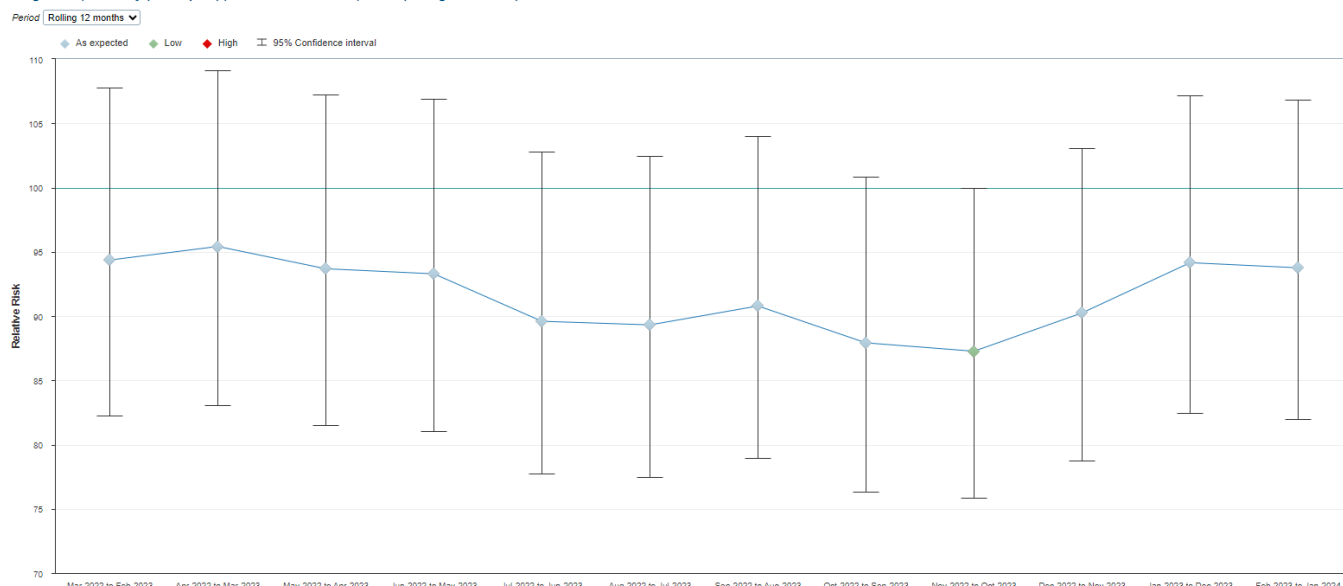
- Specialist acute trusts do not calculate their mortality rates using the summary hospital-level mortality indicator (SHMI); instead, Liverpool Heart and Chest Hospital uses information provided by Dr Foster Intelligence in the form of Hospital Standardised Mortality Ratio (HSMR) that is updated each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

To achieve statistical significance using confidence intervals:

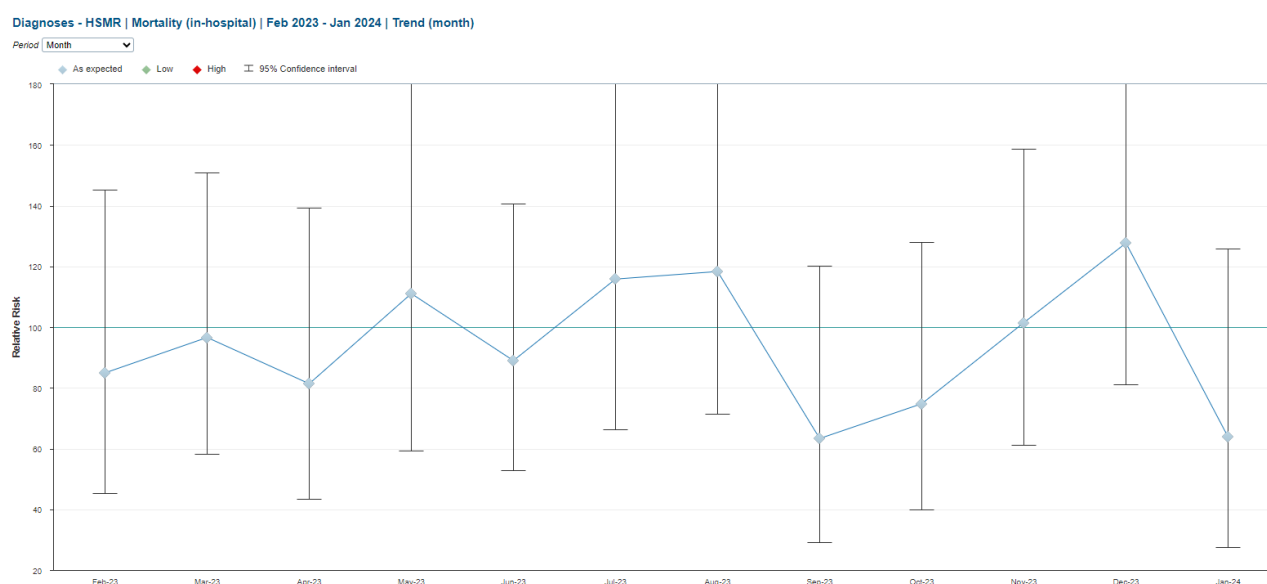
- To be high, a hospital must have HSMR and the lower confidence interval above 100. A hospital above 100 but with lower confidence interval below 100 is classed as 'within the expected range'.

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.

Diagnoses | Mortality (in-hospital) | Feb 2023 - Jan 2024 | Trend (rolling 12 months)



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



Liverpool Heart and Chest Hospital intends to continue with 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 21/22	Performance 22/23	Performance 23/24
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.	<p>Elective (Apr-Mar): 5.9% (RR: 99.9)</p> <p>Non-elective (Apr-Mar): 10.3% (RR:81)</p> <p>Total (Apr-Mar): 7.6% (RR: 89.3)</p>	<p>Elective (Apr-Oct): 4.6% (RR: 81.5)</p> <p>Non-elective (Apr-Mar): 8.5% (RR:71.5)</p> <p>Total (Apr-Oct): 7.6% (RR: 76.4)</p>	<p>Elective (Apr-Oct): 4.6% (RR 80.7)</p> <p>Non-Elective (Apr-Oct): 9.1% (RR 74.1)</p> <p>Total (Apr-Oct): 7.9% (RR 77.4)</p>

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 slightly reduced performance related to discharge question.

Question 39 “Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?”

