Liverpool Heart and Chest Hospital
NHS Foundation Trust

Liverpool Heart and Chest Hospital NHS Foundation Trust Quality Account 2025/26

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Purpose of Quality Accounts

Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality and standard of services they provide. They are required by the Government to help NHS Trusts, including providers of hospital acute services, community health services and mental health services, maintain focus and improve the quality of care for patients. Quality Accounts have become an important tool for strengthening accountability for quality within NHS Trusts and for ensuring effective engagement of Board of Directors in the quality improvement agenda. By producing a Quality Account, Trusts are able to demonstrate their commitment to continuous evidence-based quality improvement and to explain their progress to patients and their families, the public and those who have an interest in the services that the Trust provides.

Part 1: Statement from the Chief Executive Officer

Welcome to the Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH) Quality Account 2025/26.

For the wider healthcare system across Merseyside and Cheshire, this year has been a challenging one due to ongoing financial pressures. The impact of these challenges has led to additional demands being placed on staff and we would like to recognise their continued professionalism and commitment shown throughout the year.

Despite these challenges, the Trust has maintained a clear focus on continuing to deliver the highest standards of care and treatment. This was evidenced by the results of the national NHS Adult Inpatient Survey, published in September 2025. These results recognised LHCH in the top three trusts in the country for overall patient experience, hospital and ward, and for nurses.

Pleasingly, the recognition not only came from patients. LHCH was also acknowledged as the top trust in the country in four key areas (*we each have a voice that counts; we are safe and healthy; staff engagement; and morale)* in the results of this year's national NHS Staff Survey, published in March 2026.

To be recognised so highly for the quality of care and services, by both patients and staff, is testament to every single colleague and their total commitment to excellence, continuous improvement, learning and innovation.

During the year, LHCH maintained our focus on working together to benefit patients and their families across the city and the region. The Trust continued the collaborative work with Liverpool Adult Acute and Specialist Providers (LAASP), and with The NHS University Hospitals of Liverpool Group (UHLG) (the Group), which was established in November 2024.

The purpose of the Group is to create sustainable healthcare systems for the future with a clear focus on improving patient care and outcomes and finding solutions and having a simpler way of making decisions about the things that involve patients and their families, members of the public and NHS staff in the system.

During the year, a new long-term strategy, UHL2030 was launched. Shaped through extensive engagement with key stakeholders, staff, patients and partners, the strategy reflects shared ambition and collective ownership of the organisation's future direction. UHL2030 sets out a clear and compelling vision for the next decade, providing a strong and unified framework to guide decision-making, prioritisation and improvement across the Trust.

Throughout the year, work was undertaken through LAASP governance arrangements to develop a business case, supported by engagement with NHS England (NHSE). Following national consideration, it was confirmed that the proposals would not progress, and formal LAASP governance arrangements were closed on 31 March 2026. While the proposed organisational changes did not proceed, the collaborative activity undertaken during the year strengthened relationships between partners and contributed to continued system working across Liverpool and the wider Cheshire and Merseyside footprint.

During the year, progress was also made through the Corporate Services Programme, which is bringing together corporate functions across the Group to create more resilient, consistent and efficient ways of working. By improving the alignment of services such as governance, finance, workforce, digital and

estates, the programme supports better use of resources, clearer accountabilities and stronger support to frontline services. This work is a key enabler of UHL2030, helping to ensure that the organisation is equipped to deliver its ambitions in a sustainable way.

As we look ahead to 2026/27, we do so with refreshed clarity of purpose as part of UHL Group. While the challenges facing the NHS remain significant, the launch of UHL2030, the strengthening of collaborative working, and the continued delivery of outstanding care and specialist services provide confidence for the future. With our values at the centre of everything we do, and through the continued dedication of our staff and partners, we remain committed to enhancing our regional services, optimising our hospital site, and supporting UHL Group and wider system improvements.

Finally, we would like to thank everyone at Liverpool Heart and Chest Hospital for their hard work and dedication over the past year – staff, volunteers and governors. Your commitment to providing exceptional care to our patients and families is truly inspiring.

James Sumner
Chief Executive Officer

Part 2: Priorities for Improvement and Statements of Assurances from the Board

Part 2.1: Priorities for Improvement in 2026/27

Following engagement event with patients and information gathered from discharge phone calls the priorities have been developed across the organisation with stakeholder groups.

4 Priorities 26/27 (Transformational plan)

1. We are transforming outpatient care at Liverpool Heart and Chest Hospital to deliver quicker access, smoother pathways, and a better experience for every heart and lung patient. By improving how clinics run, expanding digital and virtual care, and focusing our specialist workforce where it makes the greatest difference, we will free up capacity, cut out waste, and improve outcomes. All while supporting the long-term financial health of our services.

2. We are improving the quality and consistency of diagnostic decision-making by reducing unwarranted variation in pathology, radiology, and specialist cardiothoracic diagnostics, aligning practice to evidence-based standards and GIRFT (getting it right first time) best practice where applicable, ensuring patients receive timely, appropriate tests that add clinical value and support safe, sustainable care.

3. Valuing patients' time is central to delivering compassionate cardiology care. By reducing length of stay safely and effectively, we support faster recovery, improve patient flow, and give our patients more time where it matters most, back home with their families or loved ones.

4. Our mission is to improve theatre productivity by strengthening scheduling, enhancing workforce deployment, reducing avoidable delays, and standardising perioperative pathways. Through better use of theatre capacity, improved flow, and robust data-driven oversight, we will increase throughput, reduce variation, and support sustainable elective recovery while maintaining the highest standards of patient safety and quality.

Part 2.2: Statements of Assurances from the Board

We are required to include formal statements of assurances from the Board of Directors which are nationally requested to give information to the public. These statements are common across all NHS Quality Reports.

2.2.1 Participation in Clinical Audits

During 2025/26, LHCH Trust participated in 19 National Clinical Audits and no National Confidential Enquiries including in the National Clinical Audit and Patient Outcomes Programme (NCAPOP), covering relevant health services that LHCH Trust provides.

The National Clinical Audits and National Confidential Enquiries that LHCH Trust participated in and for which data collection was completed during 2025/26 are listed in **Appendix A** 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 the audit or enquiry.

The reports of 11 National Clinical Audits were reviewed by the provider in 2025/26. A selection of these audits is outlined below, and LHCH Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

Heart - National Cardiac Audit Programme (NCAP) Annual Report 2025

This national report was published on 13/03/26 and included data up to March 2025, the full report is available online at https://www.nicor.org.uk/national-cardiac-audit-programme

The National Audit of Percutaneous Coronary Interventions (NAPCI) (Angioplasty audit British Cardiovascular Intervention Society (BCIS) and The Myocardial Ischaemia National Audit Project (MINAP) ('Heart Attack' audit / British Cardiovascular Society (BCS)

Performance against national standards for the management of acute coronary syndromes and percutaneous coronary intervention (PCI) remains strong overall, with particular strengths in timely reperfusion and access to specialist care. Median call-to-balloon time was 129 minutes, below the Cheshire and Merseyside Cardiac Network average, and approximately 50% of acute coronary syndrome (ACS) patients received PCI within 150 minutes, comparable with peer Trusts. 85% of ST- elevation myocardial infarction (STEMI) patients received PCI within 60 minutes of hospital arrival, demonstrating effective STEMI pathways. The Trust continues to perform a high volume of complex PCI, with use of intracoronary imaging now at the national average and ranking second highest in the UK for imaging use in complex cases (>2,000 procedures). Access to inpatient cardiology care remains strong, with 97% of patients managed by a specialist cardiologist and 85% admitted to a cardiac ward. Delivery of angiography within recommended times has improved significantly, with 75% receiving angiography within 72 hours, compared with 50% the previous year.

Areas identified for improvement largely relate to data completeness and coding accuracy rather than confirmed clinical shortfalls. Apparent low compliance was noted for use of P2Y12 inhibitors (a class of

antiplatelet medications), drug-eluting balloon stents, inpatient echocardiography, secondary prevention medications, and referral to cardiac rehabilitation.
Local validation audits are underway to assess data quality, particularly where care may be delivered across organisational boundaries. Early triangulation with NICOR cardiac rehabilitation data suggests true referral rates are likely above 85%.

National Heart Failure Audit:
There are 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 (National Institute for Cardiovascular Outcomes Research) data. This is due to the Primary reason for admission being a non-Heart Failure procedure or diagnosis (Audit criteria).

There is a weekly Heart Failure MDT (Multidisciplinary Team meeting) established, offering the 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 (2024/25)
The Trust continues to demonstrate strong performance in cardiac rhythm management, undertaking the highest volume of cardiac implantable electronic devices (CIEDs) within the Cheshire and Merseyside Cardiac Network. Clinical outcomes and adherence to national guidance remain favourable.

Compliance with NICE technology appraisals is high, including 97% compliance for dual-chamber pacing in atrioventricular block (TA88) and 96% compliance for ICD implantation for primary prevention (TA314). Compliance for dual-chamber pacing in sick sinus syndrome (TA324) is 70%, comparable with peer organisations. Outcomes for ICD implantation are positive, with a low unadjusted one-year mortality rate of 1.2%.

Procedural quality indicators remain strong. Re-intervention rates following CIED implantation (3.2%), including complex devices, are below national averages. For ablation procedures, the Trust's use of

general anaesthetic is below the national median, and re-intervention rates for standard and complex ablations are in line with national benchmarks, remaining stable over the last decade.

Overall, the audit demonstrates high procedural volume, strong compliance with national standards, and sustained performance against key outcome measures, providing assurance on the safety and effectiveness of cardiac rhythm management services.

National Congenital Heart Disease Audit (NCHDA) 2024/25

The Trust participated in the National Congenital Heart Disease Audit (NCHDA) 2024/25, which demonstrated a continued increase in activity, including cardiac rhythm management and interventional procedures for adult congenital heart disease (ACHD) patients. Overall activity increased by 14%, reflecting a gradual rise in surgical and diagnostic catheter procedures. Surgical outcomes remained strong, with survival rates of 98.9% for congenital heart disease surgery, comparable with peer trusts and within the nationally expected range.

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 24-25 External Validation rated the LHCH DQI was 96.5% - an increase from 90.5% in 23-24.

National Adult Cardiac Surgery (NACSA)

The Trust participated in the 2025 NICOR Cardiac Surgery National Audit and demonstrated strong performance across several key indicators. The Trust undertook the second highest volume of cardiac surgery procedures nationally, with a favourable case mix including a 42% off-pump coronary artery bypass graft (CABG) rate. Outcomes for patients requiring urgent CABG were positive, with average waiting times and a below-average length of stay (six days).

Risk-adjusted survival outcomes were in line with national expectations, and patient safety indicators were favourable, including below-average rates of re-operation for bleeding and 30-day readmission.

Areas identified for improvement include elective CABG waiting times, which were highest nationally during 2024/25, although performance has improved during 2025/26. Day-of-surgery admission rates remain below the national target but are in line with the national average. The Trust also recorded higher than average post-operative stroke rates (1.4%), although these were comparable with rates seen in similar high-volume cardiac centres.

The Trust continues to use audit findings to drive targeted improvement work and maximise patient outcomes.

National Diabetes Inpatient Safety Audit (NDISA)

LHCH takes part in the NaDISA harms audit on a monthly basis. This is led by our Diabetes Nurse Specialist. LHCH has reported no NaDISA harms since commencing participation in this audit, which 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, Diabetes Nurse Specialists,

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.

National Cardiac Arrest Audit (NCAA) 2025/26 (Q1–Q3)
The Trust continues to demonstrate strong performance in the National Cardiac Arrest Audit. Although the overall rate of reported cardiac arrests was higher than some comparable organisations, this is likely to reflect improved case identification and data quality. Importantly, outcomes following cardiac arrest are consistently better than expected.

Risk-adjusted return of spontaneous circulation (ROSC) lasting more than 20 minutes was higher than expected, with sustained improvement observed since January 2024. Ward-based ROSC outcomes also exceeded those of similar trusts, indicating effective recognition and management of in-hospital deterioration.

Survival outcomes were particularly positive. Risk-adjusted survival to hospital discharge was above expected and higher than comparable trusts, with performance remaining statistically significantly better than expected over several years. Ward-based survival outcomes showed similar sustained improvement. Short- and longer-term survival, including 24-hour and 28-day survival, was also higher than that of peer organisations.

