Blackpool Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2011-12

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006

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Chairman's and Chief Executive's Statement

THE year 2011/12 has been another challenging but successful 12 months for the Trust and we were delighted to end the year with the exciting news of the merger of Hospital and Community Health Services. This means that from 1st April 2012 the Community Health Services of NHS Blackpool and NHS North Lancashire transferred to Blackpool Teaching Hospitals NHS Foundation Trust, along with the 1,600 staff employed in these services.

The merger of Community Health Services with Acute Hospital Services gives us a real opportunity to develop better integrated services, delivering seamless care to patients. Our aim is to ensure that patients receive the right care, in the right place, at the right time. This is a key area of focus for us over the coming year.

Improving patient safety and providing high quality care to our patients has remained our top priority and we have continued to make excellent improvements in this area. Hospital acquired infections have fallen to their lowest levels ever with just two cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia between 1st April 2011 and 31st March 2012. We also saw our rates of Clostridium Difficile reduce from 101 in 2010/11 to 53 in 2011/12, a decrease of 47.52%. This is a tremendous achievement from both staff and patients, who have embraced initiatives such as our hand hygiene programme. Only four years ago we were seeing around 469 cases of Clostridium Difficile and 40 cases of MRSA per year.

Our staff have fully embraced our Vision to reduce avoidable harms for patients and provide 'Best in NHS Care' which has led to significant reductions in pressure ulcers and falls. These achievements have only been possible through the dedication and hard work of our staff to make improvements for the benefit of patients.

The Trust has shown a sustained improvement in its Risk Adjusted Mortality Index (RAMI) over the last three years and the RAMI remains below the predicted figure of 100. However other measures of hospital mortality including the Hospital Standardised Mortality Index (Dr Foster) and the Summary Hospital Mortality Indicators (SHMI) have shown mortality rates higher than the expected. These indicators do not take into account issues such as deprivation and public health issues and Blackpool has amongst the highest levels of deprivation in the country with lower than average life expectancy. We are working with the Advancing Quality Alliance (AQuA) to undertake an independent external review of hospital mortality to identify any areas for improvement.

The Care Quality Commission (CQC) carried out an unannounced visit on 27th September 2011 on regulated activity for surgical procedures in the Surgical Directorate in order to review the Trust's compliance with the essential standards of quality and safety. The CQC report overall provided positive feedback, however the Trust has taken actions to address one area of non compliance in relation to consent and three areas to maintain compliance with the essential standards.

As part of our commitment to being open and transparent we were one of eight Trusts in the North West chosen to take part in a national patient safety pilot where we publish information on our website about how we perform in areas such as falls and pressure ulcers and how we compare to our peers. We also launched 'Knowing how we are doing' boards which visually display a host of information on quality standards by individual ward.

The work that we have been doing to improve quality and safety was nationally recognised through a number of awards and accolades. Our commitment to patient safety was recognised with the award of Clinical Negligence Scheme for Trusts (CNST) Level 2, which acknowledges the quality and safety of our maternity services. The maternity service was assessed against five standards each containing ten criteria giving a total of 50 criteria. In order to gain compliance at Level 2 the maternity service was required to pass at least 40 of these criteria, with a minimum of seven criteria being passed in each individual standard. The maternity service scored overall compliance of 45/50. The Trust following an informal assessment in March 2012 also maintained compliance with NHSLA Risk Management Standards Level 3. The Maternity Team were also shortlisted for the Enhancing Patient Dignity category as a result of their work in improving the dignity of pregnant women who abuse substances in the Blackpool area.

The Trust was also reaccredited with two awards - the Information Standard in recognition of the high standard of written information we provide to patients and the Investors in People Gold Standard – the highest accolade possible for our commitment to staff development and engagement.

The facilities and environment that we are able to provide for staff and patients have vastly improved this year with the completion of two major multi-million pound developments on the Blackpool Victoria site. We were delighted to welcome Ian Holloway, Manager of Blackpool Football Club, to officially open our new £40m Surgical Centre on 26th March 2012. This new unit boasts some of the most modern, state-of-the-art facilities in the North West and brings together all of our surgical services under one roof.

We were also fortunate to have been able to complete the final phase of our new £13m Women and Children's Unit. This is thanks to the generosity of the League of Friends of Blackpool Victoria Hospital who have donated almost £2m towards the building of our new children's wards and play room. Staff and patients are delighted with the new building which is modern, bright and child friendly. The unit was officially opened on 27th April 2012 by The League of Friends.

We have continued to invest in innovative clinical services and we were pleased to launch Telestroke Medicine, a major development for improving outcomes for people who have suffered a stroke. Using a high-tech video link up consultant stroke physicians can now provide patients with a diagnosis and recommend clot-busting thrombolysis treatment 24/7. We have also expanded a number of our tertiary services, including the Primary Angioplasty service, which means all patients across Lancashire and South Cumbria who experience a heart attack now have round the clock access to this life-saving service.

There were a number of changes to the Board during the year. Chairman, Beverly Lester announced her retirement from the Trust after 10 years in the role. Medical Director, Dr Paul Kelsey, has stood down from his role from 31st March 2012 to focus on his clinical commitments in haematology. The Board would like to place on record their sincere thanks to Beverly Lester and Dr Kelsey for all of their hard work in taking the Trust forward and driving quality improvements over the past 10 years and six years respectively. There have also been a number of changes to the Non-Executive Directors and Council of Governors during the year which you can read about further in the Annual Report. The Trust welcomes our new Chairman, Ian Johnson, and Medical Director, Dr Mark O'Donnell, who bring with them a wealth of experience.

Last year we reported that due to our financial challenges the regulator of Foundation Trusts, Monitor, found us to be in significant breach of the terms of our authorisation. Each month Monitor continued to hold a formal Progress Review Meeting to assess sufficient and sustained progress towards achieving a timely return to compliance with the Terms of its Authorisation. The Trust has received official confirmation from Monitor on the 24th May 2012 that the Trust has been de-escalated from significant breach. It is the opinion of Monitor's Compliance Board Committee that the Trust is now meeting its statutory duties and has put into place proper arrangements to exercise its function economically, efficiently and effectively. The Trust has arrangements in place for setting objectives and targets on a strategic and annual basis. During 2011/12 the Trust has consolidated and developed a number of systems and processes to help achieve an improvement in the financial performance. The Trust have worked extremely closely with Monitor to improve the position, and we were able to report a surplus of £3.3m at the end of the financial year.

Looking ahead, it is a really exciting time for our Trust as we move into a new era and we look forward to the full integration of Hospital and Community Health Services. Whilst we know that there will still be tough financial challenges for the next few years we aim to be on a more sound financial footing and our focus will be about improving quality and safety of care which, by doing so, will reduce costs and improve efficiency.

We are also keen to engage more with our local community and involve you in decisions about our services. We are pleased that our public membership remains steady with more than 5,000 public members and we also have a growing number of volunteers who give up their time to help enhance the patient experience. We would like to take this opportunity to thank all of our volunteers who support us in so many different ways. We would also like to say a huge thank you to all of our staff for their ongoing dedication and commitment to providing 'Best in NHS Care' to our patients. We look forward to another successful year.

Signed:

Ian Johnson
Chairman

Date:
24th May 2012

Signed:

Aidan Kehoe
Chief Executive

Date:
24th May 2012

'Recently whilst on holiday in Blackpool I endured a fall in which I had to visit the fracture clinic at Blackpool Victoria Hospital. Diagnosis revealed a cracked bone in my left hand, I wish to express my sincere thanks to all involved at the above clinic for their kindness and most professional way in which I was treated'.

Mr J Bairstow

Hospital Highlights

Over the past 12 months there have been many new developments which have helped to improve quality of care, patient safety and the overall patient experience. Here are just some of the notable achievements we have made in the past year.

Opening of the Urology Unit

In June 2011, a brand new, purpose built Urology unit was opened. This is a dedicated facility where urology outpatient services are centralised and patients can now access one-stop clinics.

Working closely with Blue Skies Hospitals Fund, the registered charity for Blackpool Teaching Hospitals NHS Foundation Trust, and with the support of Beaverbrooks the Jewellers and Radio Wave, the Urology Department is currently looking to purchase a state of the art, 3D ultrasound scanner. This will be used to improve prostate imaging and biopsy for the diagnosis and management of prostate cancer. This is the most common cancer in men and with this equipment increasingly accurate information can be collected through undertaking Histoscanning and template biopsy, thereby offering an exceptionally high quality of care to our patients.

Nutrition Mission

The Nutrition Mission campaign was launched across the Trust in April 2011. The key aim of the mission was to ensure that all our patients receive their food and drink to help ensure good nutrition. All wards across the Trust took part in the campaign, which used the Department of Health 'Rapid Spread' methodology. This new methodology aimed to spread improvement quickly affecting '30 wards in 30 days'.

Research has shown a quarter of NHS hospital patients are either malnourished or at risk of malnutrition, and as much as 70% of malnutrition in these patients is unrecognised and not managed. Also, an estimated 40% of hospital food is wasted (British Nutrition Foundation 2009). All members of the multi-disciplinary teams working within the Division were asked to support our Nutrition Mission. Throughout the year the clinical teams have been implementing strategies to sustain the Nutrition Mission's ethos and to ensure all out patients receive adequate nutrition and hydration.

Simulation and Skills Centre

A £900,000 scheme to provide a new Clinical Skills Centre and Simulation Suite was completed in April 2011. The new centre provides excellent teaching facilities to enable training of hospital staff reflecting the Trust's status as a teaching hospital. To complete the training facility a new Simulation Suite was completed in April 2012.

Shortlisted for the Nursing Times Awards 2011

The Maternity Team was shortlisted for the Enhancing Patient Dignity category as a result of their work in improving the dignity of pregnant women who abuse substances in the Blackpool area.

A significant number of pregnancies in Blackpool are complicated by substance misuse with major implications for the developing foetus. The changes made by the team have transformed the service provided for these women, with a reduction in caesarean section rates and reduced neonatal care admissions. In many cases the women have also modified their lifestyle, and improved their family life. The work that is carried out by the team was recognised at a national level at the awards.

Surgical Centre

We were delighted to welcome Blackpool Football Manager, Ian Holloway, and his wife Kim to officially open our new £40m Surgical Centre on the 30th March 2012. The unit which was completed in July 2011 comprises seven inpatient theatres, 61 beds including single en-suite bedrooms, three day case theatres and a Preoperative Assessment and Urology Unit.

Patients and staff will benefit from the light, modern environment, improved privacy and dignity and the comfortable surroundings will help aid recovery. The state-of-the-art theatres in one central location with education suite will enable staff to work more efficiently and effectively and provide new audio visual equipment to aid training.

End of Life Care

The Trust has undertaken a lot of work to improve the service we provide to patients at the end of their life. The Liverpool Care Pathway has a strong evidence base to demonstrate that it facilitates the delivery of best practice and quality of care, improves communication and coordination of care between all care providers and reduces the number of inappropriate investigations. Preliminary figures from the pilot indicate that the training provided as part of the Gold Standards Framework pilot, increased staff confidence and competence in end of life care and has increased the numbers of communications within primary care. This is an area of end of life that the project group are keen to expand, in all ward areas of the Trust, to improve communication and coordination of care, reduce inappropriate hospital admissions and interventions at end of life, and promote best practice in caring for the dying.

In response to increasing evidence that most people would prefer to die at home or not in hospital, the Trust has developed a Rapid Discharge Pathway for patients within the last four weeks of life who wish to go home to die.

There has been a phased approach to education and training staff on core competencies for end of life care. A pilot training programme took place on wards 23 and 24 between October 2010 and March 2011. The main outcome from this pilot has been an increase in staff confidence in caring for dying patients. We will continue to monitor its effect on increase in home death (through use of the Rapid Discharge Pathway), increased use of Liverpool Care Pathway and reduction in complaints at end of life.

Opening of Children's Wards

January 2012 saw the first young patients being treated at the new children's wards at Blackpool Victoria Hospital. The facilities are bright, modern and child-friendly and are making a real difference to children and their families. The building of the new children's wards has been made possible thanks to donations of almost £2m from the League of Friends of Blackpool Victoria Hospital. The Friends were left two major legacies by local families Peter Roy Evans and the Hargreaves brothers for the benefit of children. The Trust was also delighted to receive a donation of £20,000 from a local family Gordon and Christine Hay to provide pull out beds in the new unit for parents to stay overnight. The unit comprises a children's assessment area, two four bedded bays, six single rooms with en-suite facilities, a high care area and a play room. It also has a new Adolescent Unit which includes seven en suite bedrooms, one with disabled access facilities and a lounge area. The unit was was officially opened by the League of Friends on Friday 27th April 2012.

New Mortuary

February 2012 saw the completion of the new £2.4m mortuary which has provided a much needed and improved facility. The new building also houses a special infection control room where forensic examinations can be undertaken. The facility also has a dedicated office which is used for training purposes.

Social Networking sites

The Trust ventured into the world of social networking during 2011/2012 to improve its communication with staff, patients and the wider community. You can follow the Trust on Twitter to keep in touch with the latest news and events related to Blackpool Teaching Hospitals. In September 2011, the Trust launched its own Facebook site and at the end of March had more than 700 followers. You can find us at www.twitter.com/BlackpoolHosp or www.facebook./com/BlackpoolHospitals

Duncan House – Relatives Accommodation

A new facility for relatives of leukaemia patients to stay overnight opened at 28 Whinney Heys Road in April 2011. The house was refurbished thanks to funding from the Rosemere Cancer Foundation and Blue Skies Hospitals Fund. This four bedroom facility includes a lounge, kitchen and bathroom facilities. The unit was officially opened by celebrity singer and entertainer Joe Longthorne who has previously received treatment at the Haematology Unit at Blackpool Victoria Hospital.

Information Communications Technology

The Information Communications Technology department has implemented many projects throughout the year including:

- **Voice Recognition** - recognised by clinicians using it as 'the future';
- **111** - the new number 'when it's less urgent than 999';
- **Wireless Access** - improving the lives of residents and visitors with internet access;
- **Managed Print** - providing process and efficiency savings whilst modernising print management; and
- **Laboratory Servers** - reducing the risk to the Organisation from technical failure.

Information Communications Technology provided ongoing support to staff with day-to-day issues and on projects, such as Vision and the large capital build projects. The department has improved its own processes by fully automating the Estates Helpdesk, part of the Information Communications Technology Service Desk, providing users with a way of logging and tracking faults on-line.

Accreditations

Histopathology successfully retained their Clinicial Pathology Accreditation after a full assessment in January 2012. All the laboratories/departments within the Pathology and Radiology Directorates are fully accredited for the services they provide. This is a major achievement as only three other Trusts in the country have achieved this distinction. The Sterile Services Department and the Gastroenterology Decontamination Department also achieved accredited status during 2011/12, which now ensures that these critical clinical services comply with all relevant legislation and Care Quality Commission best practice guidelines.

'I would like to convey my thanks and those of my brother, to all at Accident and Emergency, AMU and Ward 25 for their combined excellent care of my father. At all times he was treated with great respect and dignity, and we could not have wanted any better for his final hours'.

Judith Summersville, Manchester.

Directors' Report

This section includes information about:

- **Our Trust**
- **Our Vision**
- **Our Services**

This section also includes information about our achievements in the following areas:

- Our Patients
- Our Staff
- Our Finances
- Our Performance
- Delivering Our Plans
- Our Future Plans

Our Trust

Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust was established on December 1st 2007 under the National Health Service (NHS) Act 2006. In October 2010, the Trust was awarded teaching hospitals status and changed its named to Blackpool Teaching Hospitals NHS Foundation Trust in recognition of this.

The Trust comprises:

- Blackpool Victoria Hospital
- Clifton Hospital
- Fleetwood Hospital
- Rossall Hospital Rehabilitation Unit
- Bispham Hospital Nurse Led Therapy Unit (became Spiral Health Centre of Excellence (CIC) for Intermediate Care on 1st April 2012)
- Wesham Hospital Rehabilitation Unit
- Blenheim House Child Development Centre
- National Artificial Eye Service

The Trust has three main commissioners; NHS Blackpool, NHS North Lancashire and the North West Specialist Commissioners for tertiary cardiac services and haematology services. Further information on the funding streams of the Trust is provided in Our Finances section of this report.

'On the 8th November 2011, I was admitted to the Lancashire Cardiac Unit for a double cardiac bypass graft. Whilst there I identified total commitment, an extreme level of skills/knowledge and deep understanding of patients from all who cared for me. Following surgery I then spent a week in the Lancaster Suite where the treatment there is best described as superb!!! All their caring attitudes nursing skills and medical knowledge made a major contribution to my recovery process'.

Michael Bryan, Garstang

Our Vision

The Trust revised its Vision in 2010 following extensive consultation with staff, patients and visitors and below is Our Vision.

Quality	To provide Best in NHS Care for our patients
Safety	To reduce avoidable harms to our patients
People	To realise the potential of our staff and be a great and safe place to work
Delivery	To exceed all national and local standards of service delivery
Environment	To deliver the Best Environment for Patients, Staff and the wider community
Cost	To achieve Best in NHS Care at the lowest cost

(Further details can be found on page 21 on how this has been embedded across the Trust)

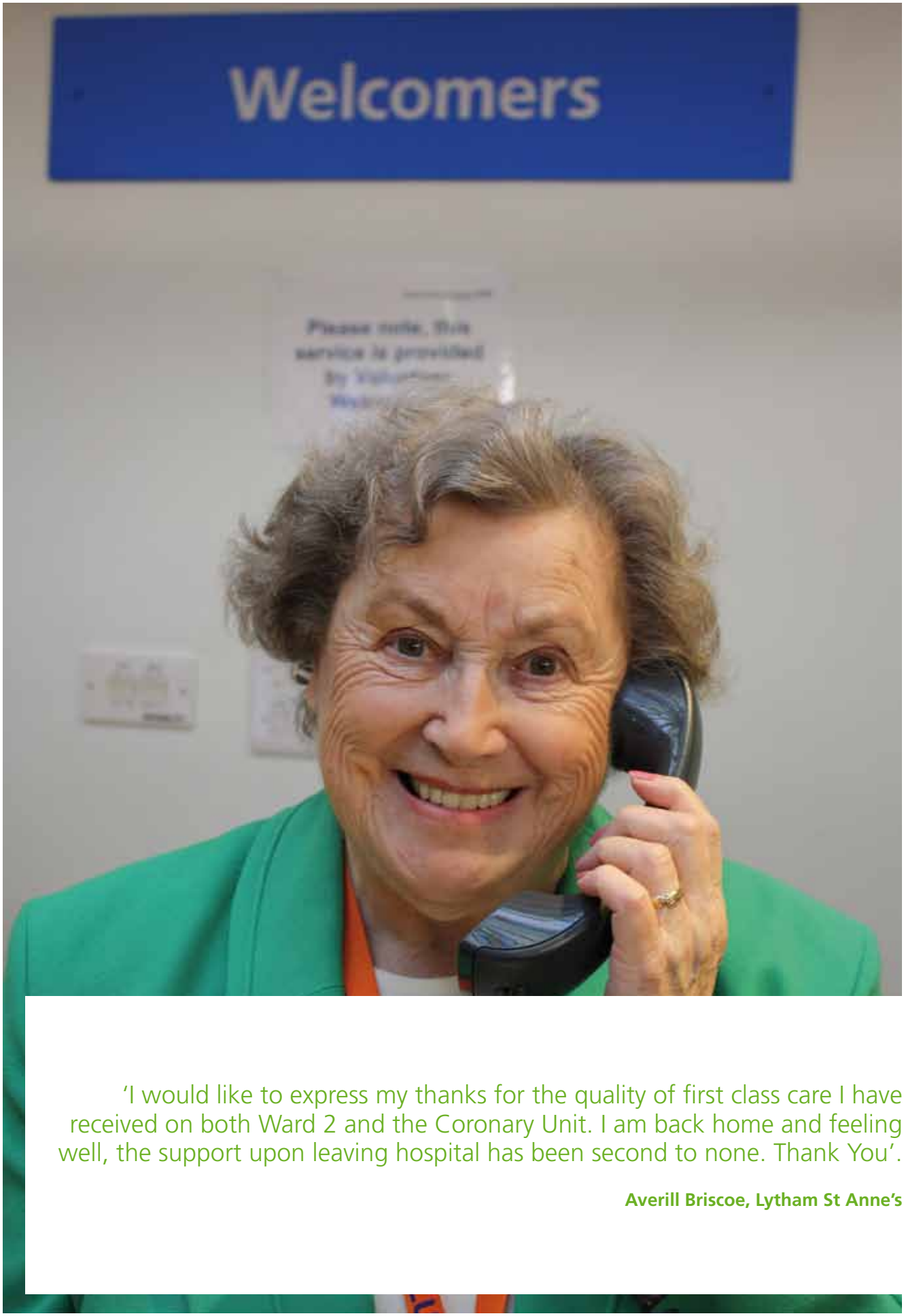
Our Services

The Trust is responsible for the management of Blackpool Victoria Hospital, which is a large and very busy acute hospital, and several community sites, including Clifton Hospital, Rossall Hospital Rehabilitation Unit, Fleetwood Hospital, Wesham Hospital Rehabilitation Unit, Bispham Hospital Nurse Led Unit, Blenheim House Child Development Centre and the National Artificial Eye Service.

As well as providing the full range of district hospital services, the Trust provides tertiary cardiac and haematology services to a 1.6m population catchment area covering Lancashire and South Cumbria.