	Performance 20/21	Performance 21/22	Performance 22/23
Trust’s responsiveness to the personal needs of its patients during the reporting period	8.3	9.4	9.2

Actions taken:

- 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 21/22	Performance 22/23	Performance 23/24
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	91.6%	90.62%	92%

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 21/22	Performance 22/23	Performance 23/24
The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period	95.0%	95.65%	94.04%	94.59%

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 investigations (PSII) and feedback of lessons learned.
- Ward level Identification of assessments not undertaken and reasons why.

Clostridium difficile infection

LHCH 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 2023/2024.

	Target	Performance 21/22	Performance 22/23	Performance 23/24
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	11.98	5.72	11.24

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 21/22	Performance 21/22	Target 22/23	Performance 22/23	Target 23/24	Performance 23/24
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.	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		1505 patient incidents 6.54 per 100 admissions (13,912 admissions) 11 (1.2%) Resulted in severe harm or death

LHCH 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:

- Continuing to embed the Patient Safety Incident Reporting Framework Methodology
- Medical Trust Safety Lead and Champions to continue a focus on safety
- Patient Safety Specialist to access training
- Monitoring of the Trust's safe from harm
- Monitoring of the Speak up Safely campaign

Part 3 Other Information

Performance Review

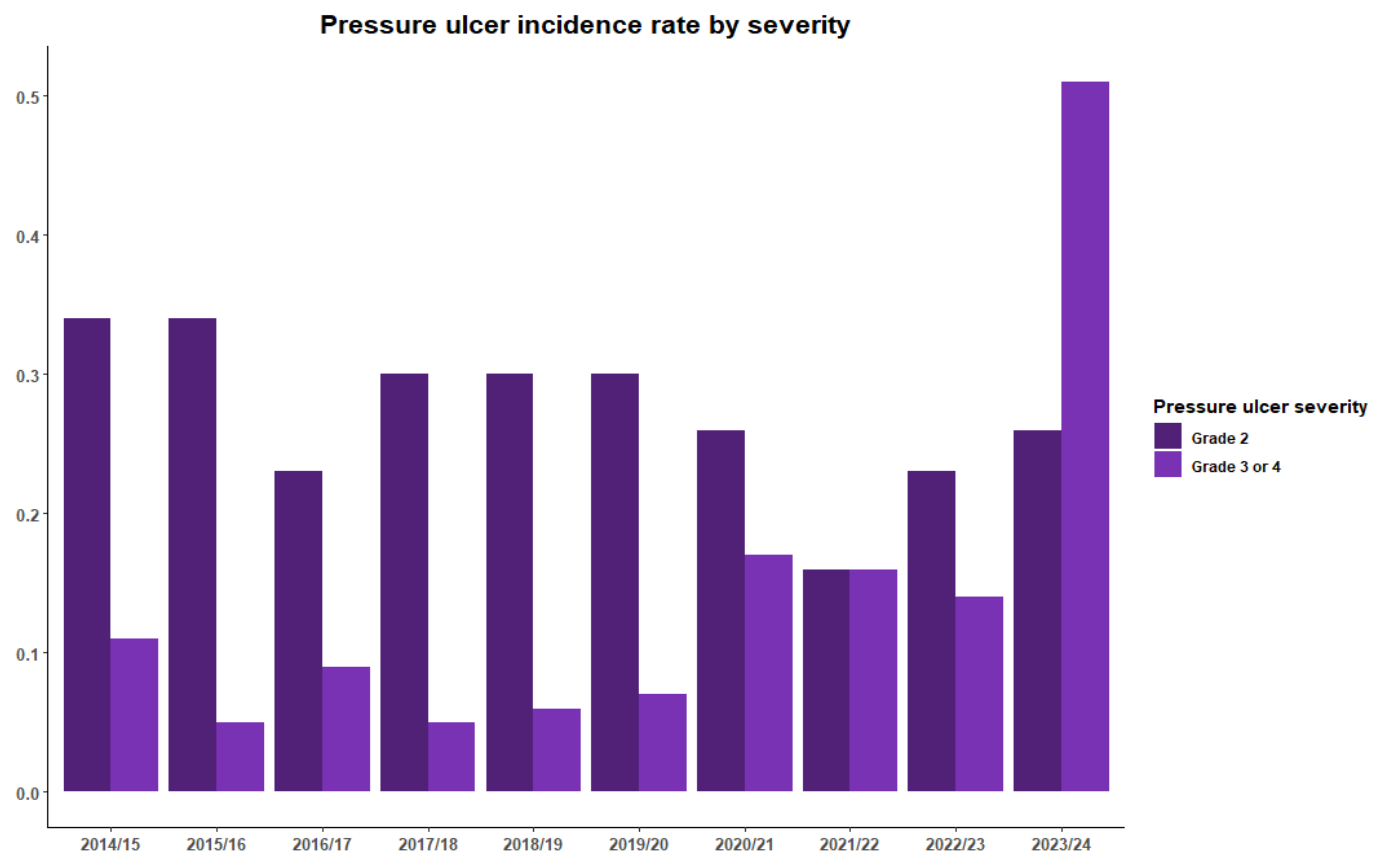
This section of the Quality Account presents an overview of performance in areas not selected as priorities for 2023/2024.

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.