Overall, these findings demonstrate high-quality resuscitation practices and ongoing improvement in the management of cardiac arrest, reflecting the Trust's strong clinical processes and commitment to patient safety.

Sentinel Stroke National Audit Programme (SSNAP) Post-acute Organisational Audit
The 2025 SSNAP national audit demonstrates that the Knowsley Early Supported Discharge (ESD) CRT team continues to provide a dedicated, stroke-specific service with strong engagement in national clinical audit. The service achieved a number of key quality indicators, including participation in SSNAP, provision of rehabilitation to people living in care homes, access to vocational rehabilitation, commissioned support services, and the absence of a waiting list. The team also undertook regular patient and carer experience surveys, supporting a patient-centred approach to service development.

Areas identified for improvement relate primarily to workforce capacity and multidisciplinary working. The service did not meet national standards for recommended staffing levels across core disciplines, access to the full range of specialist professionals (including clinical psychology), or seven-day rehabilitation provision. In addition, the audit highlighted the need to strengthen formal multidisciplinary team meetings, attendance at inpatient MDTs, research engagement, and clarity around time-limited-service provision.

UK Cystic Fibrosis (CF) Registry Annual Report 2025 (Published 2026)
The adult centre remains among the top units for lung function and body mass index (BMI), key markers for CF care. Moreover, this is on a background of lower use of IVs and high-cost treatments.

Annual review data showed age-adjusted FEV1% outcomes higher than expected for patients without a history of lung transplant. Use of DNase therapy was higher than the national average, and registry data completeness remained high at over 95%.

Royal College of Physicians Falls and Fragility Fracture - National Audit of In-patient Falls (NAIF - 2025)
Any patient who sustains a hip fracture at LHCH is transferred to the local acute trust A&E department for

management of the fracture. The receiving acute trust is responsible for recording the admission on the National Hip Fracture Database (NHFD).

The service provider hospital assigns a new fall record to LHCH; this is automatically generated via email notification from the NHFD. LHCH then submits the relevant information to the National Audit of Inpatient Falls (NAIF) database.

No LHCH cases are included within the NHFD hip fracture data presented in this report. However, the LHCH Falls Lead has reviewed the NAIF report recommendations to identify any learning opportunities for service improvement. Following this review, LHCH is meeting the relevant recommendations, with additional actions planned.

Participation in local clinical audits:
The reports of local clinical audits were reviewed by the provider in 2025/26, 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.

Audit	Improvement work
Surveillance - Cleanliness	The audit tool and programme introduced in the previous year have continued to deliver positive outcomes. The tool remains in routine use and is well embedded in practice. Ongoing collaborative working between infection prevention nurses, matrons, and hygiene service supervisors has supported a consistent and standardised approach to cleanliness monitoring. As a result, average cleanliness scores have been consistently high throughout the year, ranging from 97% to 100%.
Infection prevention audits	Infection prevention audits are undertaken across all clinical areas of the Trust by Infection Prevention Nurses, working in collaboration with ward staff. These audits assess compliance with key infection prevention standards, including decontamination and environmental cleanliness, equipment management, waste disposal, sharps handling, and linen management.

Surgical site Infection prevention bundle:	Components of the Surgical Site Infection (SSI) prevention bundle were audited for patients undergoing cardiac surgery. The audit assessed compliance with standards relating to hair removal, appropriate pre-operative skin preparation, surgical prophylaxis, timely dressing removal, and pre-operative screening prior to surgery. Overall compliance was consistently high, typically ranging between 95% and 100% across most elements of the bundle. However, compliance with appropriate hair removal remained below the expected standard, despite some improvement during the year. Further work is underway to address this area and ensure full compliance with agreed standards.
Risk adjusted Surgical Site Infection rates	Risk-adjusted surgical site infection (SSI) rates have been implemented to provide a more robust and meaningful measure of infection performance. This approach enables more accurate assessment and comparison of SSI rates across surgical procedures by accounting for patient-specific risk factors. The introduction of this methodology supports improved monitoring, benchmarking, and continuous improvement, and contributes to the ongoing enhancement of patient safety and quality of care within surgical services.

NatSSIP2 (National safety standards for invasive procedures) and LocSSIP (Local safety standards for invasive procedures) Compliance

During 2025/26, the Trust has commenced implementation of standardised LocSSIP reporting aligned to NatSSIP2 standards. This represents a significant step in strengthening Trust-wide assurance and consistency. Critical Care is already operating in line with NatSSIP2 requirements, providing early implementation assurance and learning to support wider rollout.

Progress against NatSSIP2 is supported by a robust Trust action plan and an established steering group, with delivery taken forward on a cross-divisional basis, including corporate services. The Clinical Audit and Effectiveness Team has enabled improved oversight through automated, Trust-wide LocSSIP compliance reporting, supporting improved visibility and governance.

Catheter laboratories continue to demonstrate good LocSSIP compliance through routine audit. Key improvement priorities for 2025/26 include:

- Strengthening compliance with mandatory NatSSIP training.
- Improving the quality and consistency of debrief documentation, supported by structured prompts within Carecube.
- Addressing non-compliance with sign-out processes through targeted staff engagement.
- Improving clinician engagement with debriefs in partnership with clinical leads.
- Prioritising ward-based LocSSIPs, including endoscopy (Holly Suite) and chest drain insertion and removal, where Trust-wide compliance improvement is required.

Theatre services demonstrate overall good compliance with NatSSIPs, with identified improvement actions in progress. Assurance mechanisms include:

- Enhanced reporting to Divisional Boards, alongside existing monthly compliance monitoring and staff feedback.
- Planned peer review of NatSSIP practice to provide additional independent assurance.
- Ongoing alignment of local processes, documentation and reporting with NatSSIP2, published in 2024.

Collectively, these actions support continued improvement in procedural safety, consistency of practice, and Board-level assurance.

Pharmacy and other local audits/projects:

During 2025/26, all local audits, projects or service evaluations - including re-audits, were registered with the Clinical Audit Team. Results are routinely shared through divisional audit meetings, with high-impact findings disseminated more widely through Trust-wide audit days.

Project Title
National British Thoracic Society (BTS) Endobronchial Ultrasound (EBUS) Audit
Cystic Fibrosis Physiotherapy Feedback - Inpatient Stay
Reduction of Surgical Site Infection using a Novel Intervention (ROSSINI)- Platform Baseline Audit
Evaluation of Pseudomonas infection rates in people with Cystic fibrosis over the last decade and how this has been impacted by the initiation of highly effective modulator therapy (HEMT).
Cardiac conditions and medication for attention deficit hyperactivity disorder (ADHD).
Exploring student perceptions of barriers and facilitators to hybrid learning in Postgraduate Critical Care Education: A Qualitative study/Service Evaluation.
Reducing the incidence of post-operative surgical emphysema
Stage III non-small cell lung cancer (NSCLC) outcome audit
Exploring student perceptions of barriers and facilitators to hybrid learning in postgraduate critical care education: a qualitative study.
Re-audit: Consent form documentation for Computerised Tomography (CT) Guided Lung Biopsies.
PEACE (Pleural Effusions After Cardiac surgEry)
Review of contemporary extraction practice @ LHCH.
Strengthening patient safety through structured Cardiothoracic surgery handover
Accuracy of device guided heart failure detection in patients with heart failure diagnostics-enabled cardiac implantable electronic device (CIED) in situ
Retrospective Review of Post-Operative Pain Management of Patients that Undergone Cardiac Surgery via Sternotomy
Flutter bag after thoracic surgery
Evaluation of Patient Initiated Follow Up in a Transcatheter Aortic Valve Implantation Clinic: A comprehensive service evaluation on Patient Satisfaction and Clinical Outcomes
Does providing specific thoracic aortic aneurysm education to lung cancer screening nurses improve their confidence when discussing incidental finding of thoracic aortic aneurysm?
Evaluation of Radiologist Use and Diagnostic Impact of Chest X-ray AI at the Heart and Chest Hospital, Liverpool
Lung cancer with cystic airspaces project: Examining the accuracy of clinical staging: A multi-centre UK audit
Bridging Policy for preoperative patients on warfarin according to the most recent guidelines
Affera On-going Service Evaluation
Cardio-Oncology service evaluation

Assess data available on Surgical AF ablation at LHCH to standardise and establish a uniform policy.
A quality improvement project to develop the identification and management of frailty within a lung cancer clinic and occupational therapy (OT) community follow up visits.
Complex PCI and CTO PCI Practice (2020–2024)
Outcomes of Mini-AVR Compared with Conventional AVR Over the Last 3–5 Years at LHCH
Inpatient Tobacco Dependency Service Evaluation
Post-Myocardial Infarction Surgical Ventricular Septal Defect (VSD) Repair
Auto-generation of proximal and distal MDT discussion letter
Improving efficiency in Wednesday afternoon aortic clinic
Assessment of pain management in patients undergoing minimally invasive coronary artery bypass graft surgery.
REAUDIT- Assessment of the diagnostic quality of PA erect cXR based on anatomical image criteria.
Examining regional referral variation and related factors – deprivation/ geographical location in: Lung volume reduction surgery/ endobronchial valves; Diaphragm plication: Open/VATS(video assisted thoracoscopic surgery) /RATS(robotic assisted thoracic surgery)
Assessment of cardiopulmonary exercise testing in individuals with permanent tracheostomy
Compliance of management of stroke pathway
Audit of Care Compared to British Thoracic Society Guidelines for Bronchiectasis
Pre- peri and post-operative cholesterol optimisation in elective coronary surgery: giving grafts the best chance of survival
Are temporary pacing wires necessary? A snapshot study on the indication and use of temporary epicardial pacing wires and criteria for their removal in adult cardiac surgery at Liverpool Heart and Chest Hospital
Evaluating Missed Opportunities for Primary Sternal Plating: A Retrospective Review of Re-operations for Sternotomy Wound Dehiscence
Cholesterol management in elective coronary surgery
Cholesterol management in elective coronary surgery
Patient satisfaction survey
Improving patient understanding and retention of information in TAVI preassessment clinic
Evaluation of Liver and Spleen T1 and T2 maps in Fontan Patients and Normal healthy Volunteers
Comparing Outcomes of the ‘Urgent @ Home’ Cardiac Surgery Pathway versus Inpatient Management
Analyse and enhance documentation accuracy and completeness for IABP procedures over the past six months- Complete Audit Cycle
Yearly re-audits of the transfusion service and policy
Stress echocardiography audit for the year 2024
2025 National Comparative Audit of NICE Quality Standard 138
Del Nido Cardioplegia initial experience
Review of the prognostic assessment template within the Knowsley Cardio Vascular Disease (CVD) heart failure service, outcomes after 6 months post assessment. An evaluation of effectiveness and value to both service users.
Delivery of ACHD procedures at LHCH
Assess outcomes of Radial T graft vs Free Radial graft during isolated CABG - LHCH
Frequency of simultaneous CKMB and Troponin ordering in clinical practice
Service Evaluation Project: Evaluation of External CT-Guided Lung Lesion Biopsy Referrals: High vs Low Risk.
Cardiac Advanced Life Support (CALS) Quick audit
Electroanatomic mapping system guided endomyocardial tumour biopsy
Signed, Sealed, Sputum: Detecting Non-tuberculosis Mycobacterium by Post in Cystic Fibrosis
Consent when inserting chest drain
Urinary catheter insertion in Thoracic Surgical Patients – A quality improvement program
Chest Drain Management Post Lung Resection – Service Improvement Project

Ablation in patients with pre-operative atrial fibrillation (AF)
Aortic surveillance policy re-audit
Determining the Yield of Insulin Syringes Released from the Aseptic Unit Between May 2024 and April 2025
Assessment of appropriateness and accuracy of raised alerts in radiology scans reported by an external organisation.
Retrospective audit on acute imaging of stroke
Urgent Cases in North-West Adult Congenital Health Disease (ACHD) MDT
Adapted Anatomical Image Criteria for posteroanterior (PA) Chest Radiography
To assess the use of the TYRX pouch and prevention of arrhythmia device infection trial (PADIT) score in preventing cardiovascular implantable electronic device (CIED) infections.
Impact of the Stability+ algorithm on procedural outcomes using High-Power, Short-Duration (HPSD) QDOT+ ablation for Atrial Fibrillation
Audit cycle on Cardiac surgery consent form completion
The clinical utility of febriDx in an integrated community respiratory service.
Out of Hospital Cardiac Arrests - Direct vs Indirect Transfer from field to LHCH
A retrospective clinical audit and service improvement project assessing whether patients undergoing pacemaker/ICD generator change were appropriately considered for CRT upgrade
TOE-based mitral repair study
Evaluating the Compliance to Appendix 2 of the Anticoagulation Policy at Liverpool Heart and Chest Hospital for Patients on an Intravenous Heparin Infusion
Audit of the incidence, consequences and influencing factors of patient prosthesis mismatch following aortic valve replacement
Anticoagulation Audit: Direct Oral Anticoagulants (DOACs)
Temporary pacing wire removal post cardiac surgery, adherence to LHCH policy
Anticoagulation Audit: Low Molecular Weight Heparins (LMWHs)
Adapted Anatomical Image Criteria for PA Chest Radiography
Utilisation and access to a HOT clinic in Adult Congenital Heart Disease (ACHD) at a Level 1 Centre in the United Kingdom.
Anticoagulation Audit: Warfarin

Audit actions are monitored at monthly audit meetings as well as at Divisional Clinical Effectiveness, Research and Innovation meetings.