The Trust serves a population of approximately 330,000 residents of Blackpool, Fylde and Wyre and resort's 11 million visitors each year. We employ 3,917 staff, had a turnover in excess of £275m in 2011/12 and have a total of 722 beds.

Between 1st April 2011 and 31st March 2012 we treated approximately 97,422 day cases and inpatients (elective and non elective), 287,014 outpatients and had 80,572 A&E attendances. Clinicians from Lancashire Teaching Hospitals NHS Foundation Trust provide onsite services for renal, neurology and oncology services. We utilise assets to the value of £185.4m to support our services.



'I would like to express my thanks for the quality of first class care I have received on both Ward 2 and the Coronary Unit. I am back home and feeling well, the support upon leaving hospital has been second to none. Thank You'.

Averill Briscoe, Lytham St Anne's

Our Patients

It is really important to us that we listen to our patients and make improvements to our services in response to their views. The National Inpatient Experience Survey is undertaken on an annual basis and asks those patients who use our hospitals some key questions regarding their stay.

Improving the Patient Experience

The table opposite provides a comparison of data for 2009, 2010 and 2011 for six of the indicators. The questions on privacy, dignity, respect and cleanliness and hygiene were chosen as these are priority areas for the Trust. The questions in relation to noise at night and hospital food were chosen following consultation with the public about what is important to them. The Trust wants to ensure that these areas improve year on year.

Improvements to the indicators will be monitored on a monthly basis through the Nursing Care Indicators and this information will be presented to the Board of Directors on a monthly basis to monitor improvements made.

National Inpatient Experience Survey

Indicator	2009 Result	2010 Result	2011 Result
In your opinion, how clean was the hospital room or ward that you were in?	Very clean - 72% of patients stated that the hospital or room was very clean (national average was 65%) ↑	Very clean - 69% of patients stated that the hospital or room was very clean (national average was 67%) ↑	Very clean - 70% of patients stated that the hospital or room was very clean (national average 66.4%) ↑
Were you given enough privacy when being examined or treated?	Yes always - 91% of patients stated that they were always given enough privacy when being examined (national average was 89%) ↑	Yes always - 89% of patients stated that they were always given enough privacy when being examined (national average was 89%) →	Yes always - 88.8% of patients stated that they were always given enough privacy when being examined (national average 88%) ↑
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	Yes always - 81% of our patients felt they were treated with respect and dignity whilst they were in hospital (national average was 80%) ↑	Yes always - 81% of our patients felt they were treated with respect and dignity whilst they were in hospital (national average was 81%) →	Yes always - 80% of our patients felt they were treated with respect and dignity whilst they were in hospital (national average 78.1%) ↑
Were you bothered by noise at night from other patients?	Yes - 37% of our patients did experience noise at night due to other patients (national average was 39%) ↑	Yes - 34% of our patients did experience noise at night due to other patients (national average was 40%) ↓	Yes - 35.6% of our patients did experience noise at night due to other patients (national average 37.9% ↓
Were you bothered by noise at night from hospital staff?	Yes - 24% of our patients did experience noise at night due to hospital staff (national average was 22%) ↑	Yes - 19% of our patients did experience noise at night due to hospital staff (national average 21%) ↓	Yes – 19.5% of our patients did experience noise at night due to hospital staff (national average 20.2%) ↓
How would you rate the hospital food?	The majority of our patients rated the food highly with 34% rating it as very good and 40% as good. (national average was 21% very good and 36% good) ↑	The majority of our patients rated the food highly with 32% rating it as very good and 40% as good (national average was 21% very good and 36% good) ↑	The majority of our patients rated the food highly with 26.6% rating it as very good and 41.7% as good (national average was 21.1% very good and 34.8% good) ↑

Nutrition Mission

On 7th April 2011, 39 inpatient wards went live with the Nutrition Mission, the key aim of the mission was to ensure that all our patients receive their food and drink to help ensure good nutrition. All wards across the Trust took part in the campaign, which used the Department of Health 'Rapid Spread' methodology. This new methodology aimed to spread improvement quickly affecting '30 wards in 30 days'. Different wards have implemented different ways of ensuring that all our patients are receiving their food and drink. A summary of general changes introduced includes:

- Full days menu at a time/portion control
- Provision of more halal meal choices
- Introduction of 'Hungry to Help' Volunteers
- Oral Hygiene Champions
- Introduction of pre-meal care rounds and environment checks
- Re-establishment of protected meal times
- Review of staff rotas and break times to ensure staff are available at meal times
- Relatives and carers encouraged to assist at mealtimes
- Successful trial of bed numbered trolleys to ensure quicker distribution of meals
- Improved blended diet
- Introduction of all day breakfasts and snack boxes within the maternity unit
- Sandwiches requested for patients who do not feel like eating at mealtimes
- Provision of training re: Speech and Language Therapy (SALT) assessments
- Early timely referral to the Dietetic Department for patients deemed at risk
- Improved working relations between clinical areas and Radiology Department
- Introduction of card alert and red napkin system so patients at risk are readily identified
- Timely administration of anti emetic medication

The Nutrition Mission has given nurses greater authority to protect the patients' mealtimes and nutrition is now seen as everyone's responsibility. They have looked

for simple solutions, such as, providing radiography with a timetable to show which wards are having a mealtime so that they do not request inpatients to attend for an x-ray at that time. Instead these time slots are filled by outpatients. Culturally it is an effort by staff in the whole hospital which has ensured the success of this initiative , which can be measured by a 50% reduction in food wastage and the improved patient satisfaction survey results.

Enhancing Patient Safety

Patient safety remains a priority for all staff within the Trust and is led by the Board of Directors demonstrating their continued commitment to improving patient safety.

The Executive Directors carry out informal safety walkabouts on a weekly basis, averaging approximately 16 - 20 walkabouts per month in line with the 'Blackpool Way'. The 'Blackpool Way' which outlines and reinforces the culture across the Trust and actively encourages and supports employees to gain the skills and qualifications that will support their future employability and meet the needs of the organisation. The visits truly engage staff and patients allowing the Executive Directors time to listen to any concerns the staff and patients may have in relation to patient safety and explore options available for improvements to be made. Good practice is identified, as well as areas where improvements could be considered and this is included in the feedback report which is sent to the Ward/Departmental Manager for action. Although these visits are well received by staff, it was felt that the visits did not give enough time to either discuss issues with the Executive Directors or showcase excellent work the staff were doing within the Wards/Departments. With this in mind, the Trust has introduced additional more structured scheduled patient safety visits.

There is one scheduled walkabout visit undertaken per month and the area is notified of the visit approximately six weeks in advance. This way, off duties can be planned and the multidisciplinary team including the medical staff can prepare for the visit and ensure they are available to take part in the discussions. A poster is sent to the Ward/Department Manager to display on the Ward/Department Quality Board to inform staff of the visit and to invite staff to the meeting.

Prior to the visit taking place, the manager is provided with a short summary of any complaints and Patient Advice and Liaison Service (PALS) data received, including numbers of slips, trips and falls, medication errors, pressure ulcers and untoward incidents, for the particular Ward or Department, together with data relating to sickness absence levels within the area. A pre-visit proforma to identify issues for discussion is also provided for consideration prior to the visit. The visit normally lasts up to two hours, giving all members an opportunity to discuss any issues relating to patient safety. Some of the Non Executive Directors, the Governors of the Trust and members of the Commissioning Primary Care Trust (PCT) now regularly join the team during the scheduled walkabout visit. Feedback to staff is robust and this is provided to the clinical area soon after the walkabout has taken place. Following the visit, an action plan is developed.

This is published on the intranet, the Trust's internal website, to enable all staff to access the information and share good practice and any lessons learned. The action plan is updated on a monthly basis until all actions have been completed by the Ward/Department.

During both types of visits the patient's views are sought to ensure any areas where they feel their experience could have been enhanced can be shared with staff. The feedback of any issues discussed from both informal and structured patient safety walkabouts is currently collated by a member of the Corporate Governance Team. The summaries from both the informal and structured walkabouts are available on the intranet which is the Trust's internal website.

Patient stories are filmed and presented quarterly at the Board of Directors Meetings. The DVD's are placed on the intranet for all staff to access and are there to be used for staff training with lessons learned, and good practice being shared across the organisation.

A safety culture is evident within the Trust and the newly introduced electronic web based incident reporting system has enabled staff and managers to be notified immediately of an incident occurring and allows them to monitor trends. The staff and the organisation are able to acknowledge mistakes, learn from them and take action to put things right. Lessons learned are highlighted across the Trust in a monthly newsletter which is published on the intranet and available for all staff to access.

The Trust has introduced a standardised risk assessment form which is completed by nursing and medical staff for all patients who are admitted to hospital. The risk assessment form assesses the patient's risk of developing a Venous Thrombo-embolism (VTE) - blood clot. In addition to this, there is a patient information leaflet available for all patients to highlight how they can help reduce their risk of developing a VTE.

The Trust has made significant progress in reducing the number of falls experienced by our patients. Movement Sensors are available for patients identified as being at high risk of falling within the clinical areas. In addition hourly visits to the patients identified as being at high risk of falling have been introduced in some of the clinical areas and is being rolled out further across the organisation.

Patient safety training is provided and clinical risk issues are incorporated within the corporate and local induction and annual mandatory training programme. The Trust has also incorporated risk management and patient safety into the organisation's objectives, corporate focus, strategic direction, operational systems and day to day practice.

Improving the Patient Environment

The Patient Environment Action Team (PEAT) is a continuous programme of improvement for the environment. Environment assessments are carried out at ward and departmental level, from a patient perspective, and taking into account patient comments regarding the following:

- Cleanliness
- Food / Nutrition and Hydration Services
- Additional Services
- Access Wayfinding and Information
- Condition / Appearance
- Social Spaces & Facilities
- Cleanliness Toilets and Bathrooms
- Privacy and Dignity
- Infection Prevention & Control

All Trust sites have self assessments carried out by a multidisciplinary team which included the following representations:

- Director of Clinical Support & Facilities Management or Assistant Director
- Patient Representative
- Control of Infection Prevention Representative
- Senior Site Services Manager
- Monitoring/Residences Manager
- External Validator
- Estates Manager
- Local Involvement Network (LINk) Representative
- Matron Representative

The audit follows guidelines set by the National Patient Safety Agency and the results are published nationally on the Department of Health Website on a yearly basis.

Overall, scores have improved from 2011 with Blackpool Victoria Hospital site increasing from "Good" to "Excellent" resulting in all sites now attaining an "Excellent" rating.

Site	Overall Rating 2009/2010	Overall Rating 2010/2011	Overall Rating 2011/2012
Victoria Hospital	Good	Good	Excellent
Clifton Hospital	Excellent	Excellent	Excellent
Bispham Nurse Led Unit	Excellent	Excellent	Excellent
Wesham Rehabilitation Unit	Excellent	N/A	N/A
Rossall Rehabilitation Unit	Excellent	Excellent	Excellent

Learning from Patients

We encourage patients to give us feedback, both positive and negative, on their experiences of our hospital services so that we can learn from them and develop our services in response to patients' needs.

During the financial year 1st April 2011 to 31st March 2012 we received 2,491 thank you letters and tokens of appreciation from patients and their families.

The number of formal complaints received by the Trust during the same period was 353. There were also 39 verbal complaints made. The overall numbers of formal complaints show an increase of 44 compared to the previous year as shown in the Table below.

Date - Financial Year	Complaints
2011/2012	353
2010/2011	309
2009/2010	387

The main categories of complaints are related to:

- Clinical Care
- Communication
- Staff Attitude
- Waiting Times
- Essential Nursing Care

Once the complaint has been acknowledged by the Trust, it is sent to the appropriate Division for local investigation. Once this investigation has been completed, their response is compiled and, following quality assurance checks, the response is signed by an Executive Director and posted to the complainant. Divisions are actively encouraged to arrange face to face meetings with complainants and during 2011/12, 78 meetings were held in order to resolve a complaint in a more timely manner (nine after a final response and 69 before a final response), an increase of 11 from the previous year.

To help reduce the number of complaints within the Trust, lessons learned are discussed within the Divisional Governance meetings, whilst lessons that can be learned across the organisation and trends in the number of category of complaints are discussed at the Learning from Incidents and Risks Committee and the weekly complaints meeting to ensure learning is across the organisation.

Once local resolution has been exhausted the complainant has the right to contact the Health Service Ombudsman for a review of the complaint. During 2011/12, 21 complaints were considered by the Ombudsman. Of these, there are 14 cases where the Ombudsman has assessed the issues and decided not to investigate any further, one was not upheld, two were resolved by local resolution, and one has been closed pending local resolution. There are three cases still ongoing.

Patient Advice and Liaison Service

The aim of the Patient Advice and Liaison Service (PALS) is to be available for on-the-spot enquiries or concerns from NHS service users and to respond to those enquiries in an efficient and timely manner. The table below shows the number of issues dealt with by the by PALS team over the last three years.

Date - Financial Year	Number of Cases	Number of Issues
2011/2012	3,124	3,508
2010/2011	2,609	2,887
2009/2010	1,990	2,266

The number of cases handled by the PALS team this year has increased by 515 cases in comparison to the previous year. The main themes that have emerged from the cases recorded are:

- Administration (830 issues)
- Information (487 issues)
- Treatment Issues (638 issues)
- Waiting Times (695 issues)
- Communication (436 issues)

To help reduce the number of PALS issues within the Trust, lessons learned and service activity are reported to the Patient Experience Committee. Regular reports are produced throughout the year for Learning from Incidents and Risk Committee, Patient Environment Action Team and the Equality and Diversity (E&D) and Human Rights Steering Committee. The Complaints, Litigation Incidents and PALS Report contains the indicators that the service is required to achieve to meet the NHS Litigation Authority (NHSLA) Risk Management Standards. In addition PALS activity and lessons learned also feature in the quarterly and annual Patient Experience Board reports.

Productive Ward "Releasing Time to Care"

All wards at the Trust have now completed the foundation modules of the Productive Ward Series and noticeable changes have been reported. Working in a calmer, more effective environment where everyone knows where to find a piece of equipment or a particular dressing had become common place in the ward area. As areas progress onto the process modules the real benefits are seen.

The NHS Institute for Innovation and Improvement evidence identifies that the real benefits are seen by areas that have undertaken at least two process modules, and this has been the case across Blackpool hospitals. Staff have seen the improvements that can be achieved by the implementation of each module and the continual revisiting to ensure sustainability, enabling them to see that their daily working lives have been improved and they are actually able to give more time to care - that is the motivation to keep them progressing.

Following small, but well thought out changes in their own areas, many hours of time have been saved from using more efficient processes. Meals, handover and medication modules have been developed to be more concise and effective, this has released many hours that have now been reinvested in time to care for patients. This can be calculated not only in hours, but also in monetary terms this equates to 3.38 whole time equivalent (WTE) in years equal to £101,000.

The Patient Status at a Glance (PSAAG) boards are in place now in every ward and are used in an effective way by all multi disciplinary team members. Having an updated board, that has all the relevant information on it about individual patients, has reduced the amount of interruptions made with patient enquiries. This has left the nurses to give patients a better quality of care which makes both staff and patients experience much improved. PSAAG is one of the three foundation modules. The Standard Operating Procedure has been successful and some areas have made very slight alterations to

suit their individual needs, but the format is standard throughout, making it easier to see at a glance what stage in their care each individual patient is and what they are waiting for.

The Productive Ward Series work has now been built into the standard Ward/ Department monitoring systems and is no longer seen as a stand alone project. It is a change in thinking about processes to bring about a cultural change for all staff, having an entire team involved in this process and seeing the benefits helps sustainability. The work undertaken by the staff is realised and documented alongside all other quality and safety initiatives that the Trust is involved in. Trends are easy to recognise using these systems and acted upon efficiently as needed.

The third foundation module, Knowing How We Are Doing (KHWAD), has been a great success. Nine areas were chosen to pilot a system that helped staff produce monthly data for many quality and safety issues and present the information on large magnetic boards. The final report following the pilot shows that the staff on the wards with the boards in place would not want to be without them.
The Productive Operating Theatre (TPOT) was initially implemented with foundation modules before the move into the new Phase VI Surgical Centre. This enabled the named lead for the theatre areas to implement the move with 'Productive eyes', meaning theatre items not required were removed and led to discussions where stock and equipment would be best placed in the new surgical centre to make time more productive.

Productive Community has been undertaken very well by the smaller teams and staff are undertaking process modules at present. Community midwives have now got three allocated leads for the work and this will help with the process.

'On behalf of my family I would like to express my sincere thanks for the high standard of care and kindness given to my father, with no exceptions. We spent a lot of time on ward 25 and noted that nothing or nobody was too much trouble'.

Elaine James, Blackpool.

Our Staff

The Blackpool Way

During the past year, the Trust has increasingly focussed on building a coherent Workforce Strategy across the hospitals and the local community services anticipating the integration of these services from April 2012.

The Trust's Vision and Values have been discussed through face to face interactions between Executive Directors and staff and by the end of March 2012 over 2,000 staff members had taken part in the staff road shows. In the coming year and following the Community Services merger the Trust will be revising its Vision and Values.

In order to further develop the effective staff engagements upon which The 'Blackpool Way' is built, the Trust introduced a revised Clinical Management Structure, creating new Heads of Departments roles right across the organisation. The post holders have a specific remit for maximising the effective engagement of clinical staff.

During the year the Trust has also aimed to deliver improvements in patient and family centred care through its work developing the Patient Revolution and the Patient Safety Culture. Again these developments are built upon full staff engagement.

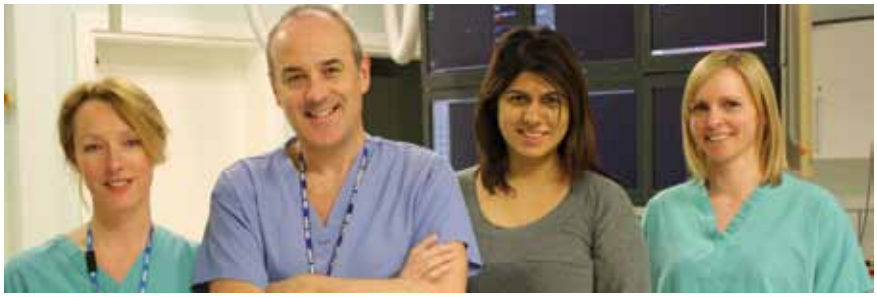
Staff Survey

The Trust performed well in the 2011/12 national survey of employee opinion. We achieved a response rate against the paper surveys of 62.4% which is slightly increased against the 61.8% achieved in 2010/11 and compared extremely favourably with the national average of 49.6% for an Acute Trust.

Based upon the Department of Health requirements the Trust issued 850 paper surveys. However, our Survey supplier, Picker, enabled us to engage with more of our employees via use of an on-line version. The Trust elected therefore to undertake a further 850 on-line surveys.

The combined participation rate for 2011 was 59.3%, with a total of 975 completed surveys being processed (511 paper and 464 on-line) which will give us greater insight as to how our workforce feels. In 2010, only 486 surveys were completed in total. The best performing Acute Trust achieved 63.6% participation, and the worst performing Trust achieved 32.3%.

The Department of Health produces reports based only upon the paper based questionnaires. The tables below detail those response rates for the Trust for 2011/12 compared to 2010/11, it also details our top four and bottom four ranked scores and our performance compared to the national average.



Survey Questions	2010/11 %		2011/12 %		Trust Improvement/ Deterioration
Response Rate	**Trust**	**National Average**	**Trust**	**National Average**	
	61.8	49.6	62.4	49.6	0.6% Improvement

Survey Questions	Staff Survey Results 2010/11 %		Staff Survey Results 2011/12 %		Trust Improvement/ Deterioration
Top 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	
Percentage of staff appraised in the last 12 months	91	78	92	81	1% Improvement
Percentage of staff appraised with personal development plan	79	66	84	68	5% Improvement
Percentage of staff working extra hours	59	66	57	65	1% Deterioration
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	14	15	12	15	2% Improvement

Survey Questions	Staff Survey Results 2010/11 %		Staff Survey Results 2011/12 %		Trust Improvement/ Deterioration
Bottom 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	9	8	9	8	No change
Percentage of staff reporting errors, near misses or incidents witnessed in the last 12 months	97	95	95	96	2% Deterioration
Percentage of staff feeling under pressure in last 3 months to attend work when feeling unwell	29	26	30	26	1% Deterioration
Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	38	37	37	37	1% Improvement

A report is submitted to the Board on a regular basis to monitor progress and ensure improvement in results are made.

Celebrating Success

The Trust held its fifth Celebrating Success Awards event in November 2011, at a celebration ball attended by over 500 members of staff. This was supported and funded by local business, media and the staff lottery scheme.

Awards were given to numerous individuals and teams with members of the public nominating some of our winners.

The Trust also held a series of recognition days throughout the year celebrating the work of individuals and teams working at all levels and across departments within the Trust.

For the third year running we also held a special series of awards for the hundreds of employees who completed 12 months service without taking any sickness absence.

Working Time Directive

All junior doctors' rotas within the Trust are compliant with the European Working Time Directive (EWTD) as are the staff within the Divisions. The Medical Workforce Department continue to review services to identify any areas of difficulty which may need to be addressed. In addition, the Trust has commenced implementation of an electronic rostering system across additional staff groups which supports compliance with the EWTD for all non-medical staff.

Equality and Diversity

The Trust continues to review its approach to Equality and Diversity (E&D) to ensure its importance continues to be at the forefront of the Trusts Vision and Values.