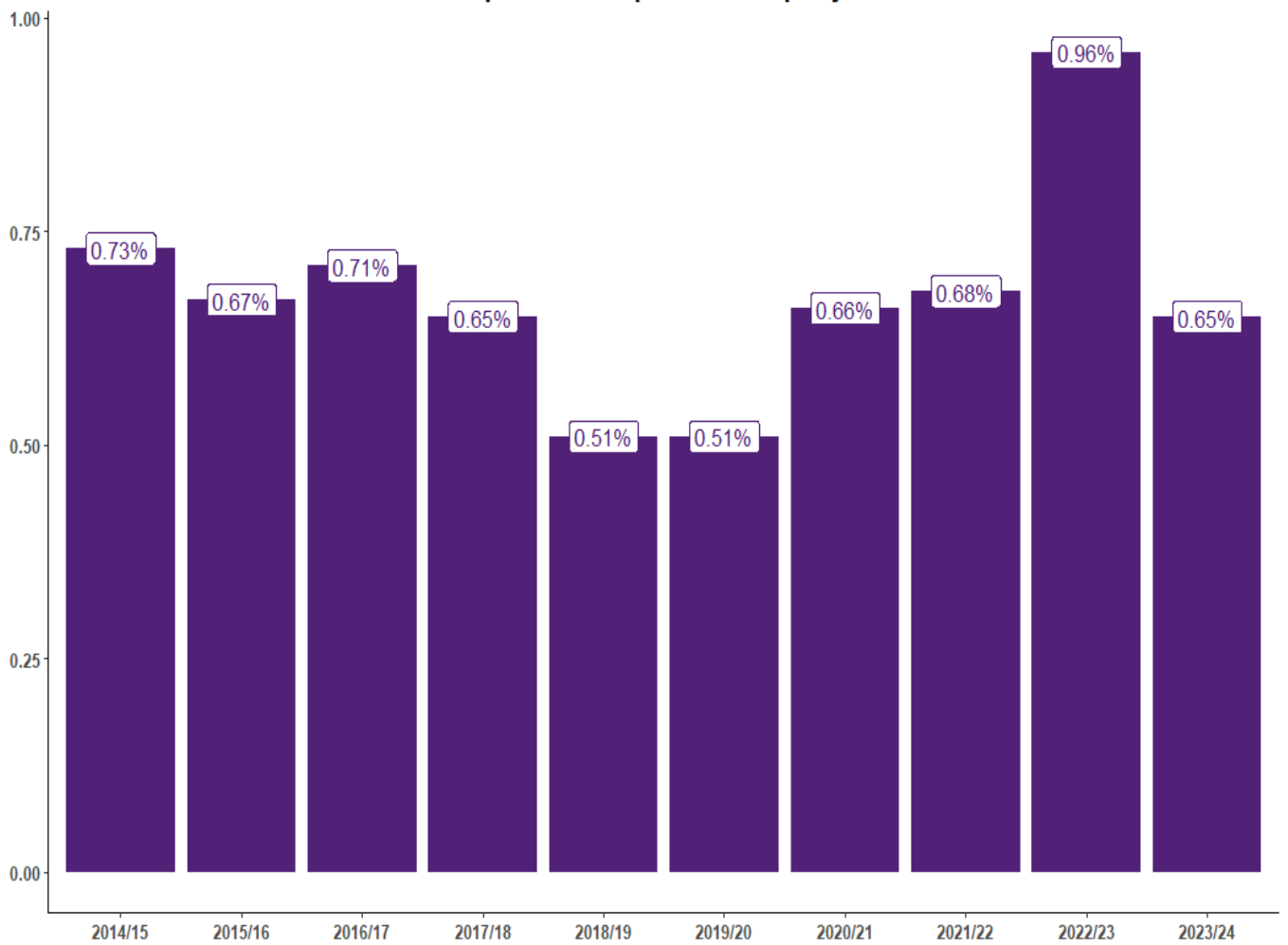
Quantitative Metrics



LHCH was one of the pilot sites for Model Hospital, working closely with the NWCSP. The Tissue Viability Service had already worked closely with the clinical coding manager to ensure that coders could more easily identify the development of hospital-acquired pressure ulcers in the patient's health record. We use a Verification of Pressure Ulcer document, completed by the Tissue Viability Nurses, to assist with this. If there is uncertainty relating to any patient, the clinical coders check with the Tissue Viability Service to clarify to ensure accurate coding and therefore accurate data on the Model Hospital system.

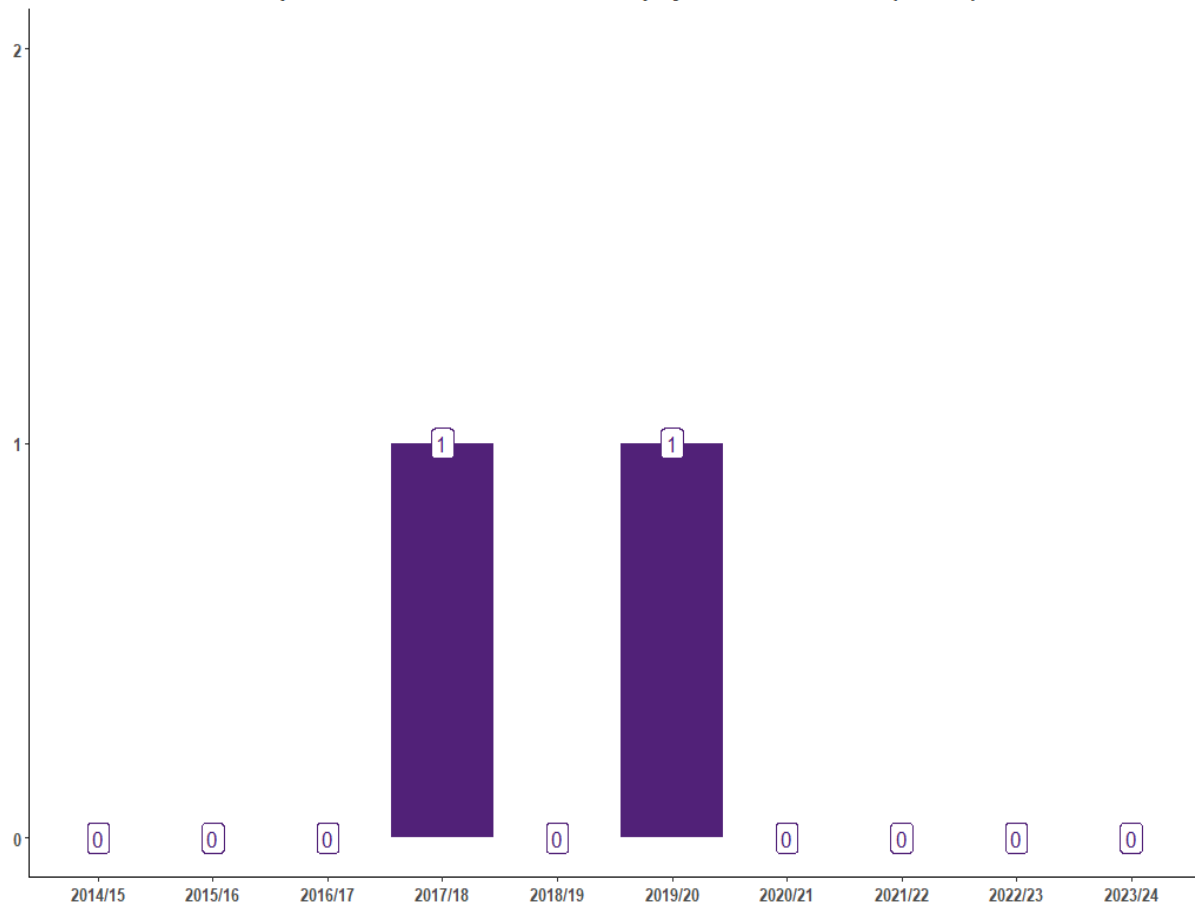
Plans are in place to implement the guidance in Pressure Ulcer Recommendations and Clinical Pathway (National Wound Care Strategy 2023) which includes the five phases of care for patients with pressure ulcers; one of these includes implementing PURPOSE T pressure ulcer risk assessment tool which is planned to be piloted on one of our wards in June/July 2024.