National clinical audits are primarily funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Although National Clinical Audits are not mandatory, organisations are strongly encouraged to participate in those that relate to the services they deliver. It is mandatory to publish participation in National Clinical Audits in a Trust's Quality Report. A high level of participation provides a level of assurance that quality is taken seriously, and that participation is a requirement for clinical teams and individual clinicians as a means of monitoring and improving their practice. Local Clinical Audit is also important in measuring and benchmarking clinical practice against agreed standards of good professional practice.

2.2.2 Research

Participation and Recruitment in Clinical Research

People living in Cheshire and Merseyside benefit from a rich research environment at Liverpool Heart and Chest Trust with 8 research studies across our specialties.

The mission of the National Institute for Health and Care Research (NIHR) is to improve the health and wealth of the nation through research. NIHR delivers against his mission through its Best Research for Best Health strategy. In line with its strategy, the NIHR launched an open call to designate and fund NIHR Commercial Research Delivery Centres (CDRCs). The aim of the centres is to be centres of excellence, offering additional commercial research delivery capacity to existing health and care organisations and to accelerate the delivery of commercial clinical research for the benefit of patients and local populations.

The selection criteria for the successful CRDCs required high standards of proven collaboration with other NHS and Care providers, proven leadership to act as a host and central hub providing expertise to all members of the collaboration, appropriate existing facilities and a demonstrated and sustained ability to deliver high quality commercial trials to time to target. LUHFT were successful in achieving £5.7M for 7 years (April 2025 – March 2032) for a CRDC. All 3 Trusts in the UHLG are part of the same CRDC as it is a hub & spoke model.

The literature suggests that patients who participate in research have better outcomes, therefore quality of care and research are intrinsically linked and the recruitment into clinical research demonstrates the Trust's commitment to improving the health of our population. Research matrons are now embedded within the clinical teams driving quality and research. During 2025/26 the Trust recruited 1048 patients to clinical trials which equates to an average of 87 per month. The Trust target agreed with the National Institute for Health Research (NIHR) was 840 recruits (an average of 70 per month).

Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. 'Clinical research' refers to research that has received a favourable opinion from a Research Ethics Committee within the National Research Ethics Service (NRES). Trusts must keep a *local record of research projects.*

Research is a core component of LHCH's strategic priorities.
Clinical research at the Trust plays a vital role in generating new knowledge, evaluating innovative treatments, and developing improved models of care that strengthen service quality and patient outcomes across the organisation. The Trust's active engagement in clinical research reflects its commitment to providing patients with access to the latest medical advances and evidence-based care.

Contemporary national evidence continues to demonstrate the positive impact of research-active healthcare organisations. Studies show that patients treated in research-active NHS organisations experience improved clinical outcomes, better care processes, and higher quality services—often referred to as the "research effect" (National Institute for Health and Care Research, 2023; NHS England, 2023). Research-active organisations also benefit from wider system advantages, including stronger staff recruitment and retention, increased opportunities for innovation, and improved adoption of new treatments and technologies across clinical services (Department of Health and Social Care, 2021; NIHR, 2022).

Through continued participation in clinical research and collaboration with regional and national partners, the Trust remains committed to embedding research within routine clinical practice and ensuring patients benefit from the latest developments in healthcare.

In 2025/2026 LHCH recruited 1048 participants to National Institute for Health Research (NIHR) portfolio studies across cardiovascular, respiratory disorders, cancer, anaesthesia, perioperative, pain medicine, infection and critical care. 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 37 actively recruiting studies within the year 25/26.

Some of the highlights and achievements are outlined below:

- Highest recruiter for the national AVIER research study.
- The NIHR Liverpool Clinical Research Facility, in partnership with LHCH and The Clatterbridge Cancer Centre, launched a pioneering early-phase trial targeting lipoprotein(a) to slow calcific aortic valve stenosis, with the first participant receiving study treatment in February 2026.
- LHCH maintained its position as the top recruiting site (out of 11 UK sites) for a respiratory study called SCOOT study (Sample collection for the integration and analysis of data using AI to improve patient outcomes with thoracic diseases).
- The BRITISH trial team at LHCH is currently second on the national recruitment leaderboard, contributing to research that aims to refine risk stratification for patients with non-ischaemic cardiomyopathy, ensuring those who would benefit most from implantable cardioverter defibrillator (ICD) implantation receive it while reducing unnecessary procedures.
- Local recruitment target achieved for ROMA-Women, the first cardiac surgery trial dedicated exclusively to women, which is a randomised study comparing outcomes of single versus multiple arterial grafts.
- A Research Fellow in Cardiology at LHCH has been awarded a British Heart Failure Clinical Research Training Fellowship to support the *“Dynamite” VT ablation study*, fully funding a three-year PhD within the Trust.
- We ranked within the top 10 of the North-West Research Network leaderboards for the Patient Reported Experience Survey, with a total of 172 responses. This reflects a strong level of patient engagement and a positive patient experience within our research delivery. It demonstrates the team’s commitment to high-quality, patient-centred care and strengthens our reputation as a leading research-active organisation within the region.

As a specialist tertiary centre, LHCH is uniquely positioned to undertake complex and early-phase clinical trials, even though it draws from a smaller eligible patient population compared to general acute providers. The Trust maintains a robust research portfolio, with strengths in respiratory and cardiology research, and is committed to ensuring equitable access to research opportunities for the population it serves.

This strategic focus enables the Trust to contribute to cutting-edge clinical innovation while delivering high-quality, evidence-based care. By supporting a diverse range of studies, including early-phase and translational trials, LHCH strengthens its role as a leader in specialised research and ensures that patients benefit from the latest advances in treatment and care delivery.

Collaboration

At LHCH, we are committed to collaboration and shared excellence, working closely with strategic partners to maximise the impact of our research activities. Following LHCH’s integration into the University Hospitals of Liverpool Group (UHLG) on 1st November 2025, the Trust’s research portfolio has been further strengthened through enhanced alignment and shared strategic priorities across the group.

LHCH actively contributes to key research partnerships, including Liverpool Health Partners (LHP), the Liverpool Centre for Cardiovascular Science (LCCS), the NIHR Liverpool Clinical Research Facility (CRF), and the NIHR Cheshire and Merseyside Commercial Research Delivery Centre (CRDC). These collaborations promote more equitable access to research for all patients, ensure studies are focused on the populations we serve, and reduce duplication of research activity across the region.

These shared efforts foster innovation and build collective research capacity, enabling the Trust to deliver high-quality, patient-centred clinical research that benefits both our patients and the wider health system.

The NIHR Liverpool CRF, a collaborative partnership with Liverpool University Hospitals NHS Foundation Trust (LUHFT) and The Clatterbridge Cancer Centre NHS Foundation Trust (CCC), has been instrumental in advancing early-phase and first-in-human studies. LHCH is collaborating to deliver an innovative cancer vaccine study, helping to bring novel, potentially life-changing treatments to patients with persistent and complex health conditions.

Through the LCCS, in partnership with Liverpool John Moore's University (LJMU) and the University of Liverpool (UoL), LHCH has supported the co-funding of a PhD studentship and is co-developing grant applications to expand research opportunities for our patient population.

LHCH is also a key partner in the NIHR Cheshire and Merseyside CRDC, participating as a spoke site in the region's hub-and-spoke delivery model. Our involvement in these nationally significant programmes positions LHCH at the forefront of delivering cutting-edge research and innovation across the region, contributing to improved health outcomes both nationally and internationally.

Strategic Research and Innovation Committee

The Committee advises on, contributes to, and helps direct the Trust's Research and Innovation Strategy, encompassing both academic and clinical research. This strategy is closely integrated with key academic partners, including the University of Liverpool, Liverpool John Moore's University, and other Higher Education Institutions, and is aligned with wider system priorities.

The Committee provides assurance to the Trust Board on the effective implementation of this strategy, supporting the delivery of world-class translational, academic, and clinical research in collaboration with our partners. Through this oversight, the Trust ensures research activity contributes to improved patient outcomes, innovation in care delivery, and strengthened academic excellence.

Patient and Public Involvement and Engagement (PPIE)

Approval by the Research & Innovation (R&I) Committee considers whether a study has actively involved patients and the public during its development. This is facilitated through Patient and Public Involvement and Engagement (PPIE) groups, which provide feedback on study design, with particular emphasis on the clarity and appropriateness of study documentation for a lay audience.

LHCH is committed to embedding the patient voice across all research activities. The LHCH Patient Research Ambassador contributes to shaping national guidance and collaborates with partners to influence study design.

The LHCH Research Unit supports investigators in embedding PPIE throughout the study design process. Following a review of current PPIE processes, the Research Unit has identified areas for improvement

and developed the Patient Review Team for New Research (PARTNER) Group, which is in the final stages of development and scheduled to be fully introduced in 2026. Once operational, this group will enable patients and members of the public to review study documents and provide structured feedback to investigators, helping to ensure study materials are patient-friendly and understandable.

The Trust is also co-developing a Patient and Public Involvement and Engagement (PPIE) Strategy as part of a collaborative approach across the UHLG partnership. This strategy ensures that diverse communities are represented in research, promoting equality, inclusivity, and relevance. Embedding PPIE enhances recruitment, delivery, and patient outcomes, ensuring that research at LHCH remains patient-centred, high-quality, and impactful.

2.2.3 Goals agreed with Commissioners.

Commissioning for Quality and Innovation (CQUINs)

Please note the mandatory CQUIN scheme continued to be paused by NHS England in 2025/26.

2.2.4 What others say about the Trust.

Statements from the Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission and its current registration status, at the end of 2025/26, is registration without conditions on the registration.

The Care Quality Commission (CQC) has not taken new enforcement action against the Trust during 2025/26.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

All NHS Trusts are required to register with the Care Quality Commission. The CQC undertakes checks to ensure that Trusts are meeting the quality statements in the Single Assessment Framework under safe, effective, caring, responsive and well-led. If the CQC has concerns that providers are non-compliant there are a wide range of enforcement powers that it can utilise which include issuing a warning notice and suspending or cancelling registration.

2.2.5 NHS Number and General Medical Practice Code Validity

Liverpool Heart and Chest NHS Foundation Trust submitted records during 2025/26 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data (as at December 2025):

-which included the patient's valid NHS number was:

- 99.7% for admitted patient care.
- 99.9% for outpatient care.

-which included the patient's valid General Medical Practice Code was:

- 99.9% for admitted patient care,
- 99.9% for outpatient care.

The Trust has a DQMI score of 98.5% which is significantly higher than the national score of 70.3%. There are no data quality concerns across both the Outpatient and Inpatient Care data submissions. The improvement plans implemented across 2024/25 has improved the areas of concern previously identified.

The patient NHS number is the key identifier for patient records. Accurate recording of the patient's General Medical Practice Code (Patient Registration) is essential to enable the transfer of clinical information about the patient from a Trust to the patient's General Practitioner (GP).