The past year has seen changes in the programme from NHS Employers regarding the Equality Delivery System (EDS) which now supersedes the NHS North West's Equality Performance Improvement Toolkit (EPIT). By moving to EDS, the Trust will be even better placed to deliver positive outcomes for patients, communities and staff in line with White Paper proposals and the Governments' priorities for the NHS. This new system will help the Trust further improve and increase equality performance, embed equality into mainstream NHS business and deliver on the requirements of the Equality Act. A second EPIT report was submitted in June 2011, just prior to the change over to EDS. We were reported as having improved from developing to achieving in three of the five goals. With already having completed two submissions for EPIT the Trust is well placed to adapt to the EDS system.

To comply with the Equality Act 2010, the Trust has set its own Equality Objectives which are monitored by the Trust's Equality and Diversity and Human Rights Steering Committee. Following a Trust wide equality audit undertaken in September 2011, the objectives were updated. To further comply with the Equality Act 2010, the Trust published the relevant equality data on its intranet website in January 2012.

The Trust's methods for monitoring performance are regularly reviewed in order to adopt the most suitable method taking into account the diversity of the services provided and our service users. In this way we can quickly identify unsuitable methods and, if necessary, amend to ensure full and meaningful data is being collated. Outcomes from all reviews are shared with staff in each department and service area to enable them to re-evaluate the way in which monitoring is carried out. There are difficulties in collating information on disability, sexual orientation and transgender (gender identity) for both staff and service users due to the particular sensitivity surrounding these protected characteristics.

With legislation and NHS national agendas around E&D we have to ensure we adapt these requirements at a local level. With this in mind, a Trust wide equality audit was carried out in September 2011 to benchmark where we are, where we need to be and any gaps which need addressing. An action plan has been developed which is monitored by the Equality and Diversity and Human Rights Steering Committee to ensure improvements are made.

Internal and external dynamics will impact on how the Trust pays due regard for each of the protected characteristics in the Equality Act. The protected characteristics are: Race, Gender, Disability, Age, Sexual Orientation, Religion and Belief, Gender Reassignment, Marriage and Civil Partnership and Pregnancy and Maternity.

Equality and Diversity and Human Rights training courses remain part of the Trust's induction and mandatory training programme in order to maintain awareness to staff at all levels the importance of equality and diversity.

The Trust continues its rolling programme of monthly lunchtime E&D workshops (March to December 2011) covering additional topics or expanding on those topics too large to cover in depth in the mandatory training sessions. The topics covered at the additional sessions include Learning Disabilities, Sexual Orientation, Religion and Belief and Disability. A new workshop on Transgender is being planned from March 2012 onwards.

The Trust is pleased with the momentum of the Staff E&D Network, which has doubled its membership in the last twelve months, reflecting the importance with which staff view Equality and Diversity. The input of this group is fed back to the Equality and Diversity and Human Rights Steering Committee. It is due to the work of the Staff E&D Network in highlighting the importance of two previous Trust Conferences that a third Trust E&D Conference is being planned for 2012.

During 2011/12, the Trust continued its work towards the Navajo Charter Mark and submitted its assessment at the end of September 2011. Following an on site review in early November 2011, by the Navajo Project Lead, the Trust was awarded the Navajo Charter Mark on 25th November 2011 for the work it has achieved and will continue to achieve for the Lesbian, Gay, Bisexual and Transgender community.

Steps to secure funding to progress with the 'Louder than Words' Charter Mark from Action on Hearing Loss (formerly Royal National Institute for the Deaf) have been made. In the meantime partnership working with the East Lancashire Deaf Society has commenced and a member of the society now has a place on the Trust's E&D and Human Rights Steering Committee.

All the Trust's E&D related schemes, policies, procedures and guidelines have been Equality Impact Assessed. The main schemes and policies all have action plans which are then reported to the E&D and Human Rights Steering Committee for monitoring and to set timeframes in order to address any shortfalls.

Table: Summary of Performance – Workforce Statistics

From analysis carried out between data collated on the makeup of the local community and that of staff employed, the Trust is reflective of the community it serves.

All Staff Groups:				
Organisation	**Ethnic Origin**	**Full Time Equivalent (FTE)**	**Headcount**	**Headcount %**
Blackpool Teaching Hospitals NHS Foundation Trust	**0 White**	10.58	14	0.30%
	2 Black-African	0.80	1	0.02%
	4 Indian	61.36	63	1.33%
	5 Pakistani	8.00	8	0.17%
	6 Bangladeshi	1.00	1	0.02%
	7 Chinese	10.47	11	0.23%
	9 Not given	1.00	1	0.02%
	A White - British	3,662.06	4,222	89.39%
	B White - Irish	22.75	25	0.53%
	C White - Any other White background	38.40	42	0.89%
	C3 White Unspecified	1.46	2	0.04%
	CA White English	0.41	1	0.02%
	CB White Scottish	1.40	2	0.04%
	CE White Cypriot (non specific)	1.00	1	0.02%
	CF White Greek	2.00	2	0.04%
	CK White Italian	1.80	2	0.04%
	CP White Polish	4.20	5	0.11%
	CY White Other European	8.80	9	0.19%
	D Mixed - White & Black Caribbean	5.00	5	0.11%
	E Mixed - White & Black African	2.00	2	0.04%
	F Mixed - White & Asian	7.73	8	0.17%
	G Mixed - Any other mixed background	3.47	4	0.08%
	GC Mixed - Black & White	1.00	1	0.02%
	GD Mixed - Chinese & White	1.00	1	0.02%
	GE Mixed - Asian & Chinese	1.00	1	0.02%
	GF Mixed - Other/Unspecified	4.00	4	0.08%

All Staff Groups:				
Organisation	**Ethnic Origin**	**Full Time Equivalent (FTE)**	**Headcount**	**Headcount %**
Blackpool Teaching Hospitals NHS Foundation Trust	H Asian or Asian British - Indian	64.68	68	1.44%
	J Asian or Asian British - Pakistani	24.00	25	0.53%
	K Asian or Asian British - Bangladeshi	2.00	2	0.04%
	L Asian or Asian British - Any other Asian background	42.52	45	0.95%
	LE Asian Sri Lankan	2.00	2	0.04%
	LH Asian British	2.00	2	0.04%
	LJ Asian Caribbean	1.00	1	0.02%
	LK Asian Unspecified	2.00	2	0.04%
	M Black or Black British - Caribbean	5.80	6	0.13%
	N Black or Black British - African	16.30	18	0.38%
	P Black or Black British - Any other Black background	4.00	4	0.08%
	PA Black Somali	1.00	1	0.02%
	PC Black Nigerian	1.00	1	0.02%
	R Chinese	8.09	9	0.19%
	S Any Other Ethnic Group	48.56	52	1.10%
	SA Vietnamese	1.00	1	0.02%
	SC Filipino	17.00	17	0.36%
	SD Malaysian	8.00	8	0.17%
	SE Other Specified	11.00	11	0.23%
	Undefined	2.57	5	0.11%
	Z Not Stated	1.00	5	0.11%
Total		**4,128.20**	**4,723**	

The results of the staff survey showed that 66% of staff reported having received E&D training. This is a key priority for the Trust and E&D training forms part of the full day mandatory training as well as being part of the new Induction Training. We expect to continue improving in this area year on year.

The Trust's E&D and Human Rights Steering Committee, chaired by the Director of Human Resources and Organisational Development, has an inclusive membership reflecting all of the protected characteristics of diversity and including representation from Trust staff, partner organisations and patient groups. This group oversees the production of an annual Trust Action Plan and reports back through the Trust's Human Resources and Organisational Development Teaching Governance Committee.

E & D Priorities for 2012/13 include:

- Continued compliance with the Equality Act and NHS Regulation Framework and agenda
- Arrange a third E&D Conference for 2012
- Progressing areas requiring development as highlighted within the Trusts Equality Objectives
- Preparing for the first submission to the new national Equality and Diversity System (EDS)
- Develop and expand the work undertaken for EDS
- Continue and develop the work already in place which helped the Trust achieve the Navajo Charter Mark
- Working with the Action on Hearing Loss (formerly the Royal National Institute for Deaf People) to develop better working/service practices for staff and service users who are hearing impaired
- Staff training – to further develop staff training emphasising customer focus
- Improve and increase engagement and consultation with service users
- Increasing social value – schools work, employment training and skills agenda

Investors in People Gold

In November 2011, we were again successful in retaining the Investors in People Gold Standard. An in-depth assessment was held, during the week of 22nd November 2011, by two assessors. The Trust was praised for its resilience during a difficult previous 12 months.

The assessors conducted a rigorous and objective assessment by interviewing over 50 members of staff across a wide cross section of roles at all sites of the Trust. We were delighted to be reaccredited with the Gold level. The report recommends some areas for improvement, but overall was a very positive outcome with substantial improvement in some areas, such as training and development and communication. There is an action plan in place to sustain our achievements and build on our developmental areas. We plan to further embed our leadership and management training, refresh The Blackpool Way, our recognition processes, our talent management processes and our communication, in particular at the community sites.

This is an excellent achievement for the Trust and the assessors were extremely impressed with all the great work that is ongoing as well as the new initiatives we continue to introduce.

Sickness Absence

The Trust has continued with the good work that was achieved during 2010/11, in terms of sickness absence management and has completed the training programmes for 2010/2011. During early 2011/2012, the entire sickness absence management training programme was revised following an Executive led steering group. The group was established to consider options, methods and practices to improve the health and wellbeing of our staff, directly contributing to the continued year on year reduction of sickness absence throughout the year. This resulted in the sickness absence targets dropping to an all-time low of 3.52% for the financial year.

In addition to the above, the sickness absence management process, documentation, workforce and management information was updated and distributed to ensure that both line managers and staff are fully aware of what to do in case of a sickness absence incident. The Staff Health and Wellbeing Department continue with case conferences and initiatives which are supported by the respective Divisions on a monthly basis, while the Human Resources Business Partners and their teams provide support to line managers.

Occupational Health invested in technology to offer appointments within five to seven days from receipt of a referral and letters following appointments are being processed much quicker than in the past. 'Did not attend' (DNA) statistics are being monitored by staff in each Division, with regular feedback being provided to the respective Divisions to ensure optimal utilisation of resources.

In order to support the Trust to reduce levels of sickness/absence, the Occupational Health department devised a new sickness/absence training package that was launched in 2012 where managers attend regular case conferences which offer guidance and advice as to how they can support employees. These have proved to be valuable and will continue in 2012/13. The nursing team within the department are now also being trained to run sickness/absence management clinics which will ensure staff continue to be seen in a timely manner.

In order to adhere to the recommendations from the Boorman Report, the department continues to be innovative in offering a variety of initiatives staff can access. During 2011, the Trust launched onsite Yoga, Belly Dancing and Zumba classes at a reduced rate, discounted gym membership and, in response to staff requests, subsidised Weight Watchers Programmes. Two cohorts have so far completed the programme and a third one is underway. Again these are run on site for staff to have easy access, and have enjoyed a superb success rate for all of the individuals who attended.

Sickness absence for the year 2011/2012 ended slightly lower than the previous year on 3.52% as detailed in the table below, it is envisaged that the Trust will achieve or improve on the new 3.2% target for 2012/2013.

Overall Trust Sickness Absence Rates

Year	Sickness Absence Results
2007/2008	5.01%
2008/2009	4.70%
2009/2010	4.47%
2010/2011	4.23%
2011/2012	3.52%

The table below details national sickness absence data and the figures given are for the calendar year.

Statistics Produced by IC from ESR Data Warehouse		Figures Converted by DH to Best Estimates of Required Data Items		
Quarterly Sickness Absence Publications	iView Staff in Post			
Average of 12 Months (2010 Calendar Year)	Average FTE 2010	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
3.2%	3,955	889,875	28,786	7.3

Appraisal

Throughout 2011/12, we fully rolled out our e-appraisal system across the Trust, which allowed individuals to have objectives set that aligned to our Vision. For example, all staff were required to have a 'cost objective' in view of the intensive cost improvement programme, ensuring that all staff were able to make an individual contribution. Again, we used a three month appraisal window for non-medical staff and were able therefore, to target training in the use of coaching questions in appraisal as well as technical training about how to use the system on-line. 92% of staff were fully appraised in 2011/12 and we are working to ensure that this figure improves in 2012/13. It is anticipated that this will be achieved with further training and the cascade of objectives and scheduling of objectives set to commence earlier than in previous years.

We were pleased to launch our Talent Management Programme in 2011/12 and the appraisal system was used to identify staff who aspire to key roles in the organisation who regularly meet or exceed their objectives and conduct themselves in line with The Blackpool Way.

For 2012/13, we hope to make the appraisal system even better to use, with the opportunity for ongoing reviews and six month reviews. We will also be looking to develop a fully integrated appraisal system for community staff who have joined the Trust under the Transformation of Patient Pathways (ToPP) agenda.

Staff Achievements Ceremony

In September 2011 we held our annual Staff Achievements Ceremony where we celebrated the contribution of staff completing 20 years service with the Trust, as well as celebrating the successes of those employees who have completed formal programmes of learning. More than 180 staff and members of the public attended the ceremony, with 18 employees being presented with their Long Service Award by the Chairman and 49 receiving certificates for successfully completing their chosen training and/or studies.

Training and Development

The Trust continues to invest in the development of its staff in many ways, from skills for life, such as literacy training to leadership and management development programmes. The learning and development, clinical skills, medical education and organisational development teams work closely together to design and deliver training that is fit for purpose and meets individual staff needs.

The Trust's compliance with mandatory training continued to climb throughout 2011/12 with increased engagement from staff and their managers. The Trust has achieved 87% compliance against NHSLA Risk Management Standards which demonstrates the commitment of staff to attend mandatory risk management training. Trust Board members have participated in bespoke risk management training.

We are still a recognised high performance centre for our National Vocational Training provision, our Assistant Practitioner placements and Cadet Scheme are moving towards apprenticeship frameworks in 2012. We can efficiently record and monitor all training on the Oracle Learning Management (OLM) system enabling staff to assess their own progress.

The Corporate Induction process was refreshed in 2011/12 to include more interactive events, mandatory training and staff engagement. This means we have safe, competent and enthusiastic staff from the start of their employment with us. We provide innovative development opportunities, bespoke to the development of all levels of staff and pride ourselves on the amount of achievements gained by all.

Health and Safety – A Safe Working Environment

Over previous years, with continual improvements being introduced, the Trust has developed into a safer place both to work and to receive treatment. The chart below shows how our performance is steadily improving in relation to slips trips and falls incidents and sharps incidents. This last year there has been a slight increase in the number of injuries related to moving and handling. Together these make up the top three incidents reported annually.

The reduction of 38% in needlestick injuries is encouraging and is due, in part, to the continuing use of the "Safer Needles", a project launched a few years ago, which is now reducing injuries in the areas where the most commonly used types of needle caused a significant number of injures. This work is continuing with the Occupational Health Department and the re-named Sharps And Splash Injuries (SASI) Group (formerly the Needlestick Working Group).

Moving and handling incidents have shown a slight increase of 6%, an increase of five injuries over the previous year. The use of better manual handling aids has helped keep the increase to a low level, but this increase must be judged against more patients being treated, many with mobility problems in the Trust, and the increase in the number of bariatric patients being treated, which cause staff problems when having to move or assist them with their mobility.

Slips, trips and falls have reduced by 12%, down by 10 incidents over the year; this is an excellent result bearing in mind additional activity and some bad weather which increased the risk of falling during the frost in February 2012. The Trust dress-code policy was revised to include guidance on suitable footware and this has clearly been instrumental in the reduction of this type of injury.

The figures in the table below show an overall improvement compared to the previous year in all categories, which is encouraging and demonstrates that the processes that are in place to reduce harm to staff are continuing to be successful.

The graph below details reported Health and Safety, Security and Violence and Abusive Incidents 1st April 2011 to 31st March 2012 compared with 1st April 2010 to 31st March 2011.

Security Management

One of the key areas of work for the Local Security Management Specialist is working to reduce violence against NHS staff, and a key part of this is to constantly measure the scale of the problem. All staff are encouraged to report any incident to enable changes to be driven forward within the Trust, helping to deliver an environment that is safe and secure for both patients and staff. Constant development in incident reporting, action planning, risk assessment and ongoing monitoring ensures that all safety risks within the Trust, including property assets, staff and patient safety, are protected, thereby allowing care to be delivered without fear of violence and aggression.

Reported Health and Safety, Security and Violence and Abusive Incidents 1st April 2011 to 31st March 2012 compared with 1st April 2010 to 31st March 2011

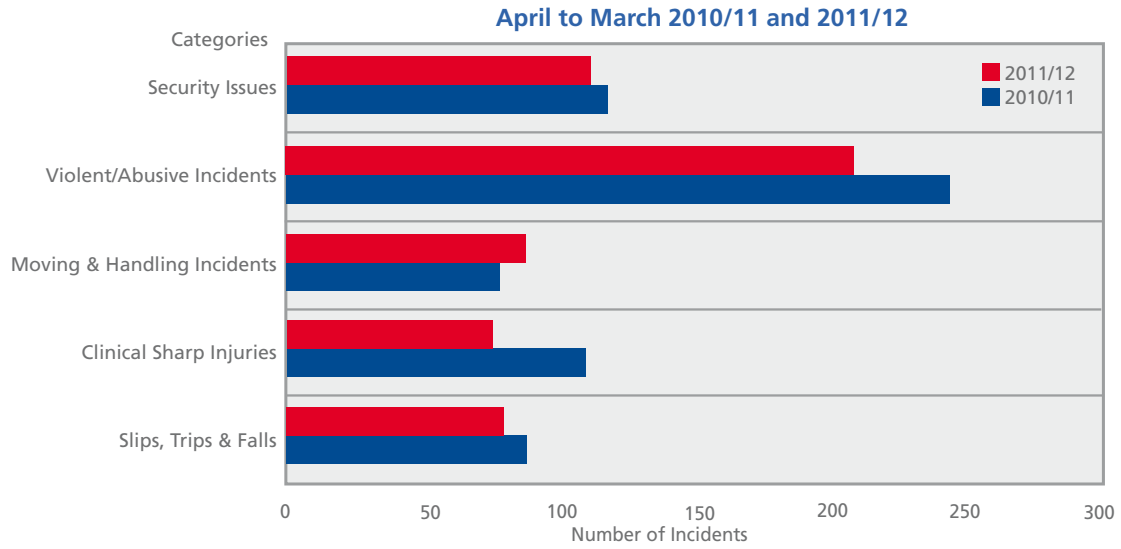
The number of verbal abuse and/or aggressive incidents reported between 1st April 2011 and 31st March 2012 were 207, compared to 245 reported incidents in the previous financial year, showing a decrease of 18%. The A&E Department accounted for 15% (32 reported incidents) of all violence and aggression reported across the Trust.

Violent crimes reported to Lancashire Constabulary have shown a decrease of 40% from the same reporting period in 2010/11. In 2011/12, there have been a total of 12 violent offences recorded to date compared to 20 violent offences recorded in the previous year.

The Trust has a focus on positive reporting giving details of any security event; these consist of physical and non physical assaults against staff; theft or damage (including burglary, arson, and vandalism) to NHS property or equipment issued to staff; theft or damage to staff or patients' personal property.

We are committed to ensuring that Trust staff are properly protected and appropriate training is recognised, as a key factor Conflict Resolution Training and Security Awareness Training is offered to all front line staff and is included as part of the Corporate Induction and Mandatory Training Programme. In addition, a three day training package has been developed for the Trust's Security Officers which incorporates conflict resolution, breakaway, push away and restraint training.

Health and Safety, Security and Violence and Abusive Incidents



The lone worker system introduced within the Trust has been continually financially supported by the Board of Directors. The lone worker device enables staff to be better protected by discreetly calling for assistance in a potentially aggressive situation. Additionally, this ensures that staff are quickly and accurately located and the whereabouts and movements of lone workers obtained when an alert is activated. We are delighted that the NHS lone worker service introduced into the Trust was a winner at the National Personal Safety Awards 2010. This award recognises those who have helped people to stay safe from violence and aggression, and demonstrated best practice in the field.

The Trust is presently underway with phase one of a new Closed Circuit Television (CCTV) monitoring system, this phase consists of the upgrade of the existing control room, a new Digital Video Recorder (DVR), network server, new monitors and a new system controller. This infrastructure will now allow for all the existing cameras/DVR's to be controlled by one software package with site map facility. This is the base infrastructure for future CCTV installations/camera upgrades. The DVR hard drives are also to be upgraded to give longer storage of images.

A Security and Safe Expectations walkabouts has been introduced within the Trust by the Local Security Management Specialist, where monthly visits at all Trust sites are conducted so staff can express any concerns they have regarding any security/safety issues.

The Trust has a robust policy on the prevention and management of violent, aggressive and abusive behaviour by patients, relatives or visitors. Posters continue to be placed in prime locations around the hospitals, and anti social behaviour letters signed by the Chief Executive continue to be sent to those patients and visitors who have been abusive to NHS employees. These actions are helping the Trust in the deterrence of unacceptable behaviour.

Occupational Health

Our Occupational Health and Well Being Department employs a team of specialist doctors, nurses, counsellors, therapists and support staff who provide a comprehensive service to staff and Trust managers. The Department also provides services to external customers and all income that is generated is re-invested into the department; this enables us to offer benefits to employees that ensure service requirements are achievable.