Proportion of inpatient falls per year

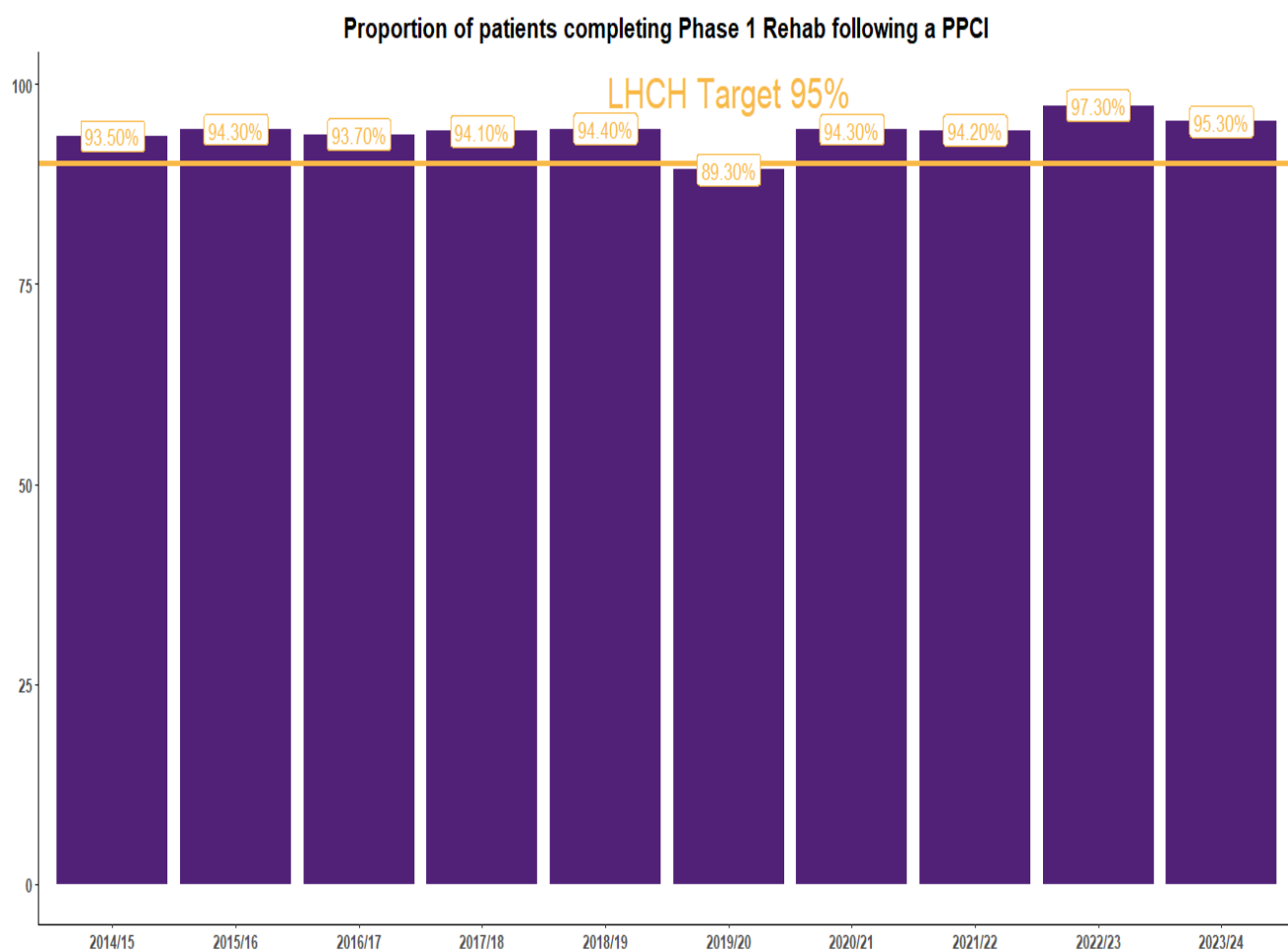


The figure shows the proportion of inpatient falls. This is an important metric as falls can cause significant harm, and severely compromise the recovery of patients. Falls are recorded through a bespoke incident reporting system, and monitored continuously. This year the proportion of inpatient falls has decreased from the previous year, close to the average of the previous 10 years.

Number of inpatient methicillin-resistant staphylococcus aureus (MRSA) infections