2.2.6 Information Governance Toolkit

The Data Security and Protection Toolkit (DSPT) is a mandatory submission. The toolkit allows organisations to measure performance against the data security and information governance requirements. All organisations that have access to NHS patient data and systems must use the toolkit to provide assurance that they are practising good data security, and that personal information is handled correctly. From September 2024 the DSPT changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) and become a CAF aligned framework. It is split into 47 contributing outcomes, each of which are supported by indicators of good practice, grouped into levels of achievement – 'Not Achieved', 'Partially Achieved' or 'Achieved'.

The Trust submitted an interim assessment in December 2025 and will publish its final submission by 30th June 2026. 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 against the revised standards.

The Information governance function continues to deliver a broad workplan and works collaboratively with the wider digital and cyber security service. Assurance of compliance and reporting of key information governance activities are reported and monitored through the Trust's governance and committee structures.

During 2025/26, four data security incidents were deemed as externally reportable and were reported to the Information Commissioners Office (ICO). All incidents were closed by the ICO as no further action required from the Trust.

Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The Data Security and Protection Toolkit is a performance tool produced by the Department of Health (DH) and now hosted by NHS Digital. It draws together the legal rules and central guidance related to Information Governance and data security.

2.2.7 Clinical Coding Error Rate

This audit was performed to provide an objective appraisal of the clinical coding at Liverpool Heart and Chest NHS Foundation Trust for the period June-July 2025 (covering the 2025/26 financial year). The

audit is to be used as evidence of compliance with the Data Security & Protection Toolkit (DSPT) Standard 1. The audit was commissioned by Farzad MacDonald, Clinical Coding Manager (LHCH) and carried out by Leah Ashton, NHS Approved Clinical Coding Auditor and Training & Audit Manager (LUHFT) and Andy Foat, NHS Approved Clinical Coding Auditor (LUHFT).

Key Findings:
The Trust's clinical coding was of a very high standard with the audit result exceeding the requirements of DSPT Assertion 1.1.7-1.1.8 set out by NHS England. The results are consistent with the previous year's audit, and a high quality of coding has been maintained.

For compliance of the Data Security and Protection Toolkit (DSPT) a sample size of 200 coded episodes were audited. The results for 2025/26 coding audits are:

	Primary Diagnosis	Secondary Diagnosis	Primary Procedure	Secondary Procedure
DSPT Objective	**≥90%**	**≥80%**	**≥90%**	**≥80%**
2025/26	98%	97%	99%	96%

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of patient records.

2.2.8 Learning from Deaths

During 2025/26 196 patients died whilst in hospital. Every death was reviewed by a Medical Examiner. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 43 in the first quarter.
- 47 in the second quarter.
- 55 in the third quarter.
- 51 in the fourth quarter.

The Trust has had a process for reviewing deaths for over ten years and commenced the review of deaths in a structured way that met the Learning from Deaths Guidance published in March 2017.
By March 2026, 187 case record reviews have been carried out in accordance with the Learning from Deaths Guidance, in relation to 196 of the deaths referenced in the introduction. The number of deaths in each quarter for which a case record review was carried out was:

- 43 in the first quarter.
- 47 in the second quarter.
- 55 in the third quarter.
- 42 in the fourth quarter.

7 of the deaths reviewed during the reporting period (2025/26) 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:

- 1 representing, 2.3% of 43 of deaths which occurred for the first quarter.
- 2 representing, 4.3% of 47 of deaths which occurred for the second quarter.
- 2 representing, 3.6% of 55 of deaths which occurred for the third quarter.
- 2 representing, 3.9% of 51 of deaths which occurred for the fourth quarter.

These numbers have been estimated using a version of the Royal College of Physicians Structured Judgement Review methodology supported by the Learning from Deaths Guidance. A summary of what the Trust has learnt from case record reviews and investigations conducted in relation to deaths identified above is as follows:

A description of some of the actions the Trust has taken in the reporting period and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period is as follows:

As per standard policy at LHCH, all 7 cases were extensively reviewed through the mortality review group (MRG) process including discussion at monthly MRG meeting. All learning points identified are disseminated to relevant clinical leads/teams for actioning. In addition, anonymised case presentations are undertaken at monthly cardiology or cardiothoracic/anaesthetic audit meetings, for learning in a wider audience. Specific learning points and actions from these cases in question are listed below:

- Concerns related to preop recognition of high-risk anatomy were disseminated within surgical team. Processes for ensuring appropriate MDT discussion and potential allocation to aortic surgeons for some cases has been agreed.
- Learning identified regarding intra-aortic balloon pump placement outside of Cath Labs (without direct fluoroscopic guidance). Teaching has been delivered within anaesthetic team on this including use of transoesophageal echo guidance.
- Concerns were identified in relation to decision making before or during emergency or primary percutaneous coronary intervention (PCI) procedures. There is a robust system in place at LHCH with the cardiology interventional team for discussion of all complications at a weekly review meeting, where these were all comprehensively discussed. This is well attended and aimed and team learning and education in what is a challenging area for decision making.
- The importance of pre-procedural echocardiography in non-emergent PCI procedures was highlighted and has been disseminated to all team members by clinical leadership.
- Management of ST elevation in the early post-operative period after bypass surgery is due for discussion with a presentation at an upcoming joint cardiology/surgical audit meeting. A separate incident investigation was initiated (ongoing) to determine the learning needed in critical areas on this topic.
- Potential need to streamline/improve a pathway or policy for emergency theatre cases coming from Cath Labs - this has been passed to all relevant clinical leads to take forward.

In March 2017 the National Quality Board published a document called *'National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care'.* The purpose of the guidance was to help initiate a standardised approach to learning from deaths.

2.2.9 Speaking up.

In February 2015 Sir Robert Francis published his Freedom to Speak Up Report, an independent review into creating an open and honest reporting culture in the NHS. The report recommended that each NHS organisation should have its own Freedom to Speak Up (FTSU) Guardian.

The Trust has a Freedom to Speak Up (FTSU) Policy, one designated FTSU Guardian supported by a Deputy, a network of 30 FTSU Champions and designated Non-Executive and Executive Director Leads. During the year the Trust re-launched the 'Be Civil, Be Kind' work, and the new Domestic Abuse and Sexual Safety policy has been ratified, allies have been trained and FTSU identified as an avenue to raise concerns.

The Hospital Leadership Team have made a three-point pledge to all staff commencing employment within the Trust, and this message is repeated to all staff on a regular basis via Team Brief and is on posters around the Trust:

1. The Hospital Leadership Team will actively encourage staff to speak up about any concerns.
2. The Hospital Leadership Team will review fully, openly and transparently and will provide feedback wherever possible.
3. The Hospital Leadership Team 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, staff wellbeing and safety and bullying and harassment**.**

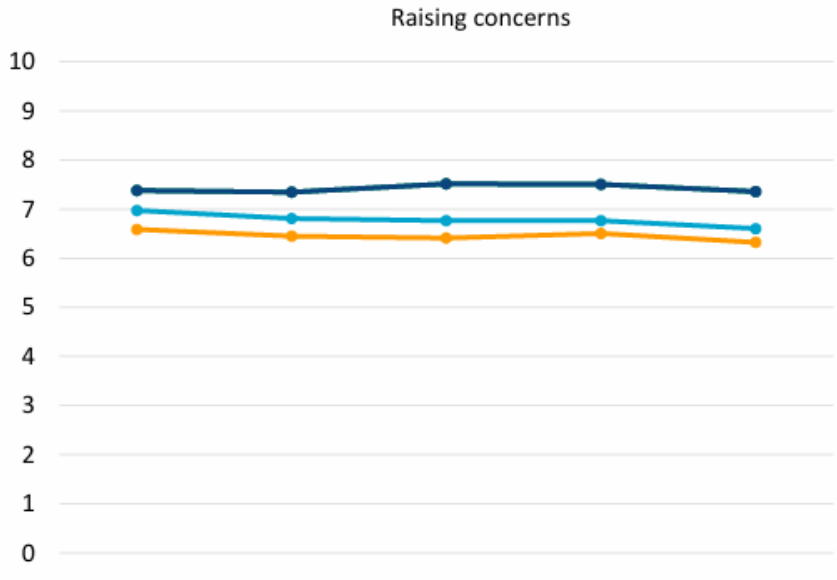
These are as follows:

- Access to Freedom to Speak Up Guardians and Champions.
- Daily Trust-wide Safety Huddle led by the Hospital leadership team.
- Incident reporting through InPhase.
- FTSU reporting facility available on InPhase including anonymously if needed.
- 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 / staff side representatives.
- Introduction of Patient Safety Champions across all areas.

All colleagues who contact the Freedom to Speak Up (FTSU) Guardians are thanked for raising their concerns and are offered a meeting at the earliest opportunity. Timely feedback is consistently provided, and regular support is maintained until each case is either resolved or the individual no longer requires assistance.

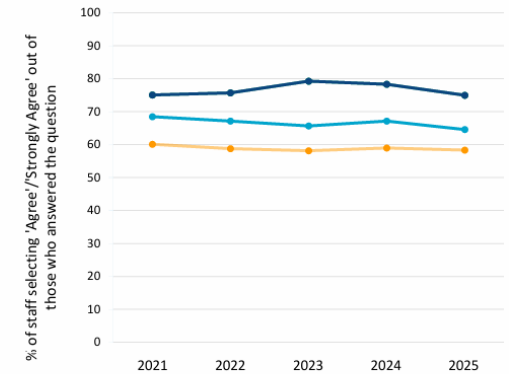
Liverpool Heart and Chest Hospital (LHCH) ranked top nationally for the element We Each Have a Voice That Counts in both the 2023 and 2024 NHS Staff Survey results. This achievement has provided strong reassurance about the quality and accessibility of the FTSU provision. Work continues to strengthen the service further and to expand the network of FTSU Champions.

The 2025 National NHS Staff Survey results indicate that LHCH continues to perform well in the element, We Each Have a Voice That Counts and staff feeling safe to speak up and that the Trust would address concerns when compared with other Trusts, as shown in the tables below.



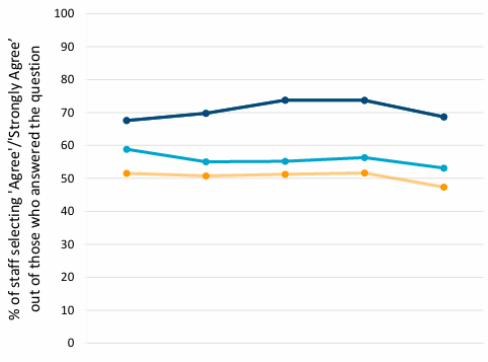
	2021	2022	2023	2024	2025
Your org	7.38	7.34	7.51	7.50	7.36
Best result	7.38	7.34	7.51	7.50	7.36
Average result	6.97	6.81	6.76	6.77	6.60
Worst result	6.59	6.45	6.41	6.50	6.32
Responses	1013	1235	1199	1136	1128

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



	2021	2022	2023	2024	2025
Your org	75.08%	75.72%	79.27%	78.30%	74.99%
Best result	75.08%	75.72%	79.27%	78.30%	74.99%
Average result	68.49%	67.14%	65.69%	67.17%	64.57%
Worst result	60.12%	58.77%	58.15%	58.99%	58.34%
Responses	1015	1236	1202	1144	1128

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



	2021	2022	2023	2024	2025
Your org	67.56%	69.76%	73.75%	73.70%	68.67%
Best result	67.56%	69.76%	73.75%	73.70%	68.67%
Average result	58.85%	55.04%	55.19%	56.31%	53.14%
Worst result	51.56%	50.76%	51.27%	51.64%	47.36%
Responses	1011	1235	1204	1147	1129

Although the 2025 results are reassuring, they do show a slight decrease in overall scores when compared with previous years and in line with the national trend. Further exploration of the results with People and OD colleagues will be undertaken to understand the underlying causes and identify any required actions or learning.

2.2.10 NHS Doctors in Training

LHCH has received no exception reports during the time-period covered by this report. Our Guardian of Safe Working engages closely with the resident doctor population at LHCH via the Resident Doctor Forum, and our HR Team ensure that all resident doctors new to LHCH are aware of the process for completion of an exception report to ensure that our low/absent level of exception reporting is not due to a barrier to completion.