The services offered range from pre-employment screening for new employees to assessment of fitness to work following serious illness or injury. The Department offers direct access to cognitive behaviour therapy. The department's team undertakes regular work-related health checks, vaccinations and immunisation programmes, and develops and drives programmes to reduce risks in the workplace. They offer advice and support to employees and managers in relation to the rehabilitation of staff returning to work following illness or with a known disability.

As part of our ongoing commitment to assist the Trust in managing stress, the Clinical and Therapy Teams monitor a number of work-related cases within the organisation and ensure support is available for all to access. In addition to the internal services offered, all employees have free access to the Employee Assistance Programme, which offers a confidential telephone helpline and online advice to staff.

Once again, during the latter part of the year, the team was heavily focused on the programme to vaccinate as many employees as possible against the influenza virus. Our strategy for the 2011/12 campaign was to train our lead clinicians to vaccinate colleagues and peers to ensure we achieved a high uptake, this approach proved extremely successful and by the end of December 2011 we had achieved a 68% uptake (63% in 2010), this new approach will be adopted for future years. We believe this increase has been achieved through greater staff awareness and once again our Communications Team devised a most innovative 'flu film' to get the campaign underway, which other NHS employers were most complimentary about.

In 2012/13, the Department will be aiming to achieve Safe Effective Quality Occupational Health Service (SEQOHS) Accreditation that is overseen by the Faculty of Occupational Health Medicine. In order to enhance Cumbria and Lancashire partnership working, the Department will be undertaking an independent audit review of its service in order to identify key areas for development and future initiatives that should be implemented, all of which should enable us to share some services, learn from best practices and enhance all of our profiles even further as key leads for the provision of health and well being services in the North West.

'On the 15th September 2011, I was rushed into hospital and diagnosed with Pneumonia and severe complications with an empyema. I underwent a severe operation and was then transferred to Blackpool Victoria Hospital. I hope you will be able to convey my gratitude. I will never forget all the staff that saved my life and treated me with such kindness. They are a credit to they're hospital, the NHS and their professions. It is easy to see why Blackpool Victoria Hospital has a national reputation for excellence'.

Tim Barry, Morecambe.

Our Finances

Detailed below is a summary of the Trust's financial performance against plan for the year.

Income and Expenditure Performance

Before the reporting of exceptional items the Trust achieved a surplus of £4.5m for the year, however taking into account a net impairment of assets £1.0, net restructuring costs of £1.8.m and an exceptional gain of £1.7m as a result of HM Treasury guidance on the treatment of government grants and donated assets, the surplus is £3.3m for the year.

Full details of the Trust's financial performance is set out in the accounts for 1st April 2011 to 31st March 2012 that accompanies the Annual Report in Annex F.

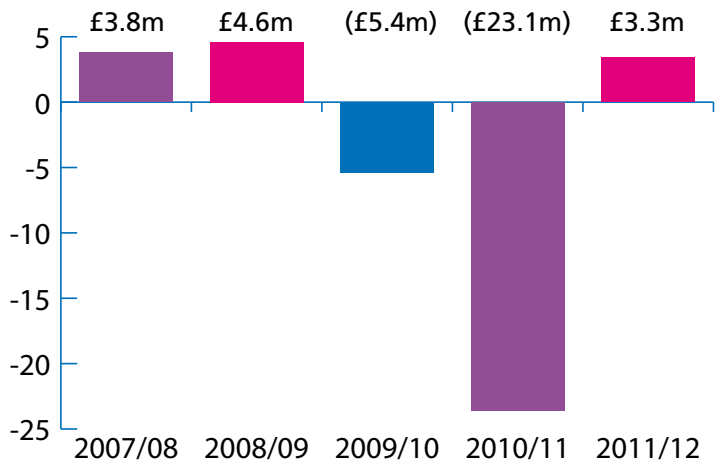
Table 1 compares the 2011/12 actual performance to the 2011/12 plan.

Table 1	Plan £'m	Actuals £'m	Variance £'m
Total income	264.7	280.8	16.1
Expenses	(250.4)	(263.9)	(13.5)
EBITDA*	14.3	16.9	2.6
Depreciation	(6.9)	(6.4)	0.5
Dividend**	(5.8)	(4.2)	1.6
Profit (loss) on asset disposal	0.4	0.0	(0.4)
Impairment	0.0	(1.1)	(1.1)
Charitable Income	0.0	2.0	2.0
Restructuring costs	0.0	(1.8)	(1.8)
Interest income	0.0	0.1	0.1
Interest expense	(2.0)	(2.2)	(0.2)
Surplus(Deficit)	0.0	3.3	3.3

* Earnings before interest, tax, depreciation and amortisation.
** Public Dividend Capital

The Trust's financial performance profile for the last five years is summarised in Chart 1 below.

Chart 1: Surplus performance



The financial performance prior to exceptional items was £4.5m above plan and reflects the increased income the Trust received in year.

Chart 2: Completed Patient Spells

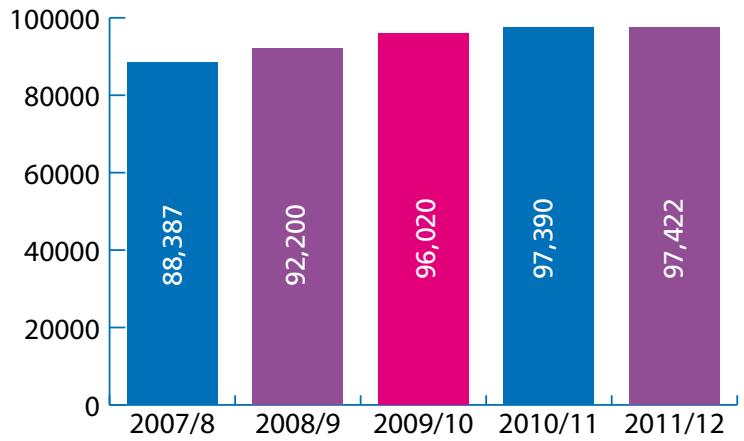


Chart 3: Outpatient Attendances

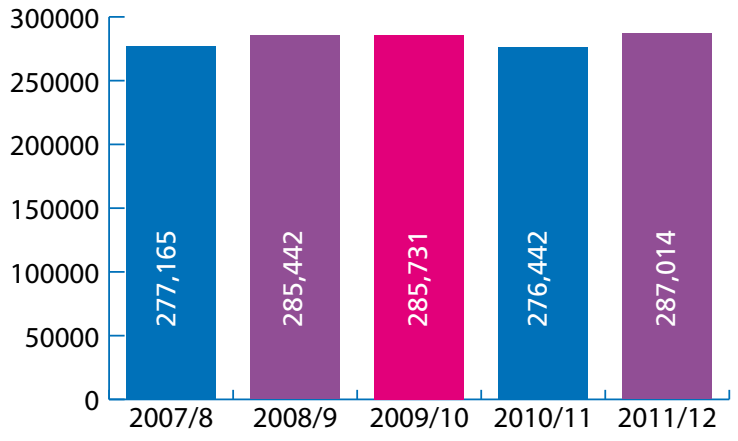
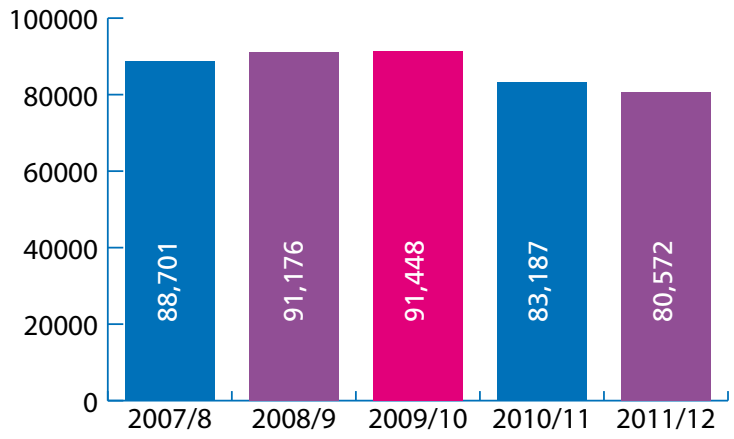


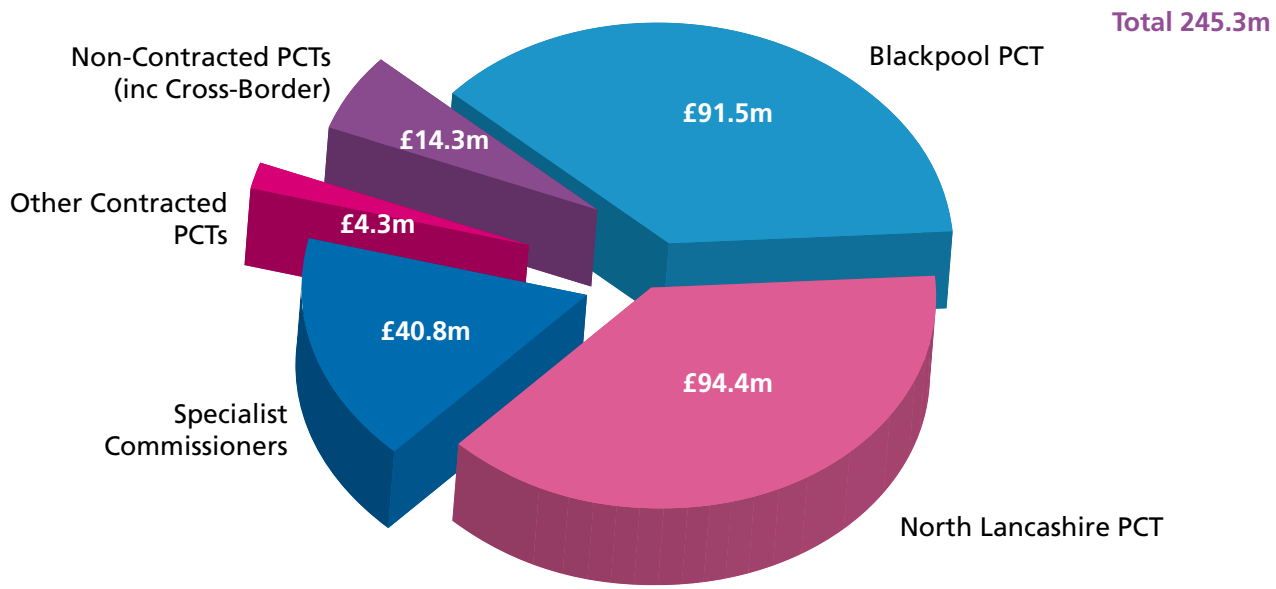
Chart 4: A&E Attendances



Income from providing clinical services to NHS patients, as above, represents the majority of the Trust's income (£256.1m or 90%). The provision of these services is covered by contracts with Primary Care Trusts and other NHS commissioners. The terms of these contracts are agreed locally between the Trust and commissioners based on the national contract published by the Department of Health and priced using the National Tariff or locally agreed prices as appropriate.

Chart 5 summarises clinical income recovery by Commissioners.

Chart 5: Clinical Income by Commissioners



In addition to the NHS Clinical income described above, the Trust receives a number of other income streams. The trend in this income is summarised in Chart 6 and performance in 2011/12 is summarised in Chart 7. Performance in 2011/12 is broadly in line with previous years with the most significant variation relating to predominately exceptional items as set out below.

The Trust has also implemented a change in accounting treatment following HM Treasury's revised interpretation of IAS20 relating to Government Grants and Donated Assets, this change resulted in an exceptional gain of £1.7m. In addition other contributions of £0.4m were received being predominantly relating to research.

The Trust commenced a review of assets in 2010/11 that saw considerable asset write offs in that financial year. The continuation of this review resulted in further asset write offs of £3.9m. The Trust also had a revaluation of its assets resulting in a gross impairment charge of £2.0m. This is offset by an impairment reversal of £0.9m.

Chart 6: Non-NHS Clinical/Non-Clinical Income 2007/08 to 2011/12

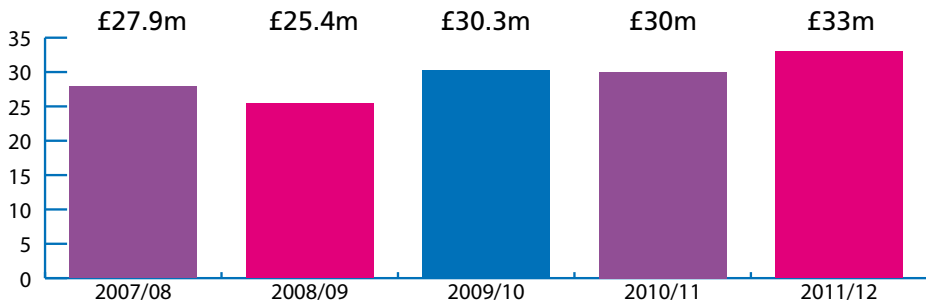
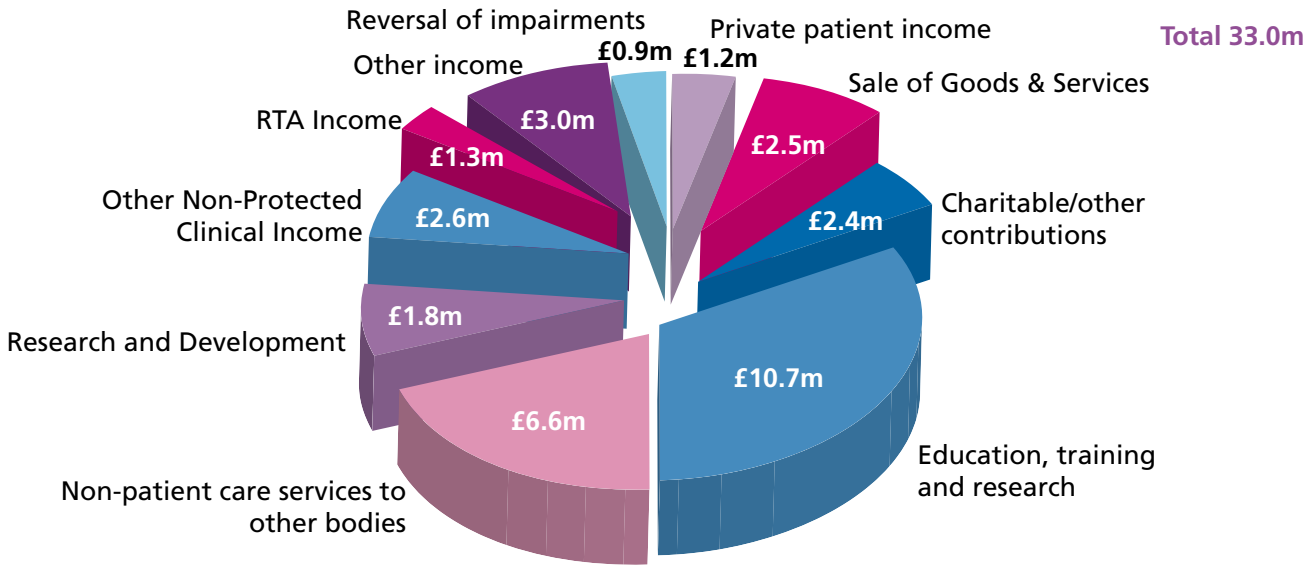


Chart 7: Non-NHS Clinical/Non-Clinical Income by type

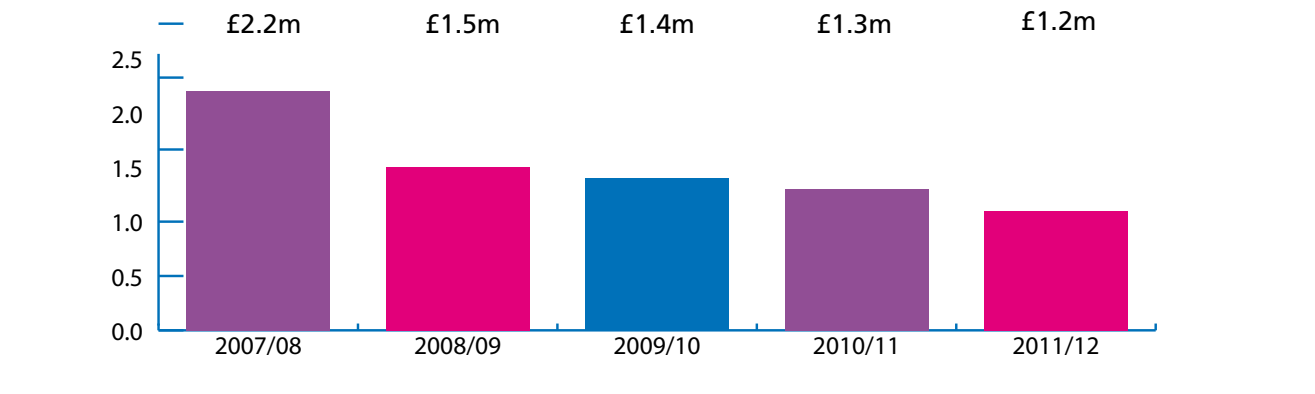


These income streams equated to £33.0m or 11.6% of the total income earned for the year. Of this £28.1m or 9.8% relates to the provision of other services not directly related to healthcare, including catering and car park income. Any surplus from these services help reduce the cost of patient related activities.

Under the Terms of the Trust's Authorisation as a Foundation Trust, the proportion of total patient related income of the Trust in any financial year derived from patient charges should not exceed that generated in the 2002/03 financial year. The results for the period are summarised in the following table with the trend in private patient income shown in Chart 8.

	2011/12 £'m	2002/03 £'m
Private patient income	1.2	3.2
Total patient related income	256.1	151.5
Proportion as a %	0.5%	2%

Chart 8: Private Patient Income 2007/08 – 2011/12



The level of private patient income is decreasing as a proportion of total patient income, reflecting the improvement in waiting times and the reduction in private healthcare insurance in the current economic climate.

Chart 9 shows the expenditure for 2011/12 broken down by expenditure type.

Chart 9: Breakdown of Expenditure for 2011/2012

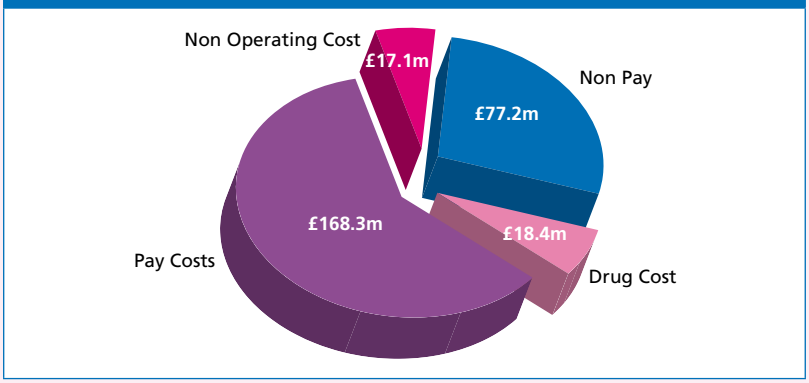
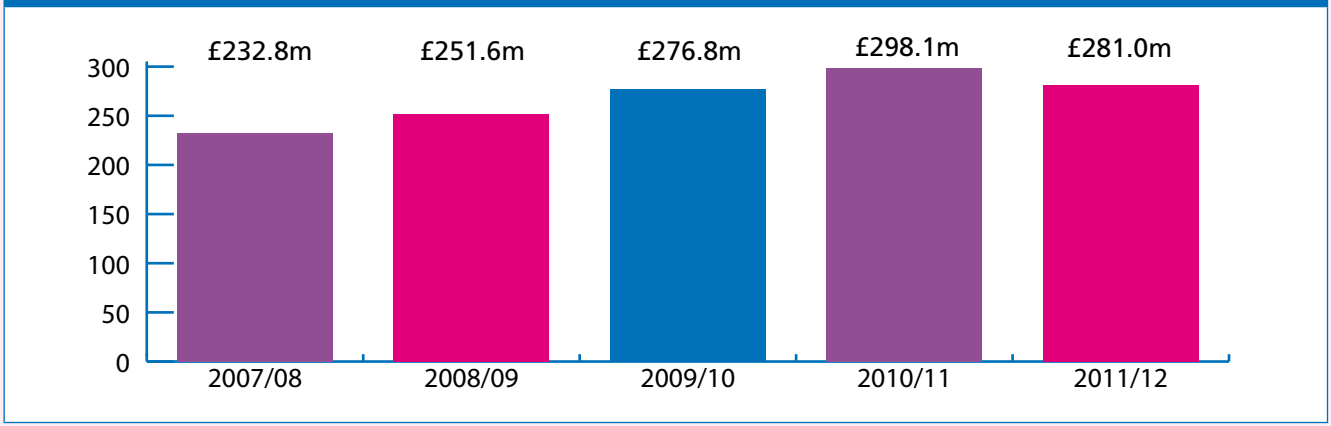


Chart 9: Breakdown of Expenditure 2007/2012



The above expenditure reflects both the increased activity plan delivered and the achievement of £15.5m of QuIPP (£0.4m better than the plan for the year).

The Trust has strengthened its processes to ensure the delivery of efficiency savings with the establishment of a programme management office and increased scrutiny by Executive Directors and the Board. During the last three years the Trust has delivered savings of £6.7m in 2009/10, £17.6m in 2010/11 and £15.5m in 2011/12.

Significant progress has already been made in the identification and delivery of efficiencies for 2012/13 with the full £15.0m identified (£18.7m including community services).

During the year the Trust spent £8.3m on management costs which represents 2.9% of total income. By comparison, in 2010/11, management costs as a percentage of total income was 4.0%.