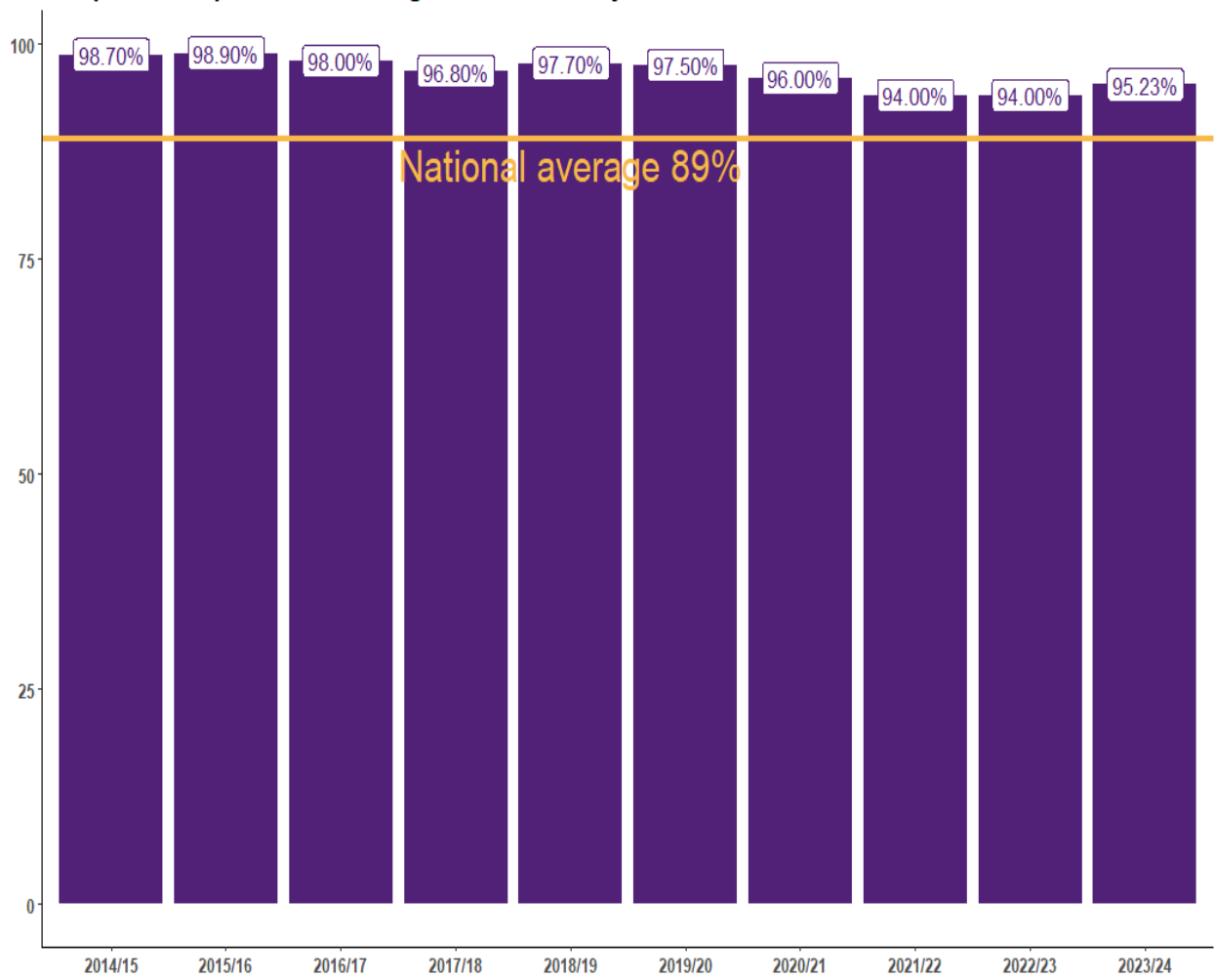


This figure shows the number of inpatient MRSA infections recorded each year. This is an important metric, as MRSA thrives in environments where antibiotics are used frequently, such as hospitals. MRSA infections are monitored with strict scrutiny by the infection prevention and control nurses. This year we have maintained a count of zero MRSA infections, seen over the past 3 years also.

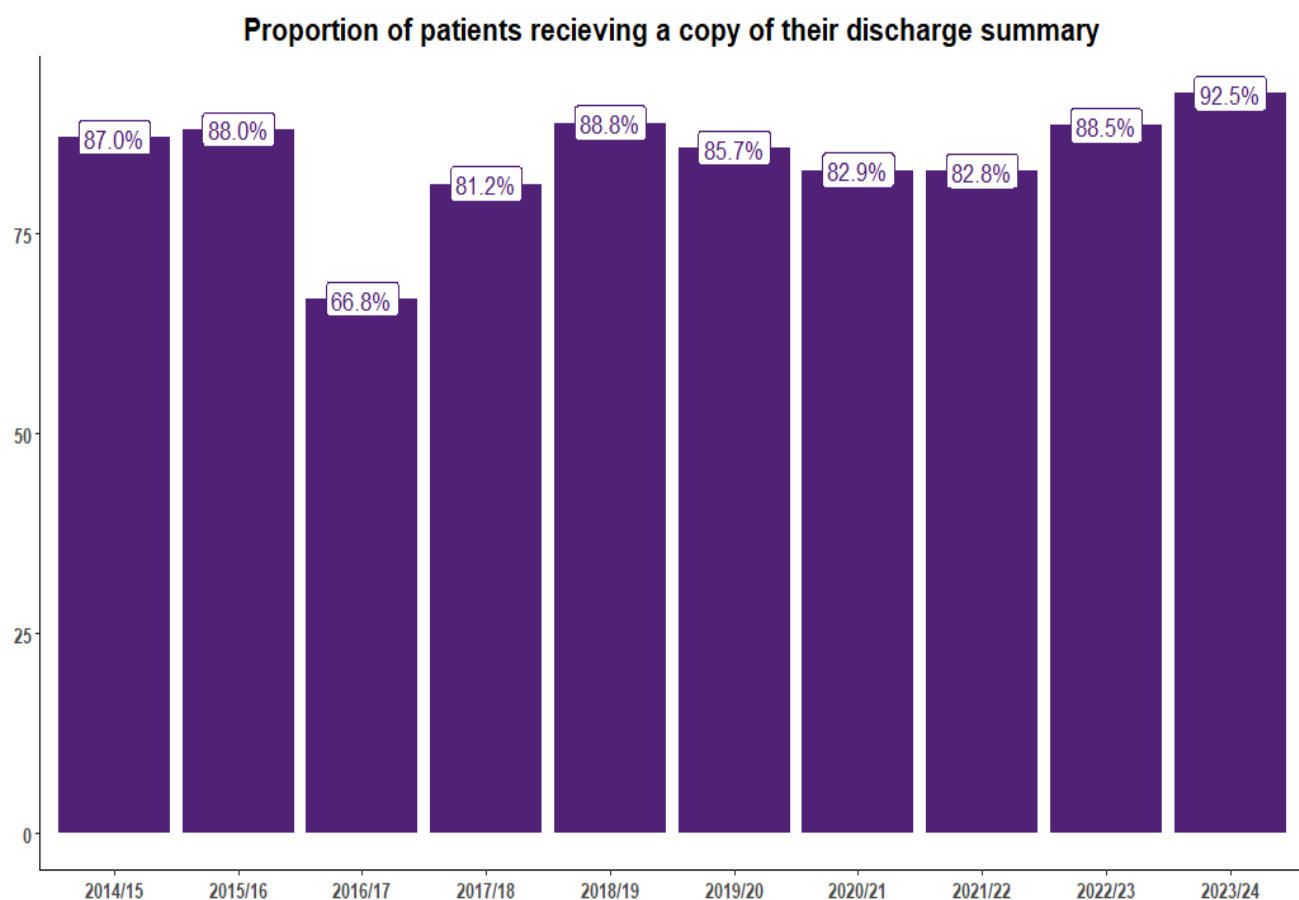


This figure shows the percentage of patients who complete phase 1 rehab after receiving a PPCI. This metric is important because promoting healthier lifestyle behaviours is a vital aspect to post intervention care. This year the trust has maintained compliance above the internal target of 95% demonstrating a commitment to improving patients lives after undergoing life saving procedures.