Specialty Group	WTE Rota Gaps					Number of vacant shifts (where known)	Total number of ad hoc shifts covered
	Apr-May 25	May-Aug 25	Aug-Nov 25	Nov25-Feb26	Feb-Mar26		
Anaesthesia					1	0	0
IMT-ICU	0.6		1.4	0.6	2.2	115	115
Tier 1 medicine					1	84	81
Cardiology						122	122
CTS Tier 1	1	1	1	1	1	30	26
CTS Tier 2			3	2	1	176	176
Respiratory Tier 2				1	2	28	28

In cardiology and surgery there were a number of vacant shifts due to paternity or maternity leave, sick leave and occupational health restrictions impacting working pattern.

As demonstrated, almost all uncovered shifts were subsequently covered with appropriate clinical staff to ensure a safe level of staffing for our patients at all times. Where rota gaps are identified early, this is through use of bank/locum shifts, ensuring suitable staff with the required skill set are allocated. Where the absence is at short notice there are clear processes in place within each division to ensure that this is recognised and escalated, with actions taken to ensure that the shift is covered appropriately and there is no gap in cover.

In addition to resident doctors allocated via Lead Employer from the NW Deanery, we also employ a number of locally employed doctors and advanced nurse practitioners to ensure we maintain continuity of care with a core group of highly trained and experienced clinicians. This also assists in supporting our resident doctors in training to ensure that where absence occurs the frequency of being moved to another clinical area for the purpose of service provision was kept to a minimum. This importance of this has been further cemented with the recent introduction of the Education Exception Report and at the time of report creation no reports of this nature have been submitted at LHCH.

One of the functions which oversee the safety of NHS Doctors in Training is the Guardian of Safe Working Hours. The guardian ensures that issues of compliance with safe working hours are addressed by the doctor and/or employer/host organisation, as appropriate. The guardian provides assurance to the Board that doctors' working hours are safe. NHS Trusts are required to provide plan for improvement to reduce these gaps.

Part 2.3: Reporting against core indicators

We are required to report performance against a core set of indicators using data made available to the Trust. For each indicator, the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods, is presented in the table below. In addition, where the required data is made available, a comparison is made of the numbers, percentages, values, scores or rates of each of the NHS Trusts indicators with:

a) National average for the same, and.
b) Those NHS Trusts with highest and lowest for the same.

We are required to include formal narrative outlining reasons why the data is as described and any actions to improve the data.

Please note: Benchmarked data is no longer provided by NHS Digital for the following indicators: hospital readmission, responsiveness to personal needs (an aggregation of patient survey results), venous thromboembolism and patient safety incidents. The Trust has utilised published Northwest benchmarking data for Clostridium Difficile.

<table>
<tr><th>Indicator</th><th>Reporting Periods</th><th>Liverpool Heart & Chest Trust Performance</th><th>National Average</th><th>Benchmarking</th></tr>
<tr><td colspan="5">Friends and Family Test (Staff)</td></tr>
<tr><td rowspan="4">The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends (Acute Trusts only)</td><td rowspan="2">National NHS Staff Survey 2024</td><td rowspan="2">Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.

Trust Score: 66.12% (n=5050)</td><td rowspan="2">Sector average score: 61.54%</td><td>Lowest: Queen Elizabeth Hospital King’s Lynn NHS FT % Score: 39.72%</td></tr>
<tr><td>Highest: Alder Hey Children’s NHS FT % Score: 89.59%</td></tr>
<tr><td rowspan="2">National NHS Staff Survey 2025</td><td rowspan="2">Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.

Trust score: 91.608% (2nd) – (n=1131)</td><td rowspan="2">Average score 88.80%</td><td>Lowest: Liverpool Women’s NHS Foundation Trust % Score: 69.83%</td></tr>
<tr><td>Highest: The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust % Score: 91.611%</td></tr>
<tr><td colspan="5">Assurance Statement
The organisation can take strong assurance from the results of Question 25d of the patient survey, which asked respondents whether they would be happy with the standard of care provided by the organisation if a friend or relative required treatment.</td></tr>
</table>

Liverpool Heart and Chest Hospital achieved a score of 91.608%, based on responses from 1,131 patients, placing the Trust 2nd out of 13 Acute Specialist Trusts nationally. This score is significantly higher than the Acute Specialist Trusts average of 88.80%, demonstrating that patients have a consistently high level of confidence in the care delivered by the organisation. LHCH's performance is very close to the highest-scoring trust in the peer group (91.611%) and substantially above the lowest reported score (69.83%), further reinforcing the Trust's strong relative position and reputation for high-quality, patient-centred care. These results provide robust assurance that patients not only report positive experiences themselves but also express confidence in recommending the organisation's care to their friends and family. This indicates strong trust in clinical quality, safety, compassion, and professionalism across services. Overall, the findings confirm that LHCH continues to deliver a high standard of care that meets and, in many cases, exceeds patient expectations when benchmarked against comparable Acute Specialist Trusts.

Clostridium difficile (C. *difficile*)

The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	January 2024 December 2024	C. Difficile Infections LHCH Total: 4	C. Difficile rate per 100,000 bed days for LHCH Total: 7.3	North-West C. Difficile average rate per 100,000 bed days Total: 40.3
	January 2025 December 2025	C. Difficile Infections LHCH Total: 5	C. Difficile rate per 100,000 bed days for LHCH Total: 9.4	North-West C difficile average rate per 100,00 bed days Total: 34.8

Assurance Statement

The specialist Infection Prevention and Control team take a proactive approach to the management of Clostridioides difficile infection, supported by robust surveillance systems that monitor incidence, identify emerging trends and enable early detection of periods of increased incidence or outbreak risk. Strict environmental cleaning and decontamination processes are in place to minimise environmental burden and reduce transmission risk. All infections are clinically reviewed, and all HOHS infections are reviewed through a structured post-infection process, with learning shared via divisional and site IPC governance arrangements to support assurance, organisational learning and continuous improvement.

Part 3: Other Information

Part 3.1: Review of Quality Performance

This section of the Quality Report provides information on our quality performance during 2025/26. Performance against the priorities identified in our previous quality report and performance against the relevant indicators and performance thresholds set out in NHS Improvement's Oversight Framework are outlined. We are proud of a number of initiatives which contribute to strengthening quality governance systems. An update on progress to embed these initiatives is also included in this section.

Performance against priorities identified for improvement in 2025/26
Each year the Trust holds an engagement event with stakeholders that includes Governors, HealthWatch, patients, families and staff, with the aim of identifying the Quality Priorities for the forthcoming year which are aligned to our Patient Experience Vision and support us to achieve our long-term quality goals. The Trust identifies these priorities from feedback, as well as considering information gained from the National In-patient survey, incidents, complaints and concerns, patient stories, shadows, excellent, efficient, compassionate and safe assessments (EECS) and PLACE assessments, and by learning from Care Quality Commission findings.

Our Quality Priorities for 2025/26 were built around our ambitions to deliver safe, reliable care and are aligned to the 10-year plan. The four key areas chosen were:

1. After Care
2. Pre-existing conditions and Additional needs
3. Communication Letters
4. Prehabilitation

Quality Priority 1 – After Care

Background
Liverpool Heart and Chest Hospital Discharge Information was raised at the Patient Engagement Event in March 2025 as an issue for patients that should become a Quality Priority for 25/26.

Aim
To ensure smooth transition from hospital to home or other care setting, with clear communication and a detailed plan of services and support that will be provided to them post discharge.

Stakeholders: Patients, Families, Ward staff, Advanced Clinical Practitioners, Matrons, Quality improvement and patient experience team.

Measures
Compare current discharge information, patient feedback through the friends and family test (FFT), follow up calls and audit.

Baseline
There is a lot of paper-based discharge information given to patients. Some of it is contradictory, unnecessary and out of date. The discharge information is not presented in a consistent format with a consistent structure or content.

Process
A working group was created to review all the current information. Task and finish groups were created to review content, format, accessibility, digitalisation and future process.

Outcome/Results
16 post discharge information booklets collated and reviewed. Discharge information is a work in progress 4/16 have been updated, a GANTT chart was created with a deadline for completion of March 2028. The next steps are digitalisation on the internet for patients and families to access. To work with the Learning and Disabilities Matron to ensure all information is accessible and ongoing telephone support.

Quality Priority 2 – Pre-existing Conditions and Additional Needs

Background
People with learning disabilities, neurodivergent conditions and other pre-existing health conditions experience poorer health outcomes and significant health inequalities compared with the wider population. These inequalities are often driven by systemic barriers within healthcare pathways, including delayed recognition of needs, inconsistent use of reasonable adjustments, communication challenges. In acute and specialist settings, complex and time-pressured pathways can unintentionally disadvantage these patients, leading to delays in assessment and treatment, increased distress, and reliance on families or carers to advocate for appropriate care.

Aim
Local reviews of patient experience, incidents and mortality have highlighted variation in how needs are identified, documented and responded to across the service. Many of these patients also live with multiple long-term conditions, increasing pathway complexity and the risk of poor outcomes if care is not coordinated and person-centred.

Streamlining and improving the pathways offers an opportunity to reduce variation, embed reasonable adjustments into routine practice, and improve patient safety, experience.

Stakeholders: Patients, Families and Carers, Clinical Teams, Quality Improvement and Patient Safety teams, EPR teams.

Measures
Reduction in delays to assessment or treatment for patients with learning disabilities, Improved patient and carer experience feedback, Reduction in incidents or complaints related to unmet reasonable adjustments, Improved equity of access across key pathways.

Baseline
At baseline, identification of patients with learning disabilities and neurodivergent needs was inconsistent, documentation of reasonable adjustments is variable, and support was often reactive rather than embedded into pathways. This resulted in variation in patient experience.

Process
Working with the Quality Improvement (QI) Team. Process mapping with the QI team has identified gaps including inconsistent collection of demographic and reasonable adjustment information, variable pre-appointment contact, limited patient administration system (PAS) data integration, gaps in MDT communication, lack of sensory-friendly spaces, and a need for improved admin and staff education.

Digital Improvements – EPR Development- The project is working in collaboration with the Electronic Patient Record (EPR) team to improve the visibility and accessibility of key information for patients with learning disabilities, neurodivergent conditions and other enhanced care needs.

Outcome/Results
Proactive contact with patients prior to appointments giving the opportunity to reduce anxiety, clarify needs and plan adjustments in advance**.** Inclusion of clinician and clinic code information flagging on PAS has improved communication sharing any reasonable adjustments that need to be adhered to.

Consultant and anaesthetist included in the email communication.

Sensory environment considerations, exploring sensory equipment that can be moved to different areas when needed.

Targeted education and training for all staff including medics to strengthen understanding of learning disability, neurodiversity and reasonable adjustments.

A new Enhanced Care tab has been developed within the EPR, providing a single, consistent location for essential documentation such as Hospital Passports, Lasting Power of Attorney (LPA) documents and other relevant care information. This enables the multidisciplinary team (MDT) to quickly locate and review important information, reducing reliance on multiple systems or manual searching.

New Enhanced Care Order tab has been created to highlight patient needs directly within the EPR banner. This allows staff to identify key requirements and reasonable adjustments at a glance, supporting safer, more person-centred care and improving communication across teams.

Quality Priority 2 – Accessible Information

Statement of outcome
A clear and personalised plan of care will be agreed with the patient/carer, for all patients with additional or complex care needs to ensure appropriate care, communication and support is provided throughout the patient journey.

Background
To ensure care is delivered which encompasses the patient's normal routine and specific needs, it is vital that care is planned with them and that staff are knowledgeable of their specific needs. This aligns to the fourth step of our Patient and Family Experience Vision which focuses on Stay and After stay ensuring provision of compassionate, safe and personalised care, delivered with dignity and respect.

Stakeholders: Patients, Families and Carers, Clinical Teams, Quality Improvement and Patient Safety teams, EPR teams.

Aim
To ensure

- That the Trust meets Accessible Information and interpreting services.
- That ward rounds document in EPR that plan of care has been discussed, and the patient understands, (if patient lacks capacity, has parent/care been involved).

- That there is real time access to interpreting services.
- That patients are offered to have their Care Partner involved in their care.