Management costs are defined as those on the management costs website at www.dh.gov.uk/PolicyandGuidance/OrganisationalPolicy/FinanceandPlanning/NHSManagmentCosts/fs/en.

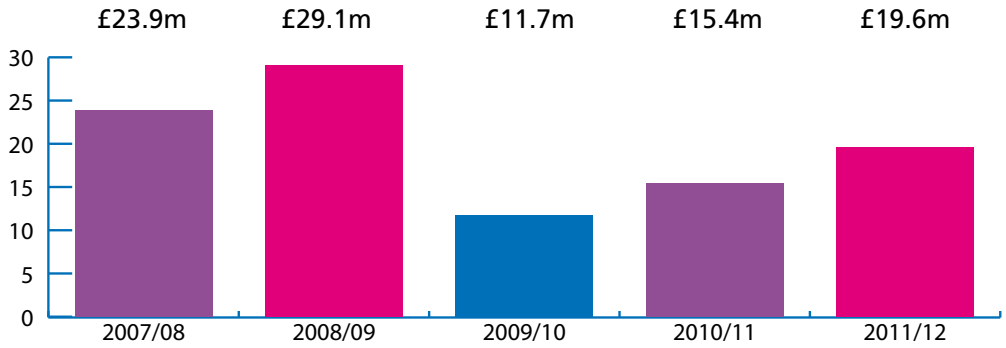
Senior employees remuneration is set out on pages 101-103 in the Remuneration Report section of this report.

Cash Flow and Balance Sheet

The Trust's cash balance at the end of the financial year was £19.6m against a forecast balance of £8.2m. The cash balance was £11.4m above plan primarily driven by active management of Debtors and Creditors, a planned reduction in the capital programme of £2.1m and improved income and expenditure performance. The deterioration of payment performance in line with the Prompt Payment Code is reflective of a planned slowdown in the payment of trade suppliers to improve cash balances.

Chart 10 summarises the Trust's year end cash balances across the last five years. Note that this reflects from 2007/08, the Trust's ability, as a Foundation Trust, to retain cash balances at year-end.

Chart 10: Year-end Cash Balances



As a Foundation Trust, the Trust is required to ensure that it has enough liquidity to support its working capital requirements. To ensure this, the Trust has a working capital facility with Barclay's Bank plc of £19m. This working capital facility expires in October 2013. The Trust did not utilise any of this facility in 2011/12 and does not expect to across the next three years. Following the merger with community services the facility increases to £24m from 1st April 2012.

To comply with best practice the Trust is required to pay 95% of undisputed invoices within 30 days of receipt. The table opposite summarises the performance for 2011/12.

Chart 11: Better Payment Practice Code

Subject	Number 2011/12	£'000 2011/12	Number 2010/11	£'000 2010/11
Total Non-NHS trade invoices paid in the year	68,670	97,442	59,594	104,555
Total Non-NHS trade invoices paid within target	25,359	44,798	47,380	88,826
Percentage of Non-NHS trade invoices paid within target	36.9%	46.0%	79.5%	85.0%
Total NHS trade invoices paid in the year	2,159	23,955	2,060	25,989
Total NHS trade invoices paid within target	960	14,865	1,620	22,745
Percentage of NHS trade invoices paid within target	44.5%	62.1%	78.6%	87.5%

The deterioration of payment performance in line with the Prompt Payment Code is reflective of a planned slowdown in the payment of trade suppliers to improve cash balances.

The Trust is continuing to work with its suppliers in a climate where a key target is to preserve and improve cash balances following a period of intensive capital investment.

No interest was paid to suppliers under the late payment of Commercial Debts (Interest) Act 1998.

The Trust invested over £8m in capital schemes during 2011/12. Expenditure during the period included the following investments;

	£m
Surgical Centre	5.0
Women and Children's service	1.2
Interim Clinical Information System	0.4
Upgrade of Mortuary	0.6

The majority of this expenditure was funded by a £5.6m loan from the Foundation Trust Financing Facility (see also below) with the balance funded from internally funded resources.

The Trust has a capital programme of £4.4m for 2012/13. In addition proposals to construct a new main entrance and multi storey car park and the budget of the PFI contracts are being considered. As an NHS Foundation Trust, the Trust, has greater freedoms to borrow money in order to finance capital investment as described above.

The limits on the amount the Trust can borrow and the conditions that it must meet to demonstrate that the levels of borrowing are affordable are set out in the Prudential Borrowing Code (PBC), published by Monitor. The PBC sets out four minimum financial ratios that the Trust must meet if it is to undertake any borrowing.

The maximum cumulative borrowing or Prudential Borrowing Limit (PBL) that the Trust may make is set by Monitor with reference to the Trust's annual financial risk rating (see below).

	Target	2011/12 annual performance	2011/12 Plan
Minimum dividend cover	>1x	3.5x	2.1x
Minimum interest cover	>3x	8.0x	6.9x
Minimum debt service	>2x	3.6x	3x
Maximum debt to service revenue	<2.5%	1.7%	1.8%

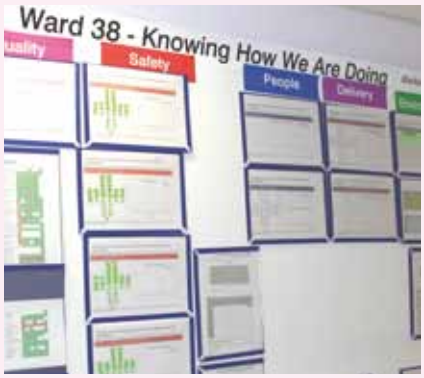
Performance Against Monitor's Compliance Framework

As a Foundation Trust, the Trust is required to demonstrate that it is operating within Monitor's Compliance Framework. The Framework sets out Monitor's approach to regulating Foundation Trusts using a risk based methodology.

A key element of the framework sets out the approach by which the level of financial risk facing the Trust is assessed and the likelihood that the Terms of Authorisation will be breached.

A Foundation Trust that has a high risk of breaching the financial element of their Terms of Authorisation would achieve a financial risk rating of 1. A low risk would achieve a financial risk rating of 5.

Based on its 2011/12 Annual Plan submission, the planned risk rating was assessed and a risk rating of 2 was identified primarily as a result of weak liquidity. Actual performance is a risk rating of 2 and the table below summarises the Trust's performance against the Compliance Framework metrics.



	Target (level 3 risk)	2011/12 plan	2011/12 Annual Performance	2010/11 Annual Performance
EBITDA % achieved	>70%	100%	120.8%	81.1%
EBITDA margin	>5%	5.3%	6.0%	5.4%
Rate of return on assets	>3%	4.0%	5.9%	4.7%
I&E surplus margin	>1%	-0.3%	1.7%	0.5%
Liquidity ratio	>15 days	1.3 days	9 days	3 days

Regulatory Ratings Report 2010/11					
Subject	**Annual Plan 2010/11**	**Q1 2010/11**	**Q2 2010/11**	**Q3 2010/11**	**Q4 2010/11**
Financial Risk Rating	3	2	2	2	2
Governance Risk Rating	Green	Amber/ Green	Green	Green	Green

Regulatory Ratings Report 2011/12					
Subject	**Annual Plan 2011/12**	**Q1 2011/12**	**Q2 2011/12**	**Q3 2011/12**	**Q4 2011/12**
Financial Risk Rating	2	2	2	2	2
Governance Risk Rating	Green	Green	Green	Amber/ Red	Green

The tables above provides a summary of rating performance throughout the year and comparison to the previous year.

The tables above also provide a summary of the actual quarterly rating performance compared with expectations in the annual plan. In quarter 3 2011/12 the Trust had a CQC compliance action outstanding and this resulted in a recording of a compliance framework score of two. A compliance framework score of two resulted in a risk rating of AMBER-RED.

Monitor look at two risk ratings for each NHS Foundation Trust:

- financial risk rating (rated 1-5, where 1 represents the highest risk and 5 the lowest); and
- governance risk rating (rated red, amber-red, amber-green or green).

Foundation Trusts' risk ratings are updated each quarter.

Financial Risk Rating

Financial risk ratings are allocated using a scorecard which compares key financial information across all Foundation Trusts. A rating of 5 reflects the lowest level of financial risk and a rating of 1 the highest. When assessing financial risk, Monitor will assign quarterly and annual risk ratings using a system which looks at four criteria:

- Achievement of plan;
- Underlying performance;
- Financial efficiency; and
- Liquidity.

The risk rating is forward-looking and is intended to reflect the likelihood of an actual or potential financial breach of the Foundation Trust's Terms of Authorisation. The rating system is on a scale of 1-5 as follows:

1. Highest risk - high probability of significant breach of authorisation in short-term, e.g. <12 months, unless remedial action is taken
2. Risk of significant breach in medium-term, e.g. 12 to 18 months, in absence of remedial action
3. Regulatory concerns in one or more components. Significant breach unlikely
4. No regulatory concerns
5. Lowest risk - no regulatory concerns

Governance

Monitor uses the term governance to describe the effectiveness of an NHS Foundation Trust's leadership. They use performance measures such as whether Foundation Trusts are meeting national targets and standards, e.g. a reduction in MRSA rates, as an indication of this, together with a range of other governance measures described below.

- Legality of constitution
- Growing a representative membership
- Appropriate board roles and structures
- Cooperation with NHS bodies and local authorities
- Clinical quality
- Service performance (healthcare targets and standards)
- Other risk management processes
- Provision of mandatory services

Governance Risk Rating

- Red - Likely or actual significant breach of Terms of Authorisation
- Amber-red - Material concerns surrounding Terms of Authorisation
- Amber-green - Limited concerns surrounding Terms of Authorisation
- Green - No material concerns

As a result of in year performance in 2010/11 Monitor's Board declared the Trust to be in significant breach of two terms of Authorisation in October 2010. These were:

(a) Condition 2: the general duty to exercise its functions effectively, efficiently and economically; and
(b) Condition 5: its governance duty.

Since October 2010 the Board of Directors has worked closely with Monitor to identify areas of the Trust's Governance and financial processes that need to be strengthened. A wide range of actions have been identified and implemented and these give the Board assurance that the Trust is now operating within its Terms of Authorisation and that there will be no further breaches of its Terms of Authorisation. The Trust has received official confirmation from Monitor on the 24th May 2012 that the Trust has been de-escalated from significant breach. It is the opinion of Monitor's Compliance Board Committee that the Trust is now meeting its statutory duties and has put into place proper arrangements to exercise its function economically, efficiently and effectively.

Following a challenging year financially in 2010/11, the Trust has undertaken a robust review of its budgeting and planning processes, including those to agree contracts with commissioners. As a result in 2011/12, the Trust has achieved a surplus before exceptional items of £4.5m (overall £3.3m). The in year performance has seen a marked improvement in both the cash and liquidity position. From 2012/13 the Trust plans to return to more historic levels of surplus that will support the continued development and improvement of its infrastructure and services.

At its meeting of 28th March 2012, the Board of Directors considered its Annual Plan for 2012/13 and supporting financial plans for 2013/14. These plans are based on prudent activity assumptions that have been agreed with commissioners, combined with expenditure budgets that have taken into account the likely cost risks in this period and the requirement for 4% efficiencies as set out in the NHS Operating Framework for 2012/13.

On the basis of these plans, the Board of Directors has a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason the Trust has adopted the going concern basis in preparing the accounts.

The Trust's main accounting policies, including policies for pensions, that are used to prepare the accounts are set out in Annex F to this report. Details of the Directors' remuneration is included in the Remuneration Report. The format of the accounts and the supporting accounting policies were reviewed by the Trust's Audit Committee at its meeting on 1st May 2012.

In the opinion of the Directors there are three reportable events after the reporting period these are detailed in Note 26 of the enclosed Annual Accounts 2011/12. The three reportable events are Transforming Community Services; Wesham Park Rehabilitation Unit and Spiral Health (CIC).

The Board of Directors is not aware of any relevant audit information that has been withheld from the Trust's auditors, and members of the Board take all of the necessary steps to make themselves aware of the relevant information and to ensure that this is passed to the external auditors as appropriate.

The Board is not aware of any circumstances where market value of fixed assets is significantly different to carrying value as described in the Trust's financial statements. The Trust's auditors have provided an opinion on our 2011/12 accounts, which is outlined at Annex F.

Financial Instruments

The Trust does not have any listed capital instruments and is not a financial institution. Due to the nature of the Trust's Financial Assets/Financial Liabilities, book value also equates to fair value. All Financial Assets and Financial Liabilities are held in sterling.

Credit Risk

The bulk of the Trusts commissioners are NHS organisations, which minimises the credit risk from these customers. Non-NHS customers do not represent a large proportion of income and the majority of these relate to bodies which are considered low risk - e.g. universities, local councils, insurance companies, etc.

Liquidity Risk

The Trust's net operating costs are incurred under service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust largely finances capital expenditure through internally generated funds and from loans that can be taken out up to an agreed borrowing limit. The borrowing limit is based upon a risk rating determined by Monitor, the Independent Regulator for Foundation Trusts and takes account of the Trust's liquidity.

Market Risk

All of the Trust's financial liabilities carry nil or fixed rate of interest. In addition, the only element of the Trust's financial assets that is currently subject to variable rate is cash held in the Trust's main bank account and therefore the Trust is not exposed to significant interest rate risk.

Cost Allocation and Charging

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Governance.

External Auditors

The Council of Governors have approved the appointment of PricewaterhouseCooper LLP (PwC) as the Trust's external auditors until 31st March 2013. PwC were paid £53,000 in respect of statutory audit fees. A supplementary fee included £12,500 for the independent reporting work in relation to the Independent Auditor's report in the annual quality report.

The Trust limits work done by the external auditors outside the audit code to ensure independence is not compromised. In 2010/11 PwC were commissioned, following review by the Audit Committee and Council of Governors, to undertake the due diligence and independent reporting accountants work in respect of the Transforming Community Services transaction. The fee for the completion of this work in 2011/12 was £161,500. PwC were also commissioned to carry out a review of the Finance Function at a fee of £21,000. In addition the Auditors also provided pension advice, with the fees for this work being £2,000.

Counter Fraud

NHS Protect (formerly The NHS Counter Fraud and Security Management Service) has set out the framework within the NHS plans to minimise losses through fraud. The Trust's local policy complements the national and regional initiatives and sets out the arguments for the reporting and the elimination of fraud.

The Finance Director is nominated to make sure that the Trust's requirements are discharged and is aided by a local Counter Fraud specialist (LCFS). The LCFS developed a plan that aimed to proactively reduce fraud and create an anti-fraud culture supported by appropriate deterrence and prevention measures. Progress against the plan is regularly reported to the Audit Committee.

'Although I haven't been a patient many times in my life, I have visited several wards in operation as a visitor, and am thrilled to say that Blackpool Victoria Hospital is the most friendly and hard-working I have ever been to. All staff have constant smiles on their faces and always make time to have conversations with the patients in their care'.

David Leathers, Blackpool

Our Performance

Despite being an extremely busy and challenging year, the Trust delivered on the majority of national and local performance targets and standards.

Registration with the Care Quality Commission

The Trust is required to register with the CQC and its current registration status is compliant. The CQC has not taken enforcement action against the Trust for the reporting period 2011/12 and remains registered with no conditions.

The Care Quality Commission (CQC) carried out an unannounced visit on 27th September 2011 on regulated activity for surgical procedures in the Surgical Directorate in order to review the Trust's compliance with the essential standards of quality and safety. The Trust recieved the final CQC report on 17th January 2012. The CQC report overall provided positive feedback. Blackpool Teaching Hospital NHS Foundation Trust took the following actions to address the conclusions or requirements reported by the Care Quality Commission.

The Trust received improvement actions in order to maintain compliance for three essential standards of quality and safety in relation to:

- Outcome 07: Safeguarding people who use services from abuse
- Outcome 14: Supporting staff
- Outcome 16: Assessing and monitoring the quality of service provision.

The Trust developed an action plan and implemented the recommendations to address the actions to maintain compliance in relation to Outcome 07; 14; and 16. This has been achieved by providing increased Deprivation of Liberty Safeguard (DoLs)) training; Root Cause Analysis Training; and the increased uptake of appraisals and coaching skills/ conversations training for clinical leaders in the surgical Divisions. The Trust have now addressed the minor concerns and are declaring compliance with Outcome 07, 14 and 16 with no further improvements.

The Trust also received one compliance action as one standard had been identified as not being met. This was in relation to:

- Outcomes 2: Consent to care and treatment

The Trust developed an action plan and commenced implementation of the recommendations to address the compliance action in relation to Outcome 2. Due to a number of improvement initiatives including Mental Capacity Act (MCA) training policy review; and ward/ departmental support from the MCA Implementation Lead, the Trust are now declaring compliance with this criteria.

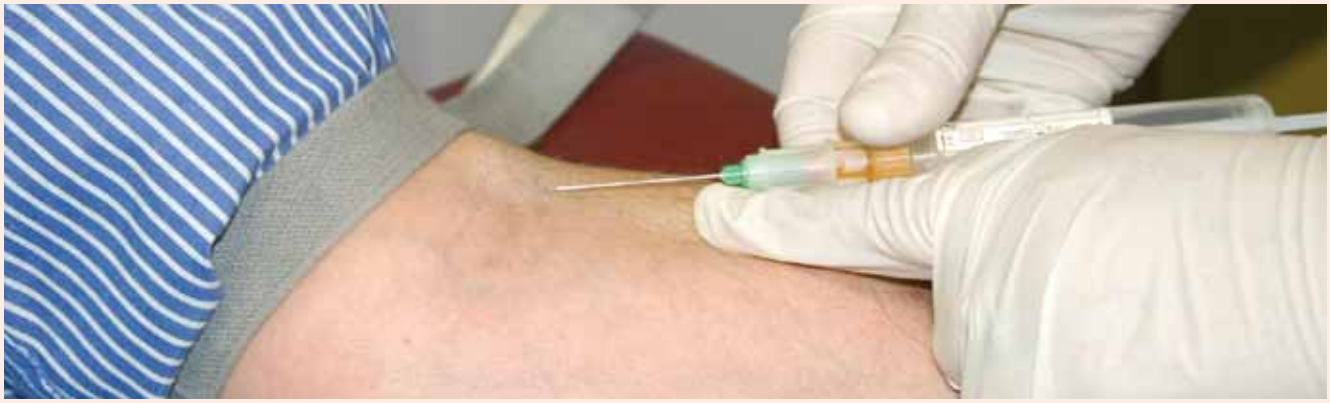
A progress report regarding implementation of the action plan has been provided to the Board in order to demonstrate the actions taken to achieve compliance with the identified standards. The completed action plan and progress report has been submitted to the Care Quality Commission in February 2012 following approval by the Board.

The Trust had a further unannounced visit from the CQC on the 21st March 2012 on regulated activity for Termination of Pregnancy surgical procedures in the Women's Unit and the Surgical Unit in order to review the Trust's compliance with Outcome 21: Records with the essential standards of quality and safety and contributed to part of a National CQC inspection. They reviewed the last 6 months records concerning women who have undergone a medical Termination of Pregnancy and reviewed 18 Case Records, in particular Form A and were satisfied with the standards. The CQC identified compliance with Outcome 21: Records and provided positive feedback with no recommendations identified.

Performance against National Quality Standards

The Trust continued to deliver excellent operational performance during 2011/12, meeting all national and local performance targets. A summary of our performance against key operational targets is given below.

Quality Standard	2010/11	2011/12
Cancelled operations - Percentage of operations cancelled	Achieved	Achieved
Cancelled operations - Percentage of cancelled operations not treated within 28 days	Achieved	Achieved
Reperfusion: thrombolysis waiting times	Achieved	Achieved
A&E	Achieved	Achieved
18 weeks Referral to Treatment (admitted pathway)	Achieved	Achieved
18 weeks Referral to Treatment (non-admitted pathway)	Achieved	Achieved
Patient experience	Achieved	Achieved
Cancer diagnosis to treatment waiting times	Achieved	Achieved
Cancer diagnosis to treatment waiting times - Subsequent Surgery	Achieved	Achieved
Cancer diagnosis to treatment waiting times - Subsequent Drugs	Achieved	Achieved
Cancer urgent referral to first outpatient appointment waiting times - GP	Achieved	Achieved
Cancer urgent referral to first outpatient appointment waiting times - Breast symptoms	Achieved	Achieved
Cancer urgent referral to treatment waiting times – GP	Achieved	Achieved
Cancer urgent referral to treatment waiting times - Screening	Achieved	Achieved
Staff satisfaction	Achieved	Achieved



Our Performance in more detail

A more detailed report on our performance is outlined below and in our Quality Report at Annex A.

18 weeks Referral to Treatment

The Trust has delivered the 18 week referral to treatment performance target consistently since December 2007. The Trust continued to monitor and redesign pathways to ensure the delivery of timely and efficient patient care. During 2011/12, Trust performance remained above the national standard with 91.89% of patients for admitted care and 95.76% of patients for non admitted care being treated within 18 weeks of referral.

Cancer Plan Access Targets

The Trust delivered all the 'Going Further on Cancer' Waiting Time standards during 2011/12. However, delivery of the standards continued to require significant work and pathway development across the Trust, the local health economy and wider Cancer Network. Achievement of the 2 week waiting time standard for symptomatic breast (not thought to be cancer) and the 62 day screening standard was particularly challenging, with developments and processes across the wider health economy putting achievement of targets at risk. A significant amount of work was undertaken to understand and address the issues within pathways and across organisations for the benefit of patients.