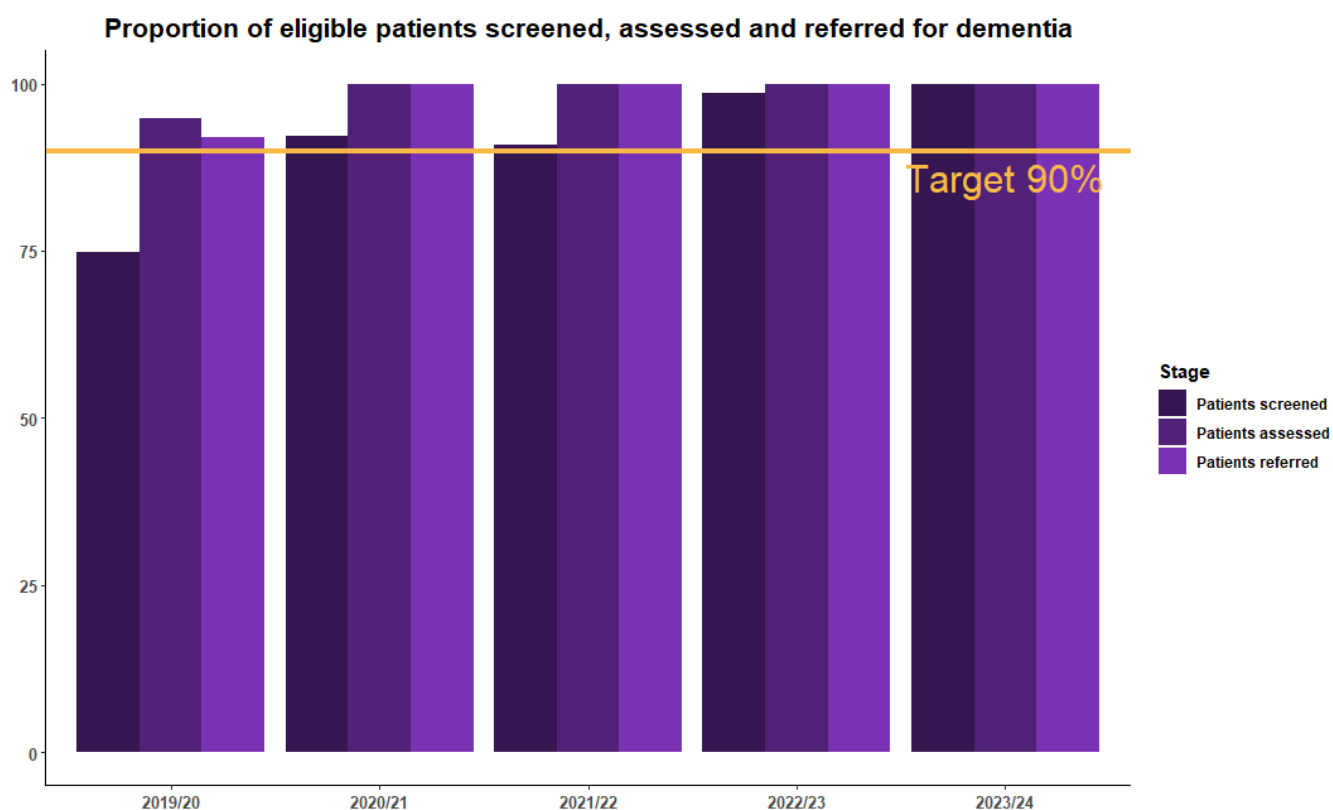
Proportion of patients receiving treatment for myocardial infarction within 90 minutes of admission



The percentage of patients admitted to LHCH with a myocardial infarction whom received treatment within 90 minutes of admission. The data is collected as part of the myocardial infarction national audit project (MINAP), using EPR. This metric is important as it reflects the speed at which the trust can provide life saving treatment. LHCH remains above the national average.