Outcomes

- EPR provides evidence that the patients choice of Care Partner and their level of involvement is recorded in the Enhanced Care flow sheets and Nursing Admission document. Care Partner compliance is now available to view on the Clinical Nursing dashboard and is currently at 92%.
- Inclusion in ward rounds and patient education is recorded in patient EPR flowsheets.
- Patient communication needs are identified, recorded and flagged EPR.
- Interpreting services are readily available, and patient information is available in braille, Easy Read and multiple languages.

Quality Priority 3 – Patient Communication Letters

Background

Communication was identified as a priority for the Divisions to ensure that patients had clear, concise information from referral through to discharge and follow-up.

Aim

To ensure patients have clear information regarding their admission and post discharge follow up appointments, communication will be reviewed and streamlined.

Impact Measures

- Complaints monitoring: Reduction in patient complaints regarding delayed first appointments will be tracked against implementation of the CENCO role.
- Waiting time improvement: Reduction in time to first appointment monitored via Surgical Performance Meetings and weekly patient tracking list (PTL) Oversight meeting against trajectory.
- Dashboard indicators: Patients over 18 weeks with next appointment booked >6 weeks ahead are reviewed to bring appointments forward.
- Outpatient Waiting List (OWL) patients >10 weeks reviewed weekly, now supported by a hard stop for missing mandatory data set (MDS) to prevent delays.

Process

- A review of InPhase/complaints was undertaken and the common theme related to our hybrid mail provider resulting in letter failures. There was no assurance from our hybrid mail procedure that clinical correspondence had been sent or received.
- Cross divisional meetings held to discuss action plan.
- Administration risks and incidents were reviewed to understand incidence of lack of information/poor communication.
- Review pre-op information and check that this aligns with discharge information.

Outcomes

Healthcare Comms for clinical correspondence was turned off and as an interim measure whilst an alternative provider was sourced, 3 temporary fixed term appointments were made for postal despatch co-ordinators. This process ensured that approved letters were all issued within the 48-hour KPI period and there was a robust audit trial in place to confirm they had been sent.

The new hybrid mail provider is yet to be confirmed, and this work will be ongoing across the Divisions.

Quality Priority 4 – Prehabilitation

Background

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

Aim

Our aim is that while surgical patients are waiting for urgent surgery their condition could be optimised, which would improve outcomes, experience and length of stay. In-patient wait times for planned urgent surgery remain of the order of 1-3 weeks. A number of measures have been introduced to resolve the in-patient wait for surgery. One of these is for the Consultant Surgeon and Cardiologist of the week to identify patients within this pathway that can safely wait at home for their urgent surgery.

Patient Feedback

- 100% of patients recommend this service whilst awaiting cardiac surgery
- 83% patients always felt safe and supported whilst awaiting surgery at home, 17% said sometimes
- 88% patients found surgery at home a positive experience

Outcomes

- 119 patients have been through this programme so far
    - Financial year 25/26 = 75 patients
- Total bed days saved = 2496 days
    - Financial year 25/26 = 1689 days
    - Median = 18 days per patient
- Total cost = £1,160,640*
    - Financial year 25/26 = £785,385*

*This is a productivity saving, not a cash saving as beds are filled.

Prehabilitation – Urgent in Hospital

Background

Currently there is no prehab provision for inpatients awaiting urgent cardiac surgery. Evidence shows people in hospital spend up to 83% of their time in bed and 12% in a chair (Arora, 2018). 65% of patients over the age of 65 experience functional decline during hospital stay (British Geriatric Society, 2020). This is seen in an increased length of ITU & hospital stay, potential readmission to ITU, surgery cancellations and poor patient experience.

Aim
To provide at least 1 prehab session to a minimum of 50% of inpatients awaiting urgent cardiac surgery by May 2026.

Next Steps

- Leading ongoing 'prehab' working group
- Devising EPR prehab document for data collection
- 3-month pilot (aiming start date of 1st Feb 2026) with providing 'one stop shop'
- Review data/PDSA cycles on feedback
- Consider business case and further development to include inpatient waiters at home.

Measures

Planned Outcome measures:

- Critical Care length of stay (EPR)
- Post-op length of stay (EPR)
- Readmission rates to Critical Care (EPR)
- Number of physio contacts/ contact time (EPR)
- Patient satisfaction (survey)
- Staff satisfaction (survey)

Lessons Learnt

- Different approaches to engage different key MDT members (e.g. medics)
- Early input from EPR (delays to initial start date of Jan 26 as document not ready)
- Keep it simple in terms of outcome measures

In the Liverpool Heart and Chest NHS Foundation Trust Annual Report, the Chief Executive Officer (CEO) provides a statement on performance at the Trust. Information is provided on the Trust's improvement journey, hospital site specific performance, the latest staff survey results, research and innovation and system collaboration.

Indicator	Target	Performance 2022/23	Performance 2023/24	Performance 2024/25	Performance 2025/26
Maximum time of 18 weeks from point of referral to treatment in aggregate- patients on an incomplete pathway	**92%**	**72.56%** (***M12 position***)	**73.90%** **(M12 position)**	**69.11%** **(M12 position)**	**80.46%** (***M12 position***)
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	**85%**	**69.20%**	**Q1/Q2 64.2%** **(Old standards)** **Q3/Q4 47%** **(new standards)**	**75.70%**	**86%**
C. Difficile variance from plan	**4**	**3**	**3**	**4**	**3**
Hospital Standardised Mortality Ratio (HSMR)	**<=100**	**95.4** **(All diagnoses Apr-Mar)** **97.8** **(HSMR diagnoses, Apr-Mar)**	**95.2** **(All Diagnoses Apr – March 24)** **93.7** **(HSMR diagnoses, Apr – March 24)**	**83.8** **(All Diagnoses Apr 24 – Dec 24)** **88.2** **(HSMR diagnoses, Apr 24 – Dec 24)**	**99.5** **(All Diagnoses Apr 25 – Jan 26)** **95.6** **(HSMR diagnoses, Apr 25 – Jan 26)**
Maximum 6-week wait for diagnostic procedures	**99%**	**98.69% (YTD)** **99.45%** (***M12 Position***)	***86.92% (YTD)*** ***81.90%*** ***(M12 Position)***	***86.77% (YTD)*** ***96.12%*** ***(M12 Position)***	***98.16% (YTD)*** ***95.6%*** ***(M12 Position)***
Venous thromboembolism (VTE) risk assessment	**95%**			**94.20%**	**95.7%**

Performance against the relevant indicators and performance thresholds set out NHS England's Performance Assessment Framework

In March 2025, NHS England launched the Performance Assessment Framework (PAF), replacing the Oversight Framework, setting out how success and areas for improvement will be identified, and how organisations will be rated. The PAF is published quarterly, and every NHS Trust is allocated a segment. This indicates its level of delivery from 1 (high performing) to 4 (poorly performing) with an additional segment 5 to indicate the most intensive support requirement. Each organisation is assessed on their relative performance on a 1-4 scale, (broadly reflecting quartile of performance), and metrics are combined in each domain and combined to give an overall delivery score for each organisation. The PAF has 5 domains:

- Access to service
- Effectiveness and experience of care
- Patient Safety
- People and workforce
- Finance and productivity

The lower the domain score, the better the ranking	Domain Score					Domain Segment				
	Q1	Q2	Q3	Q4	+/-	Q1	Q2	Q3	Q4	+/-
Access to service domain score	1.4	1.02	1.02	**1.02**	-	1	1	1	**1**	-
Effectiveness and experience of care domain	1.12	1.17	1.15	**1.15**	-	1	1	1	**1**	-
Patient safety domain score	1.94	1.93	1.92	**1.49**	-0.43	1	1	1	**1**	-
People and Workforce domain score	1.46	1.73	1.31	**1.63**	+0.32	1	1	1	**1**	-
Finance and productivity domain score	1.79	2.44	2.43	**2.41**	-0.02	2	3	3	**3**	-
Average Metric Score	**1.52**	**1.55**	**1.48**	**1.45**	-0.03	**1**	**1**	**1**	**1**	-

LHCH is ranked overall in segment 1 and 4th nationally in Q4 2025-26. This is an improvement from 5th in Q3 2025-26.

Access to Services	Metric Value					Metric Score				
	Q1	Q2	Q3	Q4	+/-	Q1	Q2	Q3	Q4	+/-
Percentage of people waiting less than 18 weeks	72.75%	77.48%	**80.3%**	**80.89%**	+0.59%	1.16	1.07	1.07	**1.07**	-
Difference between planned and actual 18 week performance	-0.51%	+3.03%	**+4.74%**	**+4.18%**	-0.56%	2.43	1	1	**1**	-
Percentage of patients waiting over 52 weeks	0.96%	0.84%	**0.63%**	**0.24%**	-0.39%	1	1	1	**1**	-
Percentage of patients waiting over 52 weeks for community services score	0%	0%	**0%**	**0%**	-	1	1	1	**1**	-

Effectiveness and Experience of Care	Metric Value					Metric Score				
	Q1	Q2	Q3	Q4	+/-	Q1	Q2	Q3	Q4	+/-
CQC inpatient survey satisfaction rate score	-	-	**-**	**-**	-	1	1	1	**1**	-
Average number of days from discharge ready date to actual discharge date score	0.1	0.22	**0.21**	**0.16**	-0.05	1.24	1.34	1.31	**1.31**	-

Patient Safety	Metric Value					Metric Score				
	Q1	Q2	Q3	Q4	+/-	Q1	Q2	Q3	Q4	+/-
NHS Staff Survey - raising concerns sub-score	7.51	7.51	**7.51**	**7.36**	-0.15	1	1	1	**1**	-
12 month rolling count of MRSA cases	0	0	**0**	**0**	-	1	1	1	**1**	-
12 month rolling count of C. difficile cases as a proportion of trust threshold score	2	2	**2.5**	**2**	-0.5	3.91	3.92	3.95	**3.92**	-0.03
12 month rolling count of E. coli cases as a proportion of trust threshold score	1.4	1.4	**1.4**	**1**	-0.4	3.71	3.67	3.59	**1**	-2.59

People and Workforce	Metric Value					Metric Score				
	Q1	Q2	Q3	Q4	+/-	Q1	Q2	Q3	Q4	+/-
Sickness absence rate	4.96%	4.84%	**4.56%**	**5.76%**	+1.2%	1.93	2.46	1.62	**2.26**	+0.64
NHS staff survey engagement theme	7.72	7.72	**7.72**	**7.54**	-0.18	1	1	1	**1**	-

For detail in relation to sickness absence rates and the Trust's NHS Staff Survey results please refer to the LHCH Annual Report.

Finance and Productivity	Metric Value					Metric Score				
	Q1	Q2	Q3	Q4	+/-	Q1	Q2	Q3	Q4	+/-
Planned surplus/deficit	+3.69%	+3.69%	**+3.69%**	**+3.69%**	-	1	1	1	**1**	-
Variance year-to-date to financial plan score	-0.29%	0	**0**	**0.02**	**+0.02**	2	1	1	**1**	-
Implied productivity level	+2.77%	-5.83%	**-4.1%**	**-3.44%**	**+0.66%**	2.58	3.89	3.86	**3.82**	**-0.04**

Complaints, Patient Advice and Liaison Service

There have been 36 formal complaints in the 2025/26 year, 2 remain open. 3 have been upheld and 19 are partly upheld. There have been 331 informal concerns (PALS) contact via the Patient and Family Support Team.

Complaints Theme and Brief Summary	Actions Taken and Lessons Learned
Medicine complaint under the cardiology service, medication not prescribed on discharge which meant the patient was at a higher risk of a Stroke. Patient did suffer a stroke some months later and incident review was undertaken.	Changes to standard practices recommended in how medications are updated and reviewed on ward rounds and discharge summaries are updated.
Medicine and Clinical services complaint- This was related to the lack of escalation regarding blood results prior to his operation. The patient sadly had a complication and passed away.	Full PSIRF was undertaken and the divisional leads met with the family and provided the report and action plan on the recommendations made.
Clinical services complaint relating to the transfer of a patient from ITU to the RLUH. Patient sadly had a fall a few hours after transfer and passed away some days later.	Joint PSIRF completed alongside RLUH this has been provided to the family with the action plan with the recommendations.

Improvement as a result of complaints referred to the Parliamentary Health Service Ombudsman

The role of the Parliamentary and Health Service Ombudsman (PHSO) is to provide a service to the public by undertaking independent investigations into complaints that government departments, a range of other public bodies in the UK, and the NHS England, have not acted properly or fairly or have provided a poor service.