Bowel Cancer Screening Centre

The Lancashire Bowel Cancer Screening Programme (BCSP) has been in operation since April 2008. From the beginning of the programme to the present time, more than 324,000 screening invitations have been sent to GP registered populations, and starting in April 2010, with a phased approach, the programme fulfilled the necessary criteria to commence age expansion of its screening population. This initiative has now been fully rolled out to the extended age range of 60 – 74 year olds, which only 50% of programmes were able to achieve at the start of the initiative. During the first four years in operation, the Lancashire Screening Centre has also seen just over 187,000 kits returned by participants to the BCSP Regional Hub in Rugby, Warwickshire. Following the processing of these kits, the results showed that more than 3,300 participants received a positive cancer screening result. The service has continued to produce quality outcomes in terms of the health benefits for patients taking up the offer of screening within our population, especially relating to early detection and treatment of cancers.

On commencement of the programme in 2008, the cancer detection rate was seen to be 11% with the rate now at a level of around 8% at the present time. This is a testament to the early detection and prevention ethos of the screening initiative.

Since April 2008, we have diagnosed 280 patients with cancer at an earlier stage. We have also removed bowel polyps in 48% of patients who underwent a colonoscopy, therefore reducing the risk of cancer in the future.

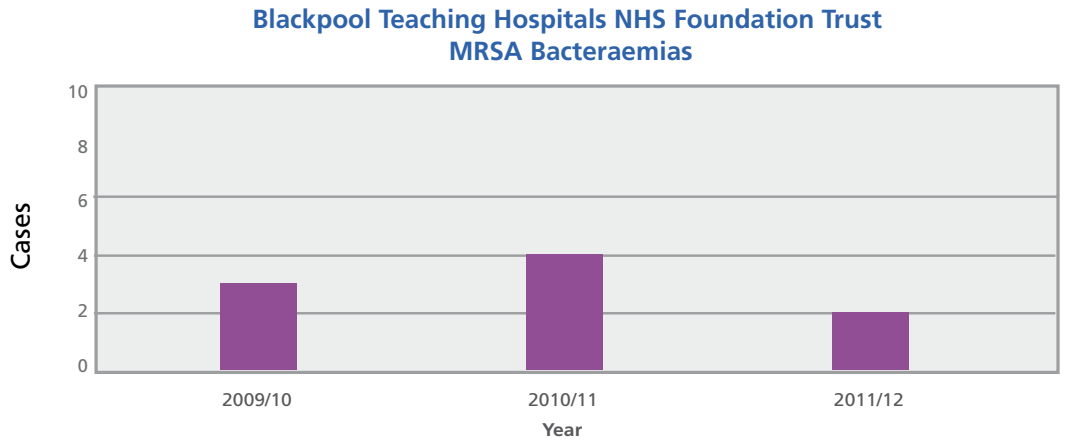
Hard work and close co-operation between Acute Trusts, Endoscopy Units and PCT Public Health and Commissioning Departments has enabled the roll out of the programme to an extended age range. Also in 2011/12, we have developed locally agreed pathways, in partnership with Her Majesty's Prisons (HMP) located in each PCT area, to commence roll out of the Lancashire programme for participants from their organisations. NHS Central and North Lancashire, in conjunction with HMP Wymott, HMP Kirkham and the BCSP Regional Hub have all contributed to the development and implementation of robust and efficient pathways.

Challenges for the programme in 2012/13, include the roll out of flexible sigmoidoscopy screening, which will bring the offer of the new screening test to 55 year olds. Programmes across the country will be invited to submit proposals to deliver this new form of screening and we are currently looking at the various operational models available to us, to ensure efficient and effective provision.

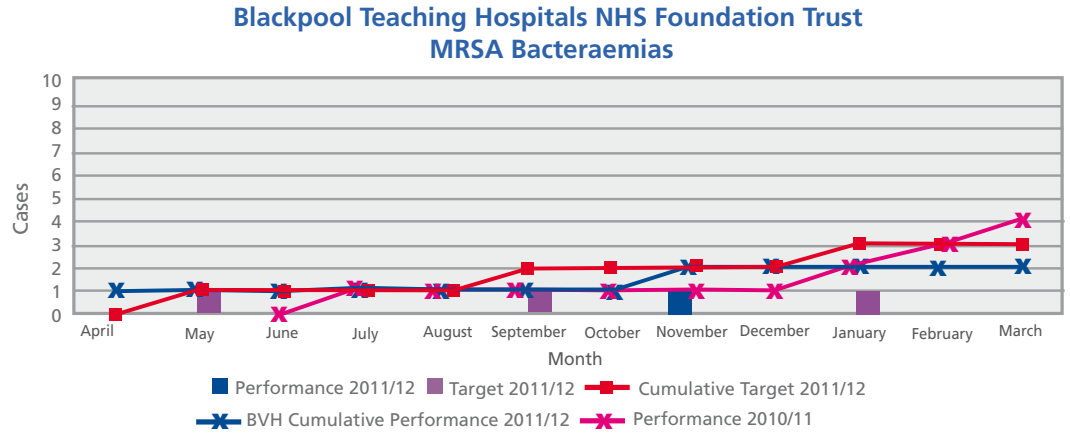
Early in January 2012, there was a nationwide campaign to raise awareness of early signs and symptoms of bowel cancer and we worked closely with our colleagues in the symptomatic service to meet the resultant rise in demand for endoscopy services as a result.

Healthcare Acquired Infections

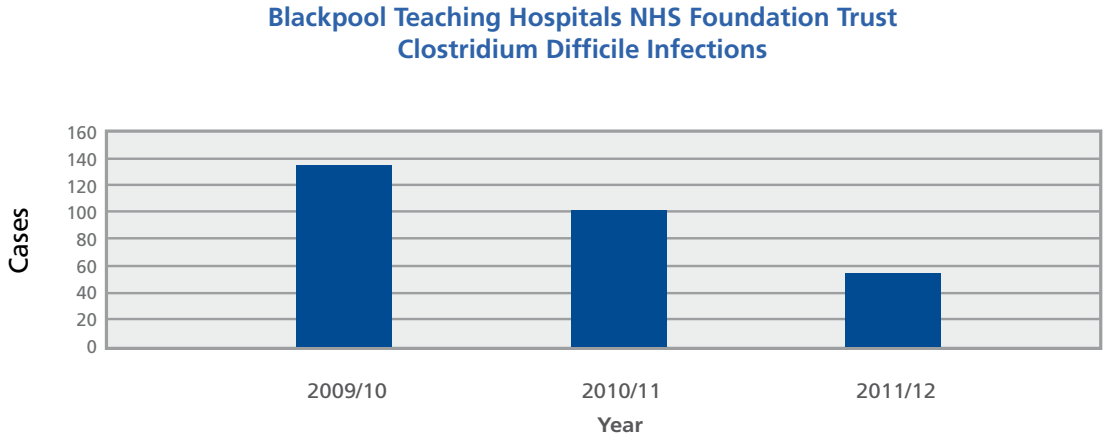
Summary of MRSA Performance 1st April 2009 - 31st March 2012



Summary of MRSA Performance 1st April 2010 - 31st March 2012



Summary of Clostridium Difficile Performance 1st April 2009 - 31st March 2012



Following the continued reductions in Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia over the last three years (92% for the Acute Trust when compared to 2007/08) and Clostridium Difficile (C.Diff) infections (83.59% for the last five years for the Acute Trust from 2007/2008) from the trajectories set by the Strategic Health Authority (SHA) at the year end 2007/8, the Trust has continued to embed Infection Prevention principles across the organisation to ensure that the risk of acquiring an infection for patients is further reduced. MRSA Bacteraemia rates continue to fall. From April 2011 to March 2012 there were only two incidences of MRSA Bacteraemia. There were 53 cases of Clostridium Difficile infection attributed to the Acute Trust between April 2011 and March 2012, in comparison to 101 for the period April 2010 to March 2011. This demonstrates a reduction of 47.52%, which is above the 14.85% annual reduction that is incorporated into the three-year plan trajectories.

Further information on our work to prevent and reduce infections is outlined in Delivering Our Plans section.

Emergency Access Targets

The national A&E performance standard is 95% of patients attending being admitted or discharged within four hours, in addition to new Clinical Quality Indicators. The new mandatory indicators which apply to all A&E's were introduced from April 2011.

The purpose of the new Clinical Quality Indicators is to provide a balanced and comprehensive view of the quality of care provided, including clinical outcomes, clinical effectiveness, patient safety and patient experience thus promoting continuous improvement.

The headline measures are:

- Percentage of patients seen in A&E in less than four hours
- Unplanned re-attendance to the A&E Department within seven days of original attendance lower than 5% of patients
- The median and the longest total time spent by patients in the A&E Department for both admitted and non-admitted patients
- The percentage of people who leave the A&E Department without being seen lower than 5%
- Time from arrival to start of full initial assessment for all patients arriving by ambulance less than 15 minutes
- Time from arrival to see a decision making clinician less than 60 minutes
- Free text section to capture and share patient feedback

We have made progress in achieving the new Clinical Quality Indicators, and for 2011/12 achieved above the standard of 95% overall. The unplanned re-attendance rate was 2.9% and percentage of patients who left without being seen was 2.1 %, significantly lower than the 5% upper limit.

In common with many Trusts, we are continuing to work towards achieving the 15 minutes to first assessment and 60 minutes to decision making assessment measures. Following a staffing benchmarking project, the Unscheduled Care Division has invested in further nursing and senior medical posts within A&E. This investment, coupled with changes to working patterns and the changes to patient flow that have been made in A&E will assist in achieving the suite of Clinical Quality Indicators.

We are embracing the introduction of National Quality Indicators as a basis for continuing improvement in Emergency Care. With the opening of the Urgent Care Centre and the introduction of the Emergency Flow Projects, plans for continuously improving the quality of service delivery, development of care pathways and other new service and staffing models are being introduced.

Improving Patient Care – Redesigning Clinical Pathways

Studies have proved that clinical pathways reduce the length of stay, reduce the likelihood of in-hospital complications, and reduce the total costs of acute hospital admissions. At the same time, clinical outcomes, interdisciplinary cooperation and staff satisfaction can be improved.

The continued commitment to introducing standardised clinical pathways to ensure that patients receive appropriate, timely and evidence-based care has resulted in a number of Clinical Pathways introduced throughout the year to support End of Life Care, stroke care, infection control, cardiology, respiratory conditions and surgery.

These pathways are helping to ensure that the Trust is adhering to national standards, supporting the achievement of quality-based tariffs (i.e. Commissioning for Quality and Innovation, Advancing Quality) and providing quality documentation to improve patient safety and support effective clinical audit.

Interactive, electronic clinical pathways have now also been introduced into the A&E Department through the Trust's clinical information system, ALERT®, with clinical staff now prompted to put a patient on a pathway of care based on agreed national and local best practice.

Within the pathways, clinicians are able to request or perform the correct tasks associated with the clinical condition. This is expected to reduce delays, reduce duplication of tasks and improve the quality of patient care.

Information Governance Compliance

Information is a vital asset, both in terms of the healthcare management of individual patients and the efficient management of services and resources. It plays a key part in supporting Clinical Governance, Service Planning and Performance Management. Robust Information Governance (IG) provides assurance to both the Trust and to individuals that information is dealt with legally, securely, efficiently and effectively. Covering both personal information, such as that relating to patients or service users and employees, and corporate information, such as financial and accounting records, IG provides advice, support and guidance on how information is to be handled, including those set out in the Data Protection Act 1998 and the Freedom of Information Act 2000.

The Trust is monitored against its compliance with the law and central guidance (from the Department of Health), via the IG Toolkit. The Toolkit brings together a set of requirements against which organisations undertake a self assessment to provide assurance on:

- How management structures and responsibilities support IG within the Trust
- Confidentiality and Data Protection arrangements
- Information Security arrangements
- Clinical Record keeping standards
- Secondary Use (information quality) arrangements
- Corporate Record keeping

This assessment also enables the Trust to identify any areas of weakness so that they can be addressed through policies, procedures, guidance and training for staff. The aim being to maintain and raise IG standards within the Trust and in so doing:

- Demonstrate that the Trust can be trusted to maintain the confidentiality and security of the personal information that it handles.
- Support the management of corporate records so that they can be accessed where and when needed.

For 2011/12 the Trust achieved a rating of 83% against Version Nine of the Information Governance Toolkit.

Information Governance activities are supported by the Health Informatics Committee, whose membership is taken from across the Trust, which is chaired by the Deputy Chief Executive, who is also the nominated Board Lead for Information Governance and the Senior Information Risk Owner for the Trust.

Information Governance and Identifying/Managing Risks

The Health Informatics Committee reports to the Healthcare Governance Committee, and is responsible for all aspects of Information Management, IG, Information Communications Technology (ICT) and Knowledge Management throughout the Trust known collectively as Information Management.

The Health Informatics Committee:

- Monitors the setting of the Trust's Information Management Programme to ensure that the strategic goals of the Trust are met through advanced technology where applicable
- Monitors the delivery and benefits realisation of the Information Management Programme to ensure that deliverables are implemented and benefits are derived
- Oversees the creation and implementation of all Policy in relation to Information Management.
- Is responsible to the committee in relation to the Information Governance Toolkit

During the financial year 2011/12, the Trust had 74 (2010/11 25) Personal Data Information Security related incidents reported all of which were severity rated from level 0 - 2. All were thoroughly investigated and reported upon. (Note: Personal Data Information Security incidents are rated on a severity scale from 0 - 5. Incidents classified as a severity rating of 3 - 5 are reported as a serious untoward incident and reported to Monitor and the Information Commissioner). The table below provides a summary which relates to these incidents.

The Trust achieved Information Governance Toolkit (IGT) assessment compliance score of 83%. A review of the IGT assessment reporting carried out by Audit North West during 2011/12 reported a significant level of assurance.

Table: Summary of Personal Data Related Incidents 2011/12

Category	Nature of Incident	Total
i.	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises.	3
ii.	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	3
iii.	Insecure disposal or inadequately protected electronic equipment, devices or paper documents	26
iv.	Unauthorised disclosure	31
v.	Other	11

Health Record Keeping

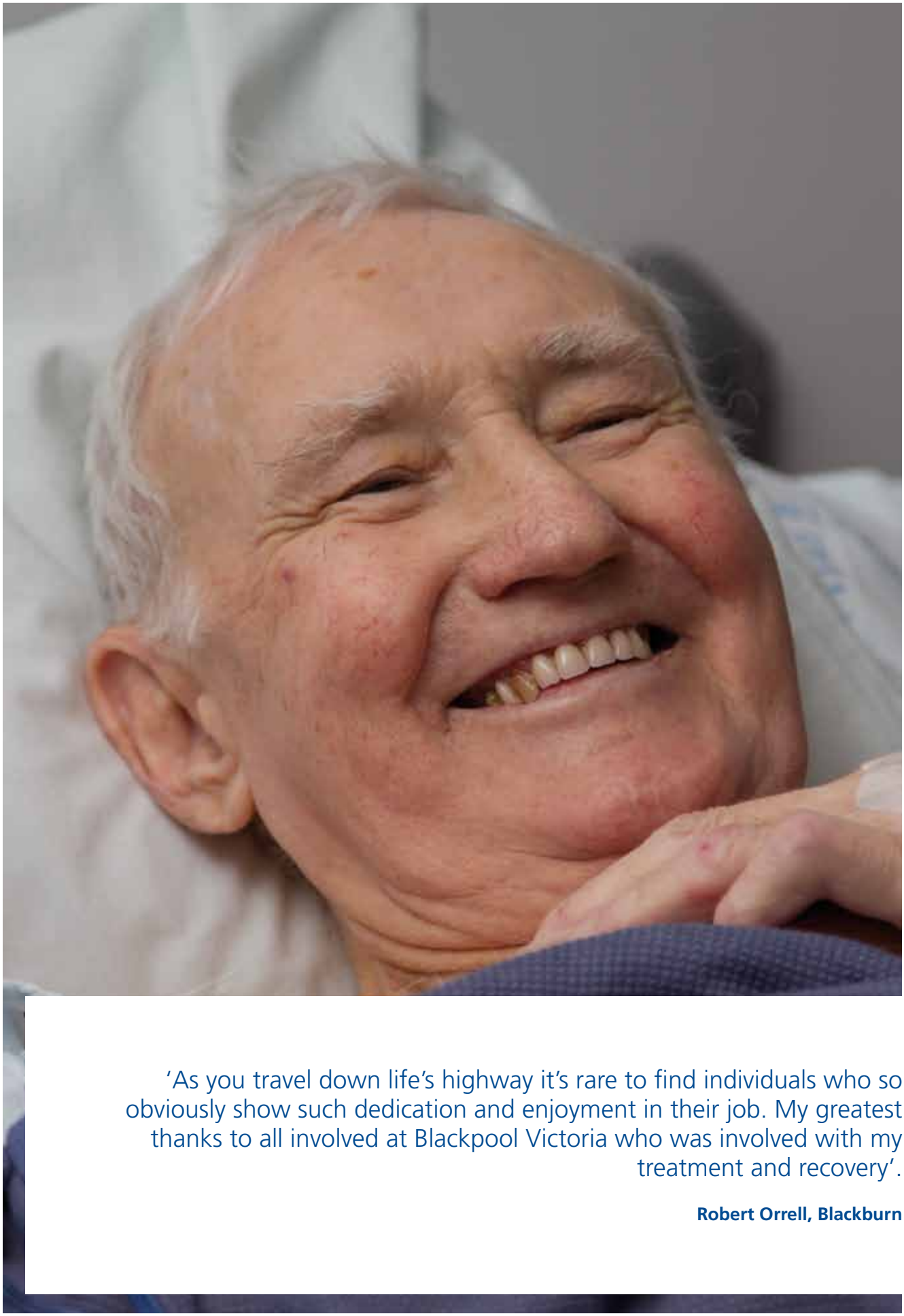
Information is one of the Trust's most important assets. Accurate and comprehensive information is fundamental to the high quality and safety of patient care. The Patient Health Record provides a detailed account of a patients' clinical care including presenting symptoms, treatment and diagnosis.

They also serve a wider purpose of teaching, research and clinical audit as well as providing evidence in the event of litigation and a vital source of statistical and managerial information for the day to day running and future planning of the NHS.

The Health Records Committee is responsible for overseeing the management of the Patient Health Record and is tasked with agreeing and maintaining a standard format for Health Records in the current paper format and will work in preparation for the migration to the electronic record envisaged as part of the Vision Project.

Standards for Health Record Keeping are monitored via a number of methods:

- IGT - the Trust achieved a rating of 83% for 2011/12 which provides a 'Satisfactory' (highest available) rating;
- NHSLA - the Trust is currently rated at level three (highest available) rating; and
- Clinical Negligence Scheme for the Trust (CNST) for Maternity Risk Management Standards -the Trust is currently rated at Level 2.



'As you travel down life's highway it's rare to find individuals who so obviously show such dedication and enjoyment in their job. My greatest thanks to all involved at Blackpool Victoria who was involved with my treatment and recovery'.

Robert Orrell, Blackburn

Delivering Our Plans

The Urgent Care Centre (UCC) brings together the existing A&E Department, the GP Out of Hours service and Primary Care GP led services into one location. From August 2011, the Trust Deep Vein Thrombosis (DVT) service moved under the control of the Primary Care GP led services.

Urgent Care Centre

The use of NHS Pathways to assess patients at one single point has meant that many patients who would have previously attended A&E are now seen and treated by primary care clinicians in the Urgent Care Primary Care Stream. In addition to this we are using clinical triage to ensure appropriate admissions and deflections in comparison to the use of NHS pathways alone.

The Trust is continuing to work closely with our partners in monitoring progress with the development of Unscheduled Care. Current workstreams include the development of services aimed at providing support at home which avoids hospital admission. Further to this, the Integrated Assessment Nurse role is now established which is reducing time to initial assessment and the A&E consultants with the GPs in UCC continue to work collaboratively to ensure that at times of pressure all resources are used effectively. The Trust has also has recently appointed a fifth substantive A&E consultant with an approved QIPP scheme to appoint a sixth.

Phase VI - Surgical Development

The new £18.3m surgical build was completed in July 2011. This build provides an excellent facility for our patients to receive quality care in a modern, clean environment.

Within the build there are 10 theatres (seven inpatient and three day case), a new Urology Unit, day case assessment area and four inpatient wards. There are also facilities within the operation rooms to televise operations that can be streamed into a training room for training purposes. This further supports our training program for Blackpool Victoria Hospital.

With the move of services into the new Surgical Unit it has also created the opportunity to develop the Ophthalmic Surgery Unit and the Medical Retina Unit within the main site which again enhances the patient experience.

Women & Children's Development

Work on the new multi-million pound Women and Children's Unit was completed this year with a number of new areas opening for the benefit of women and children. This is thanks to the League of Friends of Blackpool Victoria Hospital who have donated almost £2m towards the building of our new children's ward and play room.

Previously, Women and Children's services were spread over Blackpool Victoria Hospital in various areas and other departments. Now all the facilities are centralised in one building that is more user-friendly and patient focused, offering our patients the care they deserve in more modern surroundings.

Areas completed over the past 12 months include the Gynaecology Day suite, Gynaecology and Obstetric consulting rooms and delivery suite, Ultrasound Department offering better and more spacious facilities and modernised children and adolescent wards.

The new Neonatal Unit is more spacious and boasts new monitoring equipment and additional transitional care rooms allowing parents to stay with their babies. This service could not be offered before. The Intensive and High Dependency areas are also more spacious than the facilities were in the past.