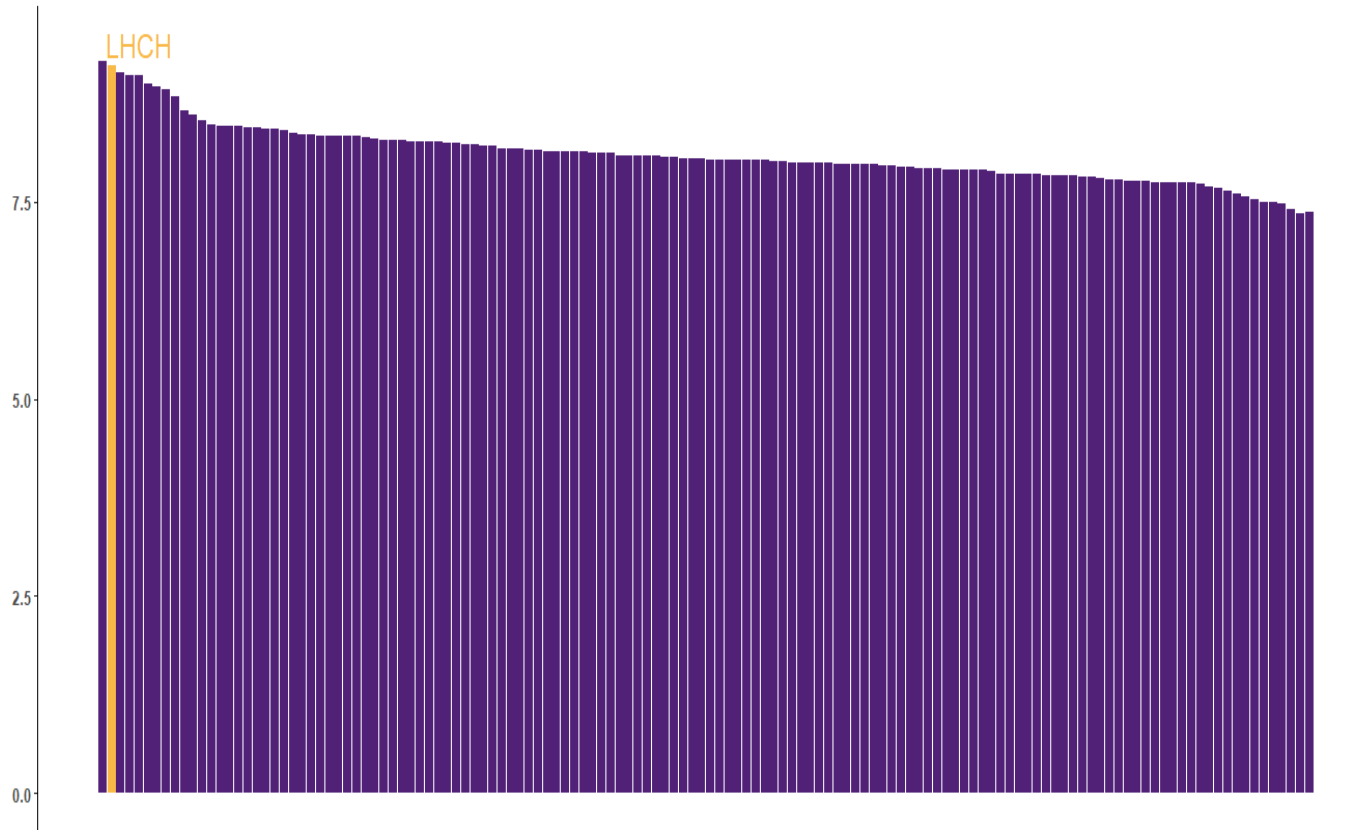


This figure shows the proportion of patients receiving a copy of their discharge summary. LHCH strives for patient centered care at every opportunity, and providing a copy of their discharge summary includes the patient in the discussion when transferring their care back to their GP. This promotes independence, and aids decision making when it comes to their own health. This year LHCH has managed to improve upon previous years, and reached over 90% compliance.

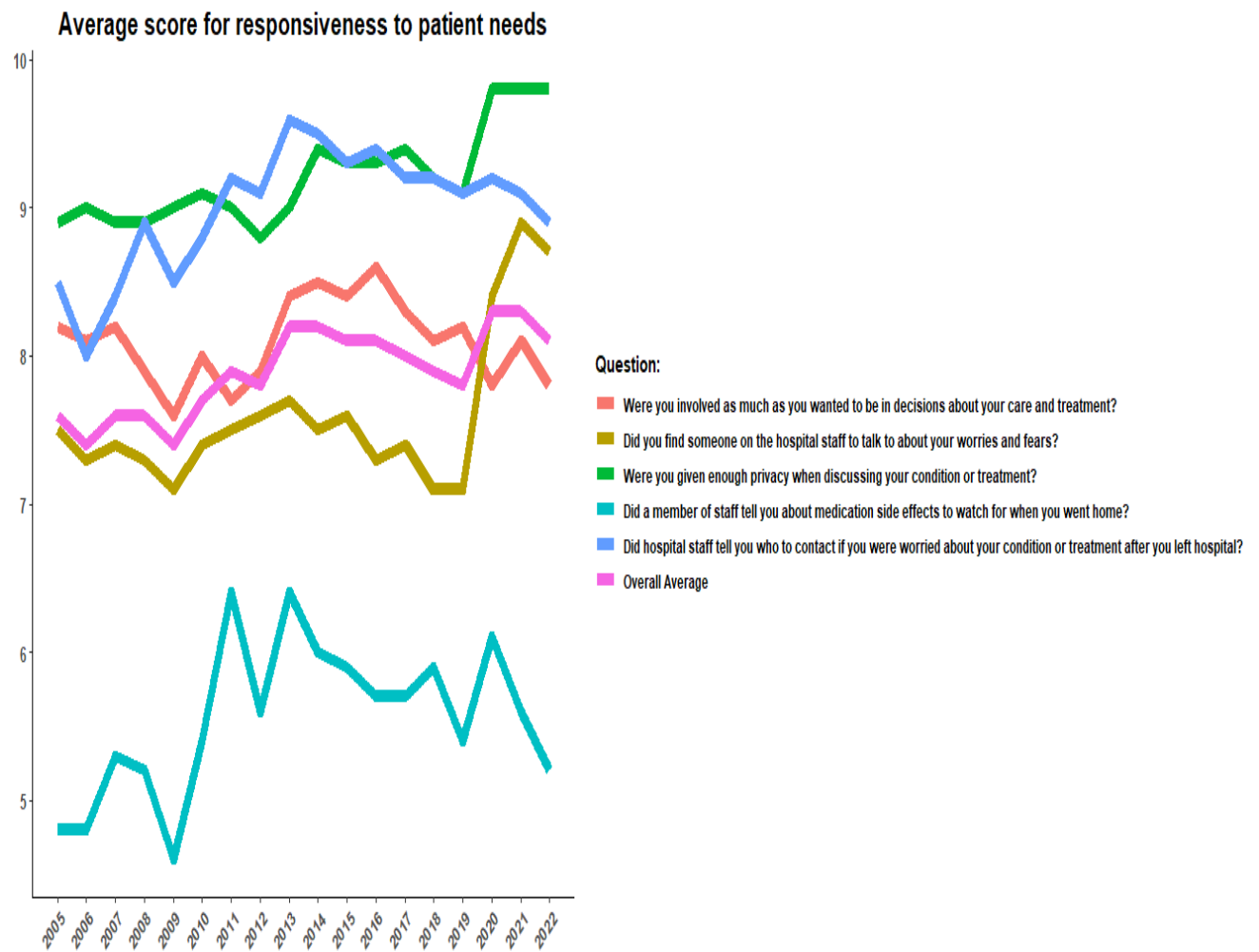


This figure shows the proportion of patients eligible whom have recieved a screen, assessment, and subsequent referral for dementia. This is an important metric because identification of dementia early has a positive impact on the quality of life of those affected. This year LHCH has achieved 100% in all 3 aspects, reflecting a commitment to identifying dementia early and making a swift onward referral to the appropriate service.

Average overall inpatient experience 2022



This figure displays the average overall experience reported by inpatients in 2022. This year LHCH ranks number 2 in the country, reflecting a commitment to patient centered care.



This figure displays the average score for the questions related to responsiveness to patient needs in the 2022 inpatient survey. This year LHCH has maintained high scores in these 5 areas, showing a commitment to fulfilling the needs of our patients.

Developments in the Single Oversight Framework (SOF) to M12

Liverpool Heart and Chest Hospital considers that this data is described from indicators arising from the Single Oversight Framework to M12.