The aim of the PHSO is to provide an independent, high quality complaint handling service that rights individual wrongs, drives improvement in the public service and informs public policy.

During 2025/26 the PHSO requested information regarding 1 complaint and is in the early stages of review by the ombudsman. This case is related to a 2025/26 complaint.

Patient Experience

Quality, Safety and the Patient and Family experience, delivered through the six steps our Patient and Family Experience Vision are at the forefront of everything we do at LHCH.

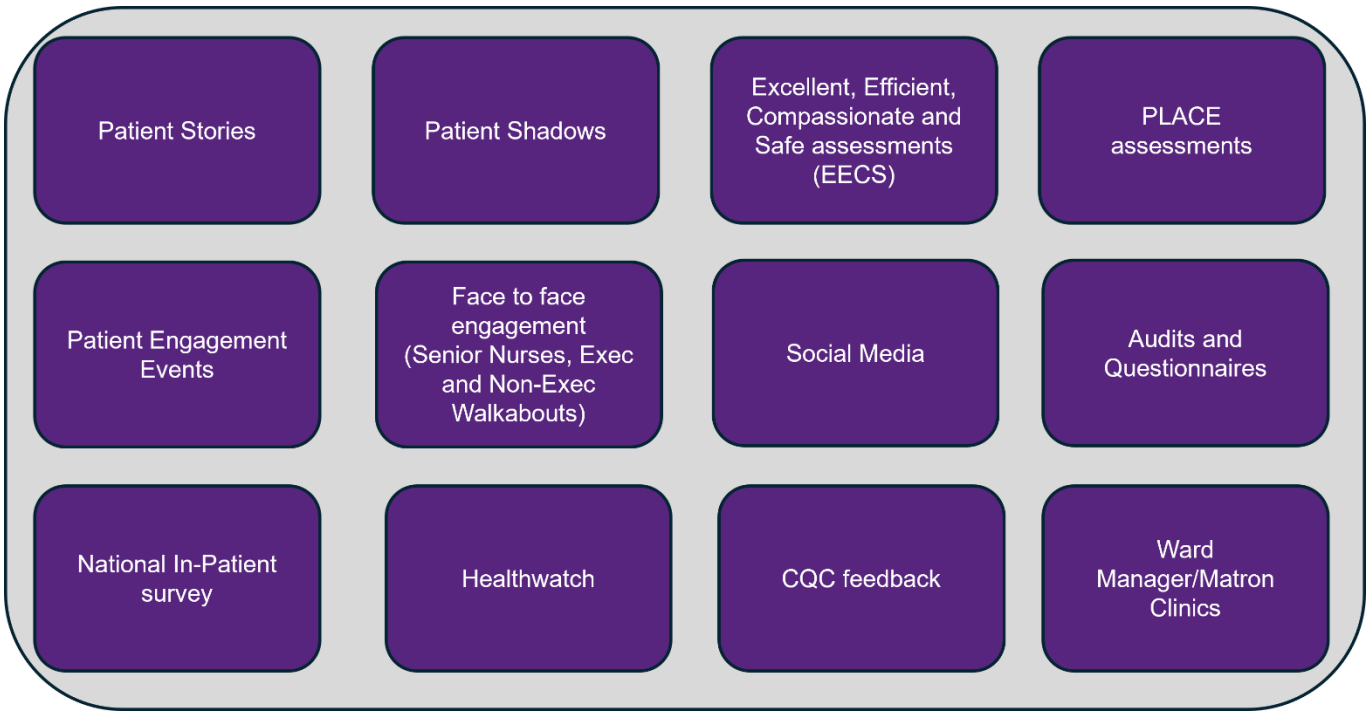
We know that a positive experience during care can lead to positive clinical outcomes and exceptional patient and family experience can only be delivered by a workforce who are engaged, competent and motivated to deliver high quality care.

Engaging with our our patients, families and carers enables an understanding of their experiences and learning from them to improve service delivery, resulting in an environment where individual patients feel supported and cared for.

We are proud that the quality of our services is reflected in feedback from many sources involving patients and families, which continues to be exceptionally good, with 99% of inpatients stating their experience was ‘very good’ or ‘good’. This reflects both the quality of clinical care and the way staff treat every patient as an individual, taking the time to listen to what matters to them.

The Trust uses many ways of capturing patient experience. During 2025-2026 we continued to engage with our patients, their families and staff members to improve the quality of care we deliver.

Listening to our Patients, Families and Carers



Friends and Family Test (FFT)

The FFT Satisfaction Score is the nationally recognised metric for measuring patient experience and allows organisations to identify any trends or variations.

The satisfaction scores for FFT are as follows:

	Performance 21/22	Performance 22/23	Performance 23/24	Performance 24/25	Performance 25/26
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	91.60%	90.61%	92%	93.23%	91.61%

The themes from the feedback for each domain can be found below.

Top 5 Positive Themes	Top 5 Negative Themes
Staff Attitude	Staff attitude
Implementation of care	Implementation of care
Environment	Environment
Patient mood/feeling	Patient Mood/Feeling
Communication	Clinical Treatment

Patient Engagement Activity

We recognise that each patient and their family experience their journey in a unique way and we work collaboratively with them to identify areas for improvement and to make meaningful change. In December 2025 we held an engagement event with the aim of empowering the patient and family and identifying the Quality Priorities for the forthcoming year, which are aligned to our Patient Experience Vision.

Empowering the patient supports us to achieve our long-term quality goals, as well as considering information gained from incidents, complaints and concerns, patient stories, shadows, EECS (Excellent Efficient Compassionate and Safe Assessment) and PLACE (Patient - Led Assessment of the Care Environment) and by learning from the Care Quality Commission findings and the NHS Adult In-patient survey.

The Patient Engagement event was well attended with a high level of involvement by patients, their family and staff and identified areas for improvement which include the need for improved waiting times for follow up appointments and lack of cardiac rehabilitation in some areas of the community, they also asked for improved recreational and environmental facilities, and increased psychological support post discharge home. The main themes for satisfaction were the post discharge follow up calls, communication and being kept informed about their condition and feeling safe and well cared for by knowledgeable, professional, and friendly staff.

Healthwatch Engagement

No engagement this year.

Part 3.2 Quality Initiatives

Quality Improvement is very embedded in the culture at LHCH. The Quality Improvement Team support staff from every part of the Trust with operational, patient safety and quality projects. In addition the QI Team ensure QI capacity and capability is optimised through ongoing culture for improvement work.

We have introduced a number of initiatives to strengthen quality governance systems and improve the care, treatment and support provided to patients across the organisation. A summary of progress during 2025/26 is outlined below.

There have been a total of 52 projects opened in 2025/26. The projects are categorised below:

Transformation and Operational	Patient Safety and Quality	Culture for Improvement
2	43	7

A3 Posters are presented to the Hospital Leadership Team every month. Of the 52 projects, 14 have been presented during 2025/26. The plan is for up 24 projects to be presented in 2026/27 (2 per month).

LHCH are also a founding member of the Cheshire & Merseyside Improvement Network (CaMIN) where all QI Teams participate in sharing & learning across the patch.

Liverpool Quality Assessment (LQA)

Liverpool Quality Assessment will replace the Trusts Excellent Efficient Compassionate & Safe Assessment (EECS) from April 2026, in line with the University Hospitals Liverpool Group (UHLG) model.

The LQA was originally developed to support nurses in understanding care delivery, the LQA has evolved into a progressive, Trust-wide framework that promotes reflection, learning, and targeted action. It helps teams understand core standards, how they are measured, and how to improve, with regular updates and feedback reinforcing progress. The LQA's adaptability is key to its success. Annual reviews and input from specialist teams ensure it remains relevant and responsive to each site's unique challenges. This flexibility has transformed the LQA into a platform for innovation and sustained improvement.

- To support areas requiring improvement, Hospital Leadership Teams (HLTs) will be responsible for developing targeted action plans for any wards that receive consecutive bronze ratings.

- A new UHLG-wide oversight meeting structure will be introduced to monitor progress, share best practice, and ensure consistency in quality improvement efforts across all sites.

- A Trust wide LQA Improvement Plan will also be developed to address recurrent themes identified through assessments.

- To further embed a culture of recognition and learning, an annual Quality Celebration event takes place involving staff from all areas.

- Providing assurance and ensuring quality care for patients is at the forefront of all assessments so clinical teams remain focused and committed.

Patient and Staff Safety Culture

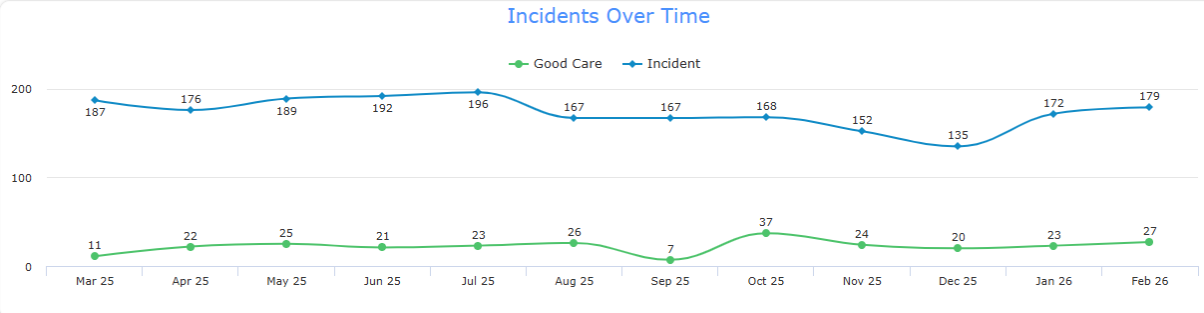
Martha's Rule is built around three core components:

1. Patient Wellness Questionnaire
2. Staff Call 4 Concern
3. Patient Call 4 Concern

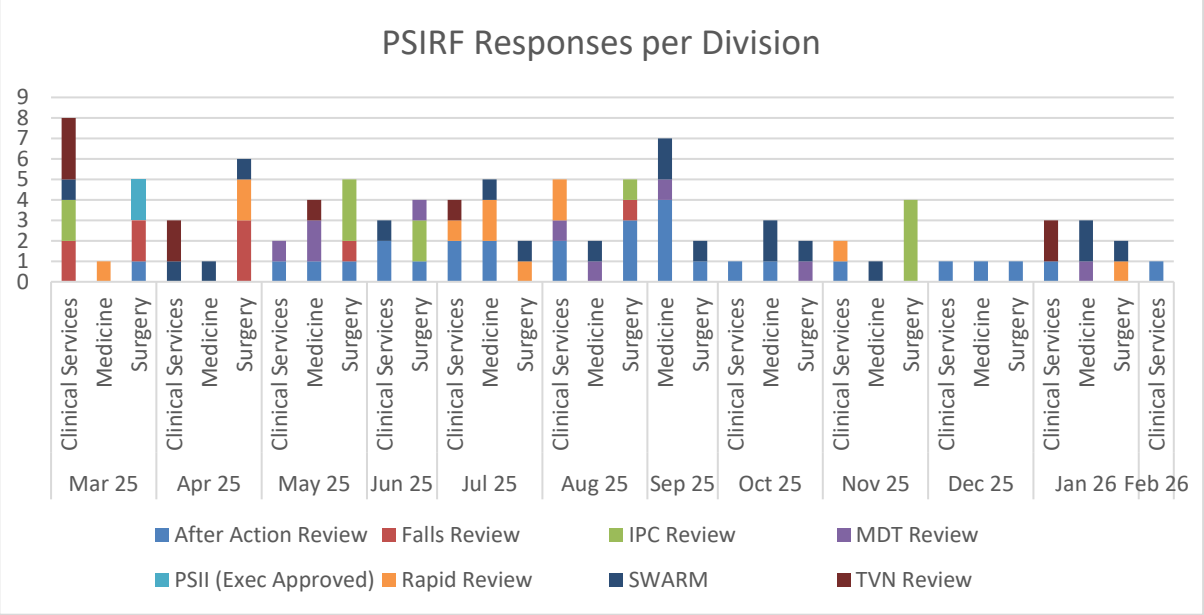
At LHCH, we introduced the Patient Call 4 Concern pathway in 2024, implemented the Staff Call 4 Concern in December 2025, and are preparing to launch the Patient Wellness Questionnaire in April 2026.