Two soft play areas for our outpatients now provide lots of fun and exercise for our young patients. For our adolescent patients an area has been specially designed with the needs of this age group in mind.

A sensory room is also a new addition to the service providing sensory stimulation to children with special needs.

Cardiac Expansion

The Trust has extended the range of cardiac services it provides to patients in the Lancashire and South Cumbria region over the past 12 months.

Following the success of the Primary Angioplasty service for patients who have suffered a heart attack within Blackpool, Fylde and Wyre, the service has expanded to a network coverage involving the cooperation of five PCT's and the North West Ambulance Service across Lancashire and South Cumbria. This has involved a revision to existing on call systems to provide 24 hour, seven day a week cover.

The commissioning of a fourth Catheter Laboratory saw the expansion of cardiology services to include an Electrophysiology Service, for which two new Cardiologists have been appointed. This service will prevent patients having to travel to Manchester and Liverpool to receive treatment.

Same Day Admission has continued to grow for patients undergoing heart surgery. Same Day Admission has had positive patient feedback as it improves the patient experience on the day of surgery and the service is now available for all patients within Lancashire and South Cumbria. The team were requested to present this model of care at a National Cardiac Forum as other centres in the UK want to adopt this service for their patients.

Healthcare Acquired Infection

Infection Prevention continues to be a priority for the Trust and further reductions have been made in Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteraemias and Clostridium Difficile infection. MRSA screening of elective patients enables the early detection of MRSA and facilitates prompt treatment to reduce the risk of infection in that patient and through transmission to other patients. The Department of Health directive to introduce screening of all emergency patients by 31st December 2010 has been fully implemented by the Trust.

The Trust screens all emergency patients admitted to the Trust by Polymase Chain Reaction (PCR) testing, which allows a positive result to be known within two hours, thereby facilitating rapid isolation and treatment. This started in April 2008, two years ahead of the Department of Health requirement to screen emergency and elective admissions by 2010.

In recognition of a need to significantly improve compliance with hand hygiene, the Trust has re-launched the Hand Hygiene Policy and Procedure to incorporate the '5 moments' of hand hygiene. To monitor hand hygiene and ensure standards improve the Trust has also introduced covert monthly hand hygiene audits.

In order to further reduce the risk of Clostridium Difficile infection, the Trust has embedded a number of initiatives including; strict adherence to the Antibiotic Formulary, Consultant Microbiologist attending ward rounds to discuss antibiotic prescribing, revised prescription sheet, deep clean of areas to reduce potential environmental contamination and education and awareness regarding the prescribing of antibiotics. An Infection Prevention Annual Audit Programme includes monthly audits of commode cleanliness to ensure that this crucial aspect of hygiene is maintained. The purpose of the audit programme is to provide assurance of compliance with the policies and procedures that are in place to reduce Healthcare Acquired Infection (HCAI) and the risk of HCAI.

Stroke Plan

The Stroke Service has made some transformational improvements to its performance against key, clinical based indicators within 2011/12, which has directly impacted on the service provided to patients and their outcomes.

The service is currently ranked fourth in the North West region against the Stroke Improvement National Audit Programme (SINAP), a national clinical audit, which collects information from hospitals about the care provided to stroke patients in their first three days in hospital and towards the top of the second quartile nationally. The work undertaken and commitment shown by the team to achieve this has been significant, particularly in the context that in the previous financial year the Trust was ranked in the fourth quartile nationally.

The Stroke Service has also performed excellently against the Advancing Quality (AQ) programme; having failed the targets during 2010/11, the service not only achieved the two stroke AQ targets every month during 2011/12, but was the third highest performing Trust within the North West region during the first quarter of the year.

Other significant achievements for the service include the introduction of clinics for high risk Transient Ischemic Attack (TIA) cases, ensuring patients are assessed and treated within 24 hours, the introduction of a 24/7 network-wide Telestroke Thrombolysis Service, which has seen the percentage of patients thrombolysed increase from 3% to 10%, and the launch of a social and support group for former patients and their families and carers. This forum has provided an invaluable opportunity for those who have experienced a stroke to make friends, share information and support each other. Gaining the opportunity to express their experiences is providing a valuable insight for the service to further improve the service and pathways for patients.

Winter Planning

The Unscheduled Care Division delivered on its plans to provide safe and effective services to patients through a period of high demand in winter. This was achieved through the recruitment of an additional 70 nursing staff, the opening of additional bed capacity and the appointment of more medical staff. The Division worked with many other providers and organisations to deliver services over this period, including a new relationship with an ambulance service to ensure patients received rapid transport home from A&E, and the Red Cross to provide enhanced support to vulnerable patients returning home from the hospital.

Transformation of Patient Pathways

The transfer of community health services from both NHS Blackpool and NHS North Lancashire to Blackpool Teaching Hospitals NHS Foundation Trust as part of the Transforming Community Services programme was due to take place on 1st April 2011.

However, due to a number of issues the transfer could not take place and was planned to happen on the 1st August 2011. The transfer was delayed again as a result of the Monitor assessment with recommendations for a number of issues to be addressed.

Robust action plans were put in place to deal with these issues and a vigorous assessment was carried out by Monitor of the transaction process. This culminated in a Board to Board meeting with Monitor on 2nd February 2012. On the 24th February 2012, the Trust was granted permission for the transaction to go ahead and the transfer took place as planned on the 1st April 2012.

The full year financial effect of the transaction will be £67m income and involves the transfer of approximately 1,350 Whole Time Equivalent (WTE) community staff under TUPE.

The whole reason for this transaction was to deliver a financially robust efficient and effective integrated healthcare provider to Blackpool, Fylde and North Lancashire that will be able to invest those efficiencies in improving patient experiences and outcomes by developing whole system pathways which begin to move care out of acute settings into the community.

Blackpool Community Health Services and North Lancashire Community Health Services provide a range of services which have been integrated into the acute Trust. By combining the three organisations into one integrated health provider, the transaction will enable care pathways to be developed which cross existing lines of responsibility and provide smoother and more efficient patient flows, avoid unnecessary duplications and deliver improved patient experiences and outcomes.

In November 2011, the Chief Executive of NHS Blackpool was appointed as Managing Director for Community Development and Transformation (MDCD) to lead the process of integration and transformation and develop the subsequent management structure. Since this appointment, a lot of work has been going on behind the scenes in relation to the transfer and a key change was the renaming of the project from Transforming Community Services (TCS) to Transformation of Patient Pathways (ToPP). It was felt that the new name more accurately reflected the work and aims of the project, recognising that the delivery of better integrated care will transform the way hospital care is provided as much as it will transform community services.

Key stakeholders and staff have been engaged throughout the process, being part of the development of the ToPP Strategies and the decision making processes leading up to the choice of preferred provider organisation. There has been extensive engagement at all stages of the process over the last two years and this approach will continue post transfer.

Clinical Benefits of Integration

The integration of hospital and community services will improve patient care through the provision of seamless services that are accessible, clinically effective and of a high quality. This Pathway work will deliver savings by reducing duplication between Providers and will provide patients with more Community support. This in turn should enable admissions to hospital to be either delayed or avoided, and discharges to be managed more effectively, thereby reducing lengths of stay within the hospital, and benefitting the health economy as a whole.

The merger of Blackpool Community Health Services and North Lancashire Community Health Services with Blackpool Teaching Hospitals will provide an ideal opportunity to integrate services, which will provide a number of benefits around:

- Developing and improving outcomes for patients by developing a proactive management model of care following agreed protocols and pathways
- Facilitating and improving patient experience by facilitating collaborative working between primary, secondary, community and social care services
- Managing the patient's journey proactively and seamlessly through all parts of the healthcare system, thereby improving the quality of their experience and outcomes
- Improving the quality of information
- Developing multi disciplinary and multi agency training programmes to maximise skills
- Preventing unnecessary admission and readmission to hospital
- Reducing length of stay

Workforce Development

The key workforce development challenges in 2011/12 included safely managing down overall staff numbers in non-clinical front line positions in order to deliver the Trust's share of the national £20 billion efficiency savings requirement and providing a range of support to assist staff in developing their competency and skills.

In addition, some nursing shortages during the year resulted in a concerted focus on achieving full, effective and safe nurse staffing levels within each area, linked to the number of beds which are open at any one time. By March 2012, the Trust had ensured that there was full staffing in each area with more effective forward planning to ensure that future demand and supply of nurses is more effectively managed.

During the past year, the Trust continued to invest significantly in developing effective leadership at all levels with bespoke programmes for Ward Managers and Clinical Leaders and an introduction of a talent management programme for staff aspiring to senior roles.

The Trust's appraisal system was completely overhauled with a new e-based system introduced, that explicitly linked an individual's objectives and development to the six key parts of the Trust's Vision.

The Trust further developed its coaching culture offering opportunities for staff to be coached and mentored.

The Trust overhauled its Induction and Mandatory Training Programmes.

The success of all these initiatives was recognised through the Trust's successful retention of Investors in People Gold Accreditation in November 2011.

Sustainability Reporting

The Trust is committed to providing sustainable healthcare to the people of the Fylde Coast and beyond. This sustainability report aims to satisfy requirements for Public Sector Sustainability Reporting and fulfil the Trust's commitment to develop systems to place information relating to the environment into the public domain.

We recognise that our operations have an environmental impact. These include, but are not limited to, waste production, the impacts of transport, energy and resource use, discharges to water, and emissions to air. In addition, we acknowledge the significance of the indirect impacts that we influence through procurement and our choice of contractors and suppliers.

It is the Trust's objective to act in a responsible manner to control and reduce any negative impacts on the environment whilst continuing to provide high quality patient care. In particular, we aim to continue to ensure that our activities comply with, or exceed, applicable regulation and we will work to meet any environmental targets imposed by the government.

We have, or are developing, appropriate strategies to ensure we reduce our environmental impact in four key areas. These will ensure that we continue to:

- Manage transport requirements
- Use energy, water and other finite resources responsibly and efficiently
- Reduce overall waste disposal, reduce the hazards from waste and increase reuse and recovery of resources where feasible
- Prevent pollution resulting from discharges to water or emissions to air – including emissions of CO2 and other greenhouse gases

We will achieve these aims by implementing a programme of continual improvement of environmental performance and will set robust objectives and targets and develop key performance indicators to measure progress.

As sustainability is included in the Trust's corporate objectives, progress against these aims and objectives is managed through our existing Corporate Governance structures.

Policy and strategy are developed and continuously reviewed by the appropriate governance committees. Public Governors are given the opportunity to attend key decision making forums to ensure that the views of patients, carers and the local community are considered.

Day to day responsibility for implementing the sustainability strategy is delegated to the Facilities Directorate. The Trust employs an Environment Officer and a Waste Reduction Officer with specific responsibility to develop our environmental management systems.

Environmental Performance in Key Areas for 2010/11 and 2011/12

Table: Environmental Performance

		Non Financial Data		Cost[2]	
		2010/11[1]	2011/12	2010/11[1]	2011/12
Waste Minimisation	Waste Arising (Total waste from all sources	1,511 Tonnes	1,473Tonnes	£359,845	£295,638
	Clinical Waste (waste disposed of via high temperature incineration)	604 Tonnes	616 Tonnes	£278,318	£232,125
	Waste sent to landfill	517 Tonnes	297 Tonnes	£68,554	£38,398
	Recycled waste	390 Tonnes	520 Tonnes	£12,973	£21,568
	Non Hazardous Incineration (Energy from Waste)	0	39 Tonnes	£0	£3,587
	Electrical and Electronic waste items	10 Tonnes	6.3 Tonnes	£1,098	£256
	Percentage of Waste subject to a recycling or recovery exercise	62% (26% Recycled)	74% (35% Recycled)	n/a	n/a
Management of Finite Resources	Water	151,156m3	142,943 m3	£430,914	£446,726
	Electricity	47,370 GJ	31,815 GJ	£1,106,203	£1,253,267
	Gas	190,783 GJ	194,941 GJ	£1,317,597	£1,575,752
	Other Energy	1016 GJ	1,028 GJ3	£15,859	£17,994
	Fuel used in Trust owned transport	34,813 Litres	34,532 Litres	£41,674	£39,494
Direct Green House Gas (GHG) Emissions	Direct emissions from the energy sources above only	16,940 Tonnes	14,879 Tonnes	n/a	n/a
Explanatory notes	[1] Data published in 2010/11 has been corrected to best available data for the purposes of this report. [2] To bring this report in line with internal monthly reports waste costs (including those for 2010/11) are reported exclusive of VAT. All other costs are inclusive of VAT. [3] This figure represents a maximum based on in year purchases. The actual figure consumed is likely to be slightly lower. The information above is an extrapolation of the best available data at the time of compilation (April 2012). Actual year end figures may therefore differ slightly from those presented. In the event of any difference between this data in this report and that presented in our annual Estates Returns Information Collection (ERIC) return the ERIC figures are to be preferred.				

The figures above represent the results of a year's hard work in difficult conditions.

The reductions in Direct Emissions of Green House Gasses arise from a number of initiatives that were implemented in late 2010/11 and early 2011/12 including improvements to the control mechanisms at our central boiler house at Victoria Hospital, insulation of steam mains, lighting upgrades and improved use of our building management systems. We also benefitted from a mild winter (although this was partially offset by a colder spring).

The Combined Heat and Power (CHP) Engine that was installed at Victoria Hospital in 2009 continued to provide energy savings and we managed to achieve improvements in the utilisation of waste heat from the engine which have increased the financial and environmental benefits. We calculate that the CHP has saved the Trust around £190,000 in 2011/12.

On a less positive note, wholesale energy prices rose significantly in 2011/12. As a result the Trust's overall energy costs increased by 12% compared to 2010//11, despite a 4% reduction in overall consumption.

2011/12 is the first full year of the Carbon Reduction Commitment Energy Efficiency Scheme. We anticipate that our liability under the scheme will be around. £150,000, compared to our beginning of year forecast of around £30,000. It should be noted that the changes to this scheme announced in the Treasury's Spending Review have removed any prospect of recovery of this expenditure through the revenue recycling mechanism.

This year we have continued to invest in energy saving measures and are in the process of implementing schemes to recover heat lost during routine boiler maintenance, installing variable speed controls on pumps and fans, as well as further upgrades to lighting.

We have seen marked improvements in the quality of Light-Emitting Diode (LED) lamps that have been available over the last year and we now believe that the light quality from these is now good enough to phase out the use of halogen spot lights.

The Trust has also made progress with our management of waste. Our contract for collection and disposal of Clinical Waste was re-tendered in early 2011 and this process has delivered cost savings equating to around £80,000 over a full year. The new contract also allows us flexibility to secure further savings through improved waste segregation as we progress with implementing our Waste Reduction Strategy.

Our contract for domestic waste was also subject to tender in 2011. By specifying that our waste must be transported to a Materials Recovery Facility we are now achieving recovery and recycling rates in excess of 80% for non hazardous waste. When our clinical waste is included, we have exceeded our target of recycling 34% of all waste. We anticipate that next year we will be able to increase this to more than 45%.

By improving recycling and avoiding landfill we have also reduced our costs by approximately £30,000 over a full year. This is in addition to the £15,000 revenue that we achieve from sales of separately collected waste streams, such as cardboard and metals.

The opening of the new Surgical Unit has allowed us to transfer our waste operations at Victoria Hospital to a new purpose built facility. The new compound has allowed us to greatly improve our procedures and provides a much safer working environment. This year waste management was awarded the maximum score during our Patient Environment Action Team assessment.

Relationship with Commissioners and Stakeholders

Relationships with Commissioners and other Stakeholders, such as the Blackpool Overview and Scrutiny Committee, have been sustained and developed during 2011/12. The organisations have worked together to identify strategies to promote and improve the health of the local population, with an emphasis on improvements to the quality and safety of patient care.

Our Executive Directors have continued to meet regularly with their Primary Care Trust counterparts, to discuss and agree the strategy for and cost effectiveness of healthcare across the Fylde Coast and to review progress against operational plans.

Future Business Plans

The Trust's Strategic Direction, as set out in the Annual Plan 2012/13, and our Vision and Values, as reviewed and agreed by the Board of Directors in March 2011, underpin the work programme for 2012/13. Over the last 12 months we have undertaken a great deal of work to develop our approach to delivering our future Vision and this is reflected in Our Future Plans section of this document.

'A very big thank you for the special care, warmth and help I received during my stay in the hospital. I could not have asked for more, thank you again to all for all you did for me'.

Zelma Jackson, Chorley

Our Future Plans

The Board of Directors recognise that the changing environment and external factors, such as The Operating Framework 2012/13, the current financial climate, patient choice and the quality improvement agenda impact on our future business plans.

Strategic Overview

We believe that our Vision and continued implementation of the Quality Innovation Productivity and Prevention agenda will ensure that our future business plans accommodate the impact of these factors and are aligned with the direction of travel for the wider NHS.

Whole Health Community Vision

As a health community, we are working in more challenging financial times and this means that we need to deliver significant savings in healthcare. As a health community, our goal is to maintain the level of services we provide as far as possible and meet our financial challenges through improving the quality of patient care. To achieve this we need to make sure that any changes we do make in the future are not only better for patients but are affordable, and our services are as efficient as they can be. We intend to undertake a joint health community consultation with our patients and the public during the spring of 2012, setting out our plans for how we intend to achieve this and seeking support for the changes which will be required to deliver our goal.

Transformation of Patient Pathways

Post Integration

The benefits of the transaction will be delivered by the integration of health services across the Health Economy along Clinical Pathways. The development of Clinical Pathways which more fully integrate services has already begun, with consultations planned initially across four long-term condition pathways, namely Diabetes, COPD, Stroke and Heart Disease.

It is intended that at least one of these improved pathways (Stroke) will be able to go live within the first wave of integration by September 2012 with others coming on stream in the 18 months thereafter. Detailed discussions are ongoing with Commissioners to ensure proposed revised pathways reflect Commissioning Intentions.

The Divisional Structures will be looked at in terms of Clinical Pathway design. Initial discussions indicate that the new structure would be more effective in divisions covering: Families and Community Services, Long Term Conditions, Scheduled and Urgent Care. The final model will be subject to detailed pathway work and links with other Health Economy Services e.g. Urgent Care Centre, 111, and Out of Hours.

The intention is for a Family and Community Services Division to be created as a first wave of integration. This division will cover all services currently provided for Women and Children within the Blackpool Teaching Hospitals Trust and all Community Services transferring from NHS Blackpool and NHS North Lancashire.

For children and young people's services, suggestions regarding pathway development include the Diabetes pathway – with an opportunity to develop the pathway to a standard so as to receive the Best Practice tariff. Further pathway work is to be developed for patients with Cystic Fibrosis, ensuring the child or young person receives the right treatment at the right time in the right place. Blackpool Community Health Services has been identified as an early implementer site for the National Health Visiting Review and partnership working with Midwifery Services has commenced. The Department of Health's guidance document 'Getting it right for children, young people and families - Maximising the contribution of the school nursing team: Vision and call to action' was published on 12 March 2012 and provides similar opportunities for development.

Links with clinical leads has also identified opportunities that can be gained through a unified nursing service across Pathways. Specialist nurses currently work in both hospital and community settings with minimal sharing of experience and knowledge. With leadership and support, staff will be encouraged to work in a more cohesive way encouraging staff development and enhancing clinical pathways.

Opportunities are available to develop practice to take advantage of services available in community settings. An example of this is the Rapid Access team with the intention of preventing attendance to A&E and hospital admissions and reducing the length of stay for patients once admitted.

The Vision Programme – The Introduction of an Electronic Patient Record

In late 2009, the Board of Directors appointed ALERT Life Sciences UK Ltd, as the Trust's strategic partner for the delivery of an Electronic Patient Record (EPR) system. The decision to procure an EPR system was taken to support the delivery of high quality patient care, whilst also improving services and empowering clinicians to make the necessary changes in clinical practice. This requires a system that provides real time, high quality clinical information. The implementation of the ALERT® system will allow clinical information to be recorded, collated, analysed and reported on, with a clear focus on outcomes and the quality of care being delivered. The system will also provide real time information to monitor and improve the effectiveness and efficiency of care, thereby improving clinical quality. The EPR system will:

- Support the provision of safe patient care and the delivery of best clinical practice in every specialty, by providing a more informed clinical environment to work in, with greater access to comprehensive patient information, as well as reference data, such as publications and evidence based guidelines
- Provide a more professional environment to work in by reducing the time clinicians spend on bureaucracy and paper-work, such chasing results, arranging treatments and answering bleeps. It will also provide effective productivity tools, such as patient scheduling. This will enable more time to be spent with patients or in reviewing and developing clinical practice
- Encourage team working and decision making since all clinicians involved in the care of a patient will share the same information resource and decision support tools, thus reducing the incidence of isolated working
- Provide real-time safety checks where decisions are evaluated against consultant approved guidelines before they are acted upon. This means that to a certain extent, consultant advice and guidance will be available at all times
- Make information available wherever patients are cared for and wherever clinicians work. Clinicians will no longer need to attend the clinical department to access patient notes, nor to authorise changes in patient medication and/or treatment. Clinicians will know the location of their inpatients and the detailed status of every investigation ordered
- Reduce the length of stay for individual patients by providing better access to information and investigations, enabling more rapid and informed clinical decisions.