Indicator	Target	Performance 2021/22	Performance 2022/23	Performance 2023/24
Maximum time of 18 weeks from point of referral to treatment in aggregate- patients on an incomplete pathway	92%	79.59%	72.56% (M12 position)	73.9% (M12 position)
All cancers: 62 day wait for first treatment from urgent GP referral for suspected cancer	85%	95.1%	69.2%	Q1/Q2 64.2% (Old standards) Q3/Q4 47% (new standards)
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	6	3	3
Hospital Standardised Mortality Ratio (HSMR)	<=100	110.3 (All diagnoses Apr-Mar) 117.4 (HSMR diagnoses, Apr-Jan)	95.4 (All diagnoses Apr-Mar) 97.8 (HSMR diagnoses, Apr-Mar)	93.9 (All Diagnoses Apr – Jan 24) 95.2 (HSMR diagnoses, Apr – Jan 24)
Maximum 6-week wait for diagnostic procedures	99%	98%	98.69% (YTD) 99.45% (M12 Position)	86.92% (YTD) 81.9% (M12 Position)
Venous thromboembolism (VTE) risk assessment	95%	95.65%	94.04%	94.59%

LHCH 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
- 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 Cheshire and Merseyside 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 (LHCH) Draft Quality Account for 2023/24.

C&M ICB Places were both impressed and assured with the Trust presentation at the Quality Accounts 2023/24 presentation event on Friday 17th May 2024.

The Trusts continued CQC status as 'Outstanding' is commended by the C&M ICB, alongside positive patient experience and staff experience continuing 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, specifically LHCH being recognised with the Social Value Quality Mark Bronze Award in February 2024, demonstrating its commitment to creating, measuring, and reporting social value.

The C&M ICB commends the achievement of LHCH to join an elite group of hospitals around the world who have been successfully validated against the Healthcare Information and Management Systems Society (HIMSS) international EMRAM Stage 7 standards, with LHCH being the first Trust in Europe to be assessed against the new and more extensive Stage 7 HIMSS standards.

It positive to see the Learning from Deaths work undertaken by the Trust and continuous learning in place from this vital work to enhance future care.

The Trust continue to work on recovering elective activity and reducing waiting times with 0 patients waiting over 104 weeks, and only 1 service line with patients over 78 weeks as of March 2024. It is also positive to note that the Trust continue to use the national patients' classification to ensure there was clinical validation of patients on their waiting lists and a clear position on the capacity required to treat urgent patients in priority order.

The Trusts achievements regarding their Quality Priorities for 2023/24 are noted, with an honest assessment of compliance provided. In addition, high compliance of the delivery of CQUINs has been evidenced throughout 2023/24, with the exception of staff flu vaccinations, which has been challenging across C&M Providers.

Significant work to embed the Freedom To Speak Up (FTSU) culture within the Trust has been recognised nationally, which is commendable and another example of providing positive staff experience.

The focused quality priorities for 2024/25 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 are supportive of the 2024/25 Quality Priorities and it positive to hear of the engagement across the Trust, including the Council of Governors and other stakeholders, to determine the Quality Priorities for 2024/25.

The C&M ICB will be monitoring the continued implementation of the national Patient Safety Incident Response Framework (PSIRF) by the Trust in 2024/25.

On behalf of the C&M ICB I would like to thank you for the Trusts work in 2023/24 and continued work to improve patient care in 2024/25.

Helen Meredith

Associate Director of Quality, Safety & Improvement

C&M ICB @ Knowsley Place

6th June 2024

Statement from the Trust's Council of Governors

I have read and reviewed the LHCH Quality Report for 2023/24 and the complexities within the FT and the procedures carried out by 'Team LHCH' are incredible.

The LHCH Quality Report 2023/24 documents an extensive range of the hospital's practices and principles to ensure the safe care of patients and their families. In addition, the Trust recognises the importance of supporting and developing our staff and the progress achieved in the delivery of the LHCH People Strategy reflects this level of commitment and is reflected in the high standards achieved in the Staff survey.

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. 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). Research within the organisation is exemplary and the continued development of the programme will raise the profile of the organisation locally, nationally, and internationally and result in the development of new and innovative treatment.

The collaborative, supportive engagement with the Cheshire and Merseyside Integrated Care Board (ICS), local Trusts and community services demonstrates the high level of commitment to building effective working relationships across the wider health economy. This demonstrates a strength of purpose to the collaborative working required to effectively reduce residual delays post Covid and streamline patient pathways.

The year has been particularly challenging with major changes at board level and the recruitment of new Non-executive Directors (NED's) Despite this the Chair Val Davies and the senior management team have worked tirelessly to ensure the high standards of the organisation during this time of change. This has been a phenomenal achievement.

The hybrid delivery of Council of Governors meetings has allowed a high level of engagement. Governors participate in 'Walkabouts' to wards and departments together with the NED's and this has aided the development of strong collaborative working relationships. In addition, the attendance at NHS Governors development days, PLACE assessments, patient engagement events, and participation in the development of LHCH Quality Priorities have played a significant role in the development of new and existing Governors.

The Annual Members Meeting was virtually on 25th September 2023 and was attended by public governors, staff governors, LHCH members, the Board of Directors, LHCH staff. A review of the Council of Governors activities, including a resume from the Membership and Communications Committee was delivered to keep members abreast of the activities and potential for further engagement with our population.

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.

Elaine Holme

Lead Governor, Liverpool Heart and Chest Hospital
6th June 2024

Statement from Healthwatch

Healthwatch Knowsley welcomes the opportunity to provide this commentary in response to the Trust's Quality Account for 2023/24.

Firstly, our congratulations on the achievements and range of recognition it gained during 2023-24.

Comment on 2023-24 Quality Objectives

We are pleased to see that discharge medication was a priority for 2023-24. This is an area that we continue to see delaying patients journey home from some of our local hospitals and therefore any efforts to improve this are welcome. Similarly prioritising Discharge Equipment is good to see.

General

The Trust has a well-deserved reputation for clinical excellence delivering services across a wide area. Drawing service-users from such a large geographical area may be one of the reasons why we do not see any real volume of patient feedback from Knowsley residents.

There may be opportunities to work with the Trust for promoting increased feedback from patients to their local Healthwatch wherever that may be.

David Aspin

Interim Support Team Manager, Healthwatch Knowsley
17th June 2024

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 England 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 NHS England's 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 2023 to May 2024
 - papers relating to Quality reported to the board over the period April 2023 to May 2024
 - feedback from commissioners dated 06/06/24
 - feedback from governors dated 06/06/24
 - feedback from local Healthwatch organisation 17/06/24
 - 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 26/07/23
 - the 2022 national patient survey - 18/09/23
 - the 2023 national staff survey - 08/03/24
 - 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 Joan Matthews, Director of Nursing, Safety and Quality
E-mail: joan.mathews@lhch.nhs.uk
or telephone 0151 600 1653).