To date, there have been four patient-initiated Calls 4 Concern, none of which related to clinical deterioration.
We now have a centralised dashboard that supports ongoing monitoring and national reporting, with all three components aligned to a single, consistent process. Both staff- and patient-initiated concerns are routed directly to our Outreach team for timely review and response.

Incident reporting culture remains consistent throughout 2025/26, with normal variation:



Patient safety responses over the last 12 months are broken down in the chart below:



Over the past 12 months, a total of 99 incident responses has been recorded in InPhase:

- 29 After Action Reviews
- 35 Falls reviews
- 23 IPC reviews
- 9 MDT Reviews
- 2 PSII (Exec approved)
- 11 Rapid reviews
- 18 SWARMS
- 22 TVN Reviews

During the year, one Never Event was reported (StEIS reference 2026/414, 20/11/2025), relating to an insulin overdose caused by the use of abbreviations or an incorrect device.

Appendix A

National Clinical Audits and National Confidential Enquiries

The National Clinical Audits and National Confidential Enquiries that Liverpool Heart and Chest Trust have participated in during 2025/26 are as follows:

National Audit	Status
Intensive Care National Audit and Research Centre (ICNARC)	The Trust is part of the ICNARC CMP and part of the Cardio-Thoracic sub-group. The data is submitted on a quarterly basis. 2025/26 submitted data on 2283 of patients admitted to Critical Care.
Lung cancer (NLCA)	Data for patients diagnosed in calendar year 2025 is submitted via the trust's monthly Cancer Outcomes and Services Dataset submissions to the National Cancer Registration System. Currently 1,064 records for suspected lung cancer have been submitted for patients diagnosed from January 2025 to December 2025.
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Q1: 644
	Q2: 629
	Q3: 666
	Q4: currently validating - due 31st May 2026
Cardiac Rhythm Management (CRM)	ICD: 1294
	EP: 1338
Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	Q1: 142
	Q2: 150
	Q3: 162
	Q4: currently validating - due 31st May 2026
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Q1: 678
	Q2: 679
	Q3: 680
	Q4: currently validating - due 31st May 2026
National Adult Cardiac Surgery Audit	Q1: 381
	Q2: 242 (currently validating - due 31st May 2026)
	Q3: currently validating - due 31st May 2026
	Q4: currently validating - due 31st May 2026
National Cardiac Arrest Audit (NCAA)	Q1: 38
	Q2: 28
	Q3: 27
	Q4: currently validating - due 31st May 2026
National Heart Failure Audit	Q1: 38
	Q2: 28

	Q3: 27
	Q4: currently validating - due 31st May 2026
National Audit of Cardiac rehabilitation	Phase 1 cardiac rehabilitation (CR) locally, is provided by Liverpool Heart and Chest Hospital team Trust working on electronic upload from EPR. Referrals from April 2025 to March 2026: 6706. Phase 2 The Knowsley cardiac rehabilitation for community cardiovascular service. Referral to Knowsley CR from April 2024 to March 2025: with completed.
Sentinel Stroke National Audit programme (SSNAP) - Post-acute provider organisational audit	Number of referrals submitted to SSNAP: 220
UK Cystic Fibrosis Registry	2025-26: 402
National Audit of Inpatient Falls (NAIF)	The trust falls lead submitted the Facilities Audit 2025 in March 2026. 0 submitted cases to report as hip fractures.
Learning Disabilities Mortality Review Programme (LeDeR)	submitted case to the Learning Disabilities Mortality Review Programme.
Transcatheter Mitral and Tricuspid Valve procedure (TMTV)	Q1: 5
	Q2: 9
	Q3: 5
	Q4: currently validating - due 31st May 2026
Percutaneous Foramen Ovale Closure (PFOC)	Q1: 19
	Q2: 29
	Q3: 29
	Q4: currently validating - due 31st May 2026
Left Atrial Appendage Occlusion (LAAO)	Currently validating - due 31st May 2026
National Vascular Registry	
The UK Transcatheter Aortic Valve Implantation (UK TAVI) Registry	Q1: 117
	Q2: 123
	Q3: 99
	Q4: currently validating - due 31st May 2026

Note: The figures above represent the information provided to the Clinical Audit Department by the relevant audit leads/departments. Data collection for some of the audits extends beyond the date of this report therefore the figures contained within the report may not correspond with the actual validated figures published in the final audit reports.

Annex A: Statements from Cheshire and Mersey Integrated Care Board, Healthwatch Liverpool and Health and Social Care Scrutiny Committee

This section outlines the comments received from stakeholders on this Quality Account prior to publication.

Cheshire and Mersey Integrated Care Board

NHS Cheshire and Merseyside Integrated Care Board welcomes the publication of Liverpool Heart and Chest Hospital Quality Account for 2025/26, which provides a clear, balanced and transparent overview of the provider's quality performance, patient safety arrangements and patient experience over the year. We recognise that the provider remains a high performing specialist Trust with strong patient outcomes, excellent safety culture and robust quality governance while remaining focused on transformation, access, and sustainability moving into 2026/27.

We recognise the progress made towards 2025/26 priorities, with quality of care enhanced through improved information resources for post discharge support, better identification and support for patients with additional pre-existing needs, better patient communication letters and better post-surgical outcomes through successful prehabilitation. This progress is supported by an ambition to continue delivery of these priorities until fully achieved.

The commitment to safety is clear through implementation and use of the Patient Safety Incident Response Framework, mortality review process, implementation of Martha's rule escalation routes and surgical safety governance. This is echoed through commitment to clinical effectiveness with robust adoption of national and local clinical audits and strong benchmarking. This commitment to best practice is also seen within the active research programme at the trust.

The largely positive feedback from patients and use of complaints and negative feedback to drive improvement provide further evidence of a learning organisation.

The focus on staff and organisational culture is clear with senior direction and staff survey feedback. The culture of Quality Improvement is strong and goes beyond performance metrics.

Looking ahead to 2026/27, NHS Cheshire and Merseyside welcomes and supports the four priorities within the transformational plan, the focus on clinical efficiency allowing for capacity to be dedicated to safety initiatives and prioritising what matters to patients is the basis of the priorities for the forthcoming year and we will be keen to work with the Trust to achieve these outcomes.

In summary, NHS Cheshire and Merseyside Integrated Care Board recognises Liverpool Heart and Chest Hospital as a key partner and looks forward to continuing a collaborative relationship as the Trust delivers its future quality improvement programme, supports system transformation and continues to provide compassionate, high-quality, person-centred care for patients and families.

Healthwatch Liverpool

Statement from Healthwatch Liverpool regarding LHCH 2025-2026 Quality Accounts

Healthwatch Liverpool welcomes the opportunity to comment on this 2025-2026 Quality Account for the Liverpool Heart and Chest Hospital NHS Foundation Trust (LHCH). As in previous years we base our commentary on the Quality Account report itself, and feedback and enquiries that we receive throughout the year.

This was a year of change for the Trust joining the University Hospitals of Liverpool Group (UHL Group) in October 2025. We hope this will provide new opportunities for joined-up patient care and for the implementation of best practice, drawing on the strengths of each hospital.

We are very pleased to see that the priorities for 2026-2027 draw on patient feedback and learning from patient experiences. We welcome the patient focus of the priorities set and would have been very interested to see more detail on how these will be delivered and improvements evaluated.

The 2025-26 priorities were, like those for the forthcoming year, around areas of great importance to patients. They were also broad and complex with a range of steps required. For that reason, it is hard to clearly measure and demonstrate which have been fully achieved. Details of the actions taken, the reasons for any complications or delays and further steps, are however documented. We can see that a Quality Improvement methodology has been applied to understanding the problem, getting a baseline picture and then working on actions to improve this.

For example, the priority on Pre-existing Conditions and Additional Needs is a huge area and even just taking neurodivergence as one group of patient need, involves so many factors that completion within one year was unlikely. However, the trust now has a better understanding of the experience of its neurodivergent patients and have undertaken a range of actions to improve patient experience. The development of an Enhanced Care tab in the Electronic Patient Record is one such example providing access to important documentation such as hospital passports and accessing key requirements and reasonable adjustments. The targeted education and sensory environment considerations are also positive changes,

This priority connects into the Accessible Communication Priority and some of the reported actions there around recording communication needs in the EPR. The Quality Account also details other steps towards ensuring accessible communication.

We note the challenges experienced with Quality Priority 3 around patient communication due to the hybrid mail provider but are pleased to see that these issues have been identified and that a new provider sourced to provide more assurance. We know how important it is to patients that they receive the right information at the right time.

Quality Priority 4 aimed at prehabilitation has been a success with 100% of cardiac surgery patients surveyed happy to recommend the service.

There was also a productivity saving detailed as some patients were able to go home earlier. The Quality Account notes a learning point of keeping it simple in terms of outcome measures. That would certainly make it easier to demonstrate the impact of future priorities.

Quality Priority 1 around improving after-care with clearer communication and detailed plans is described as in progress with some work continuing and outcome measures cannot yet be provided. We do not in any way want to discourage breath and ambition in patient focussed priorities but delivering on these may require identification of steps that can be realistically and delivered in each year and the outcome shown. This makes it easier to keep staff and partners engaged and to report back to patients.

LHCH has detailed some great work and successes throughout the year in their quality accounts. Performance against national standards for management of acute coronary syndromes and PCI were described as remaining strong and ranked second in the country for imaging in complex cases and a significant increase in angiography within 72 hours. We see in these accounts, as in patient feedback, the benefits from having the specialist focus in terms of staff expertise and ability to deliver complex care.

The Sentinel stroke Post-acute Organisational Audit showed areas for improvement around workforce capacity and multidisciplinary working identified. National standards for recommended staffing levels across core disciplines, or seven-day rehabilitation provision were not met. LHCH has identified is aiming to improve this with its quality priority 4 by strengthening scheduling and enhancing workforce deployment. Strengthening 7-day rehabilitation should also allow LHCH to reduce the length of time patients need to stay in the hospital and enable safer and more effective discharge.

While NHS staff survey scores are still good LHCH has identified that there is a slight decrease in overall scores when compared with previous years. We are please however to see the great results from staff that would recommend the Trust as a provider of care to their family or friends with LHCH placing 2nd out of 13 Acute Specialist Trusts nationally with a significant increase on the year before.

We would be interested to see if the group model has any impact on staff experience and how staff are being supported through the change.

LHCH remains listed as by the CQC as an overall outstanding organisation and staff should be proud of this achievement.

We look forward to seeing LHCH make progress towards their stated priorities for the upcoming year.

We would like to draw to the attention of the trust to the #CheckWithMefirst project which has been piloted in various Liverpool health care settings, especially within the University Hospitals of Liverpool Group. This project takes forward learning from an engagement project we ran to understand the impact of sexual trauma on patients. We would be very keen to see this approach applied within LHCH in coming years.

We would also like to remind the trust about our Readers Panel made up of local volunteers. This is an easy and cost-free way to have leaflets or standard letters reviewed for accessibility and clarity to lay people. We would be happy to use this to support the trust in its patient communication and information.

Health and Social Care Scrutiny Committee

Due to ‘all out’ elections in Sefton, the Overview and Scrutiny Committee was not in a position to provide a commentary this year as they would not have a committee formalised until the end of May 2026.

Annex B: Statement of Directors' Responsibilities in respect of the Quality Report

The Directors of Liverpool Heart and Chest NHS Foundation Trust are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement 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 the NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

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

- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2025/26* and supporting guidance *Detailed requirements for quality reports.*
- 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 2025 to March 2026
  - Papers relating to Quality reported to the Board over the period April 2025 to March 2026
  - Feedback from commissioners dated 5th June 2026.
  - Feedback from governors dated 29th May 2026.
  - Feedback from local Healthwatch 27th May 2026
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009.
  - The 2024 national patient survey.
  - The 2025 national staff survey dated.
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 23rd April 2026.
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and,
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

30 June 2026 ……Date *Chairman*

30 June 2026 ……Date *Chief Executive*

Annex C: How to provide feedback on this report.

Feedback on the content of this report and suggestions for the content of future reports can be provided by calling 0151 706 2000.