Perhaps most importantly, the introduction of an EPR system will improve patient safety by:

- Providing all clinicians with shared access to the patient's history, diagnosis and treatment information
- Ensuring only the most appropriate drugs are prescribed and administered
- Monitoring and alerting clinically critical situations
- Scheduling diagnostics and treatments to best fit the patient's care
- Removing waste and improving efficiency by reducing length of stay, and limiting the inappropriate use of drugs and clinical investigations.

During 2010/11, the Trust had its first 'go live' of the ALERT® Emergency Department Information System (EDIS) in the A&E Department, which allowed clinicians to undertake most activities electronically. In 2011/12, the ALERT® EDIS system has been upgraded, and further electronic ways of working have been introduced to the A&E Department – these include electronic prescribing and medicines administration (EPMA) and the use of clinical pathways. This use of clinical pathways will ensure that patients receive consistent and safe care for high risk conditions or common diseases when attending the A&E Department.

During 2011/12, the Vision Programme Team has been working with clinical and operational teams to map all of the current activities and processes that occur across the inpatient, outpatient, operating theatre and ancillary departments within the Trust. It is important for the team to capture all of these current state processes to ensure that, once implemented, the EPR will replicate any essential processes. This also gives the Trust the opportunity to review current processes and make them as efficient as possible before introducing new electronic ways of working.

The Trust has been working with its various clinical information system suppliers to ensure that once the ALERT® EPR system has been implemented, clinicians will only need to enter one information system to access all relevant information about a patient. This will be of great benefit to our clinical teams, providing instant access to all necessary information about a patient.

Our clinical teams have been working with the ICT Department to review new devices that would assist in the use of the EPR in the inpatient and outpatient areas. The recent advances in technology mean that clinicians will be able to use small, hand-held tablet devices at the patient bedside, instead of using traditional desktop computers.

The Executive Team and the Vision Programme Board will continue to monitor the project costs and benefits, as well as progress against the implementation timetable, throughout the duration of the programme.

The Trust plans to roll out the EPR system across inpatient and outpatient areas in 2012, with all departments using the relatively simple elements, followed by a layering of the more complex functionality once clinicians have gained confidence in using the system. During 2012, all departments will begin to use the system to request clinical investigations, such as x-rays and blood tests electronically instead of completing paper request cards, and will also receive the results electronically. This will allow clinical teams to work much more efficiently.

Use of the system for all clinical documentation, instead of clinicians recording their notes on paper and entering this into patient casenotes, will be implemented first in the outpatient areas. This will allow our clinicians to become familiar with using the system in an environment where use of this type of EPR has been proven to work successfully – most general practitioner (GP) practices now use an electronic record for their consultations and will, therefore, build their confidence in using the system before implementing in the inpatient environments where patients can be very sick and require many medications and treatments.

Continuous Improvement

The Quality Innovation Productivity and Prevention agenda has provided us with a further opportunity to galvanise the organisation to deliver change. Programmes and projects are focused on developing capability, securing engagement and improving performance. The use of effective programme management and robust Executive leadership, coupled with an inclusive and wide-reaching approach has enabled the Trust to implement solutions sustainably, engaging frontline teams supported by senior clinicians and operational managers.

In order to ensure that change is delivered, and that the benefits associated with change are realised, the Trust has strengthened the programme management office function through the introduction of a continuous improvement team resource to support the delivery of complex pathway changes across primary and secondary care.

Each project team will continue to meet weekly to design, manage and deliver change. Each team is led by an Executive Director, and progress is reported on an exception basis to the Chief Executive via the Programme Management Office and QuIPP Programme Board.

Sustainability - Future Environmental Priorities and Targets

The financial year 2012/13, will see further improvements in our energy performance and management. We intend to phase out use of halogen lamps in favour of Light-Emitting Diode replacements and will start the process of moving away from the centralised boiler plant.

We believe that we can also achieve further improvements in our control of energy use through better use of our building management system.

These measures should allow us to continue to reduce our direct CO2 emissions, however with wholesale energy prices forecast to rise by between 15 and 20%; it is unlikely that we will be able to achieve an overall reduction in energy cost.

In 2012/13, we will be concentrating our efforts on rolling out a clinical waste reduction programme that has been successfully trialled in wards 38 and 39. By ensuring that clinical waste bins are only available at point of need we have shown that we can significantly reduce incorrect disposal of non-clinical items in the clinical waste stream. This programme will also allow us to comply with the latest guidance issued by the Department of Health.

We have significantly improved our recovery and recycling rates this year but we believe that we can do even better. Our residual waste currently has high proportions of food and liquid contamination; by eliminating this we can improve recycling rates and access much better prices for waste treatment. We will build a business case for installation of waste digesters in our catering department and if approved, we will move towards disposing of all food waste via this route.

We also plan to make changes in our provisions for destruction of confidential waste to improve our internal control over this material and achieve savings in the order of £12k per annum.

Medical Education

The Trust's provision of Medical Education includes; Postgraduate and Undergraduate Medical Education, the Simulation and Clinical Skills Service and Library Services and Knowledge Management.

Postgraduate Medical Education

In March 2011, the North West Deanery conducted a Monitoring visit of the Foundation and Speciality Training Programme. The visiting team met with both trainees and trainers and provided extremely positive feedback on both programmes. In April 2012, the Dean carried out a further full quality visit to review the training experiences of the trainees and to assess quality process. We are awaiting the Dean's report from the visit within the next few weeks.

In July 2011, the Trust was delighted to welcome the new cohort of 36 Foundation Doctors, which again included a number of Liverpool graduates who had spent years four and five of their training on placements within this Trust. The majority of the new cohort spent the first two weeks in July on a voluntary basis shadowing the doctor they would be replacing when they started in August 2011. In August 2011, 100 new Speciality Trainees and GP Speciality Trainees joined the Trust following an induction day.

The Medical Education Team is committed to developing a high quality workforce driven by patient safety and quality care. We have implemented a Quality Assurance Programme to improve the training programme and experience of all trainees. This includes regular evaluation surveys and focus groups to identify areas of best practice and areas for improvement.

The Trust successfully hosted the Membership of Royal College of Physicians (MRCP) Practical Assessment of Clinical Examination Skills (PACES) examination in October 2011, led by Dr Peter Isaacs and his team and coordinated by the Postgraduate Education Team. The immense support of the patients, examiners and everyone in the PACES Committee made this event a great success. The PACES examination is the final stage, in a three step stage, required to progress through medical training in the UK.

Undergraduate Medical Education

The undergraduate academic year of 2011, once again, ended with another hugely successful examination pass rate. This success is a testament not only to the students' hard work, but also to the teaching, supervision and support that the students receive from all staff in the Trust. Blackpool Teaching Hospitals NHS Foundation Trust continues to build on its excellent reputation amongst the students at Liverpool University, ensuring it is a great place to be for teaching, curriculum content, consultant supervision and friendly supportive staff.

Liverpool University conducted their first full Undergraduate Quality Assurance visit in March 2011. The Quality Assurance visit was conducted by members of the Faculty of Medicine and the Strategic Health Authority. The overall feedback was extremely positive.

The annual regional Medical Finals known as the Liverpool Objective Clinical Assessment System (LOCAS) took place over two days in June 2011. The examination is a major event for the Trust, requiring six months of planning and involves support and commitment from many staff in the organisation. However, the examination could not run without the wonderful support of our local patients and communities, who give up their valuable time to be part of the examination. Patient involvement is essential to ensuring we train medical students who are competent to practice as junior doctors.

During August 2011, we commenced our fourth academic year, and welcomed both fourth and final year medical students from Liverpool Medical School. Thirteen final year students chose to complete year five within the Trust, after completing a successful year four at Blackpool Teaching Hospitals NHS Foundation Trust. This is one of the first steps in attracting home grown junior doctors. We will continue to strive to become 'The Place to Be' for medical education and clinical practice.

In September 2011, the Medical Education Team was successful in being granted ethical approval for a two year simulation research project. The research programme is a joint piece of work with Liverpool University and is being carried out across two clinical sites, namely Blackpool and St Helens & Knowsley Teaching Hospitals Trust. The research aims to address how we can better prepare final year medical students for dealing with medical emergencies as foundation doctors. The study is now underway and the early feedback is very positive. This study will enhance our reputation as a research-active teaching hospital as well as adding to the reputation of our medical education output.

New initiatives planned for the academic year 2012/13 include:

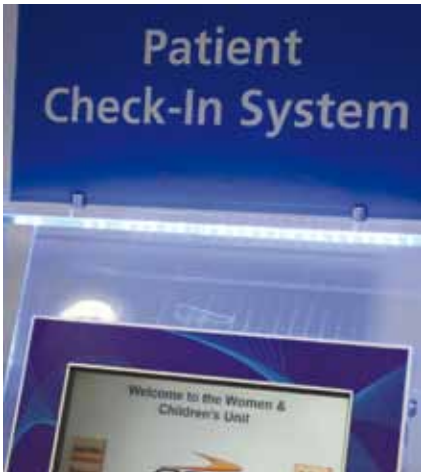
- Partnership working with Lancaster University in preparation for the formative finals to be held on site from the academic year of 2012/13.
- Simulation and Advanced Life Support (ALS) training on site for the final year medical students.
- Greater Trust representation at teaching sessions, such as, Objective Structured Clinical Examination (OSCE) examining and interviewing at Liverpool University.

The Simulation and Clinical Skills Service

This year has seen some exciting and innovative changes within the Clinical Skills Department. The move from Plymouth Road to a new on-site venue, above the old Aster Ward, heralds a new era for clinical skills training within the Trust. The new Simulation and Skills Centre, completed in June 2011, is a state of the art skills facility comprising of skills and training rooms, offices and a faculty training room. The last phase of the build, completed in April 2012, also includes a new high-tech simulation facility.

Simulation is a powerful learning tool used in healthcare to recreate nearly all of the aspects of a clinical situation in an educational setting. Using an advanced patient simulator (manikin) it can mimic 'real patients' as it can be controlled by a computer to respond to students, for example, the manikin can develop difficulty in breathing, sweating, crying and communicating its needs. This can therefore be used to teach and assess new techniques which can then be discussed and explored before implementing skills in clinical practice. Simulation gives the opportunity to rehearse complex integrated scenarios in a safe, protected, learner-centred simulated clinical setting.

Simulation is a technique for practice and learning that can be applied to many different disciplines and trainees. David Gaba, one of the pioneers of simulation technology in medicine, states: "Simulation is a technique, not a technology, to replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion. Immersive conveys the sense that participants have of being immersed in a task or setting as they would if it were the real world." Simulation facilitates learning through immersion, reflection, feedback, and practice -- minus the risks inherent in a similar real-life experience. Simulations are used in varied industries including aviation, nuclear power plants, space aeronautics, the military, business, and healthcare (McGaghie, 1999).



With thanks to support from the Dinwoodie Charity, for part funding the project, the plan included two fully equipped simulation suites, which can be used for single scenarios, or the rooms can be opened up as one large facility to run A&E scenarios and multiple cases. There is one large control room running at the back of the simulation suite, two viewing rooms with debriefing facilities and one separate communication training area. The simulation and communication rooms have modern high technology cameras and software, similar to that being used in the sporting world, in order that the faculty can debrief both technical (hands on clinical skills) and non-technical skills (communication, leadership etc). The simulation facility was completed in April 2012 and the team are expecting to hold an open day in May 2012.

During 2012, the team are adding two new courses to the Clinical Skills Curriculum, which it is hoped, will have a significant impact on the safety culture of the Trust. These courses are in response to incidents that have happened in clinical practice and will promote patient safety, a key role for these educational programmes:

- Safety Themed Update Drop in Sessions (STUDS) - these will be dropping in sessions that will allow all practitioners to practice a range of clinical skills, for example, nasogastric tube insertion on a manikin. Up to date evidence will be available for practitioners as well as podcasts that demonstrate the skill being conducted. The aim of these sessions is to allow practitioners to update and refresh clinical skills in a training environment, therefore, promoting evidence based, up to date skills in the clinical areas.
- Skills Training Responding to Incidents in Practice (Dr STRIP) - these workshops are aimed at medical staff and are based on the World Health Organisation's recommendations around patient safety. The workshop explores both technical and non-technical skills in a safe learning environment. It will investigate errors that occur in clinical practice and encourage clinicians to examine how these have occurred and what systems need to be put in place to stop errors occurring in the future. It will also give clinicians time to practice technical skills on manikins and reflect on evidence based practice and learning lessons.

Library and Knowledge Services Management

The Library and Knowledge Management Service continues to promote a culture of evidence based practice and quality improvement by providing access to knowledge, information and learning opportunities for all staff and students.

These include:

- Clinical Librarian Service - a dedicated librarian attends clinical governance and audit meetings, providing timely access to the evidence base to support QuIPP projects, business intelligence and cost/quality improvement initiatives as well as policy and clinical decision making. This service has been running successfully for a number of years and is currently the focus of a North West wide research project looking at the importance of clinical evidence and the impact of Clinical Librarian Services on patient care.
- Critical appraisal training - understanding published research is a vital part of today's healthcare and the library has this year trained 117 staff on how to read and understand published research papers. A dedicated session for Staff and Associate Specialist (SAS) Doctors was included this year and was well received.
- Current awareness and horizon scanning services - regular bulletins are published and widely distributed to ensure staff are kept up to date in their speciality. To support the Trust's research agenda a new monthly newsletter has been developed to encourage staff to become involved in research themselves. 'More Research Needed' highlights recent studies which have shown inconclusive results or need further research.
- Best Practice and Knowledge Management - sharing information, lessons learned and quality improvements is a key aspect of knowledge management. Quality improvement stories are collated and shared across the Trust on the Knowledge Management web pages, as are the Trust's Lessons Learned bulletins.
- Something for everyone - although primarily a workplace library for learning and professional development, the library now has a small but growing collection of general interest and health and well-being books. 'The Reading Well' is a corner of the library dedicated to health, wellbeing, self-help, hobbies, self-improvement and relaxation. All staff are encouraged to use this collection, which has been partly supported by the Staff Lottery Fund.

Regular feedback from library users shows that staff and students really value the library and the 'reliable and helpful librarians'.

For 2012, the library service aims to continue to develop new ways of delivering information and providing access to information. The introduction of a new mobile technology and applications system means that information will be available by a number of different means, which includes tablet devices and smart phones. Print is giving way to e-access and the library will continue to review its provision of printed material, substituting e-access wherever appropriate, plus the support needed to enable all staff to access the resources they need.

The Local Competitive Situation and Development of Commercial Opportunities

At the present time there is limited local competition in relation to services provided by the Trust. However, the introduction of the principle of 'any willing provider' poses a challenge to the services we deliver. This is particularly the case for those services which do not require hospital based support and the Trust will develop robust plans to compete to provide services required by commissioners and offered for tender under the 'any willing provider' principle. The Trust will also strive to improve the quality of services we offer and seek to move services out of hospital into the community wherever possible. We believe this will strengthen our position as the first choice provider of healthcare on the Fylde Coast.

Developing our Marketing and Competitive Capability

The last year has been characterised by significant changes in organisation, personnel and the external environment. This period of uncertainty has made it very difficult to establish and implement a clear and cohesive marketing strategy. However, now that we have a clearer view of the challenges and opportunities that ToPP will bring, in addition to the planned changes to commissioning, we are revisiting our Marketing Strategy. During the last 12 months we have introduced a number of marketing communications initiatives aimed at strengthening our relationships with stakeholders and engaging with our local community. These include the launch of a fortnightly electronic newsletter called Health Matters and the launch of the Trust's social networking sites on Facebook and Twitter to keep patients, public and stakeholders informed about the work of the Trust and celebrate our achievements. We will continue to build on a sound foundation of service which is of the highest quality and is effective and responsive to patient needs. We will need to concentrate on improving communications with partners and in particular GPs.

Contracting

The Trust's contract to provide services is coordinated by NHS Blackpool on behalf of the associate commissioners with each agreeing their respective activity baselines. All parties have worked together to ensure that the range of services and activity levels within the contract are adequate to meet the needs of the population. As previously, part of the contracting process included the agreement of a range of schemes against which the Trust will receive Commissioning for Quality and Innovation (CQUIN), which are quality incentive monies. These schemes have been targeted to areas which will benefit patients through a focus on improving outcomes.

Risk Analysis

Consideration has been given to the potential areas of risk which face the organisation over the next year under three main headings:

- Governance Risk
- Mandatory Services Risk
- Financial Risk.

Governance Risk

Consideration has been given to the potential areas of risk which face the organisation over the next year with reference to and compliance with the standards outlined in the four domains of Monitor's Quality Governance Framework as detailed below: -

- Strategy
- Capability and Culture
- Processes and Structures
- Measurement.

The principles set out by Monitor in the definition of quality governance are firmly established as the organising principle for quality governance. The Trust has a strong reputation for high quality standards based on approach and on performance.

Robust systems and processes are in place to identify and manage risks to the quality of care. The Board of Directors receives comprehensive information on risks and there is an organisational Corporate Governance Structure which provides clear roles and accountabilities for mitigation and management of risks in relation to quality.

Examples of best practice have been identified in the recent self assessment against the four domains of Quality Governance. The outcome of the self assessment indicated a high level of compliance with Monitor's Quality Governance Framework, which is monitored by the Board on a quarterly basis as part of Monitor's self certification process.

In relation to the Governance risks, discussion has taken place with the Board of Directors to assess and monitor the key strategic risks and validate the measures that are being taken to mitigate these risks. These risks are reviewed by the Board of Directors on a quarterly basis by way of the Board Assurance Framework (BAF).

The highest risk for the organisation is financial. The Trust being in significant breach of Monitor's Terms of Authorisation (November 2010) required a process of change within the finance performance and monitoring systems. The Trust was declared by Monitor to be in significant breach of two Terms of its Authorisation, namely:

(a) Condition 2: the general duty to exercise its functions effectively, efficiently and economically, and

(b) Condition 5: its governance duty.

This led to both internal and external audits of the Trust's financial governance processes and these identified a number of areas for action. A programme of work was put in place to deliver these actions which have strengthened governance within the Trust. The Trust has received official confirmation from Monitor on the 24th May 2012 that the Trust has been de-escalated from significant breach. It is the opinion of Monitor's Compliance Board Committee that the Trust is now meeting its statutory duties and has put into place proper arrangements to exercise its function economically, efficiently and effectively.

The Programme Management Office (PMO) has been effectively introduced to provide support and a defined escalation process. The clinical divisions have been asked to provide a forecast in monthly trajectory to enable the Trust to address financial concerns for future months before they arise and financial dashboards are in place to both support and hold the Divisional Management Teams to account. The Board of Directors receives monthly detailed progress reports and performance against the Annual Plan and ongoing support and advice is accessed from external financial management consultants.

Another high level strategic risk is failing to transfer and integrate with Community Health Services and achieve the appropriate risk rating required by Monitor. The date of transfer was deferred in line with guidance from Monitor with transfer planned for 1st April 2012, which was successful. An Executive Steering Group and Programme Managers monitor and direct the progress of integrated governance workstreams. A project team is in place to lead the process through to completion and the Board is provided with assurance on a monthly basis. External legal support is provided by Hempsons Solicitors.

A further significant risk is failure to recruit the appropriate numbers of nurses and healthcare assistants. With staffing levels currently not meeting the minimum staffing levels, particularly in Unscheduled Care, concern is that this may lead to a reduction in quality and safety standards of patient care. However, successful recruitment has given rise to new staff in post. A weekly reporting mechanism has been put in place to track recruitment and retention trends, the risk will remain high until all vacancies are filled and until the escalation wards are staffed by core nursing teams.

The risks which populate the BAF reflect progress towards meeting the Corporate Objectives and all of the measured high level strategic risks to the Trust. The monitoring process is outlined in the Trust's Risk Management Strategy and ensures regular review of potential organisational harms including the level of risk and provides an update on the progress in implementing defined drivers for change and improvement.

Seven Elements of Compliance with regards to Governance

In relation to the seven elements of compliance with regard to governance the position is as follows:

Legality of Constitution

The legality of the Constitution remains; however, there have been a number of changes / amendments to the Constitution in 2011/12 in relation to the following:-

- Section 6.7 – fifth bullet point – "Community Health Services (North Lancashire)."
- Section 8.3.2 – fifth bullet point – "Community Health Services (North Lancashire) – One Staff Governor"
- Section 8.3.3 – third bullet point – "Blackpool Youth Council".
- Section 8.3.3 – fifth bullet point – "North and Western Lancashire Chamber of Commerce".
- Sections 10.4 and Annex 2 (5.4) – "an elected Governor may not hold office for more than nine consecutive years and shall not be eligible for re-election if he/she has already held office for more than six consecutive years."
- Sections 10.6 and Annex 2 (5.6) – "if, at the termination of office, the elections have not been held/ completed, the Governors will be invited to become observers but will not be able to contribute to discussions or have any voting powers."
- Sections 10.10 and Annex 2 (6.3) – "an appointed Governor may not hold office for more than nine consecutive years and shall not be eligible for re-appointment if he/she has already held office for more than six consecutive years."

Growing Representative Membership

Over the past year, the Trust has seen its membership decline slightly.

As a Trust we want to have a meaningful and robust membership, therefore we have continued to conscientiously keep our database up to date with regular cleansing, which does result in a loss of members after every cleanse.

We understand that an increasing membership does impact on the Membership Budget, therefore, in turn means we maximise the budget and save money as we are not sending out information to members who are deceased, have opted out or moved away from the area.

We have also impacted on the Membership Budget by reducing the printing costs of the members newsletter, 'Your Hospitals', which now costs £5,900 per issue to produce and distribute to public members. This was achieved by reducing to an A5 size. The Trust previously spent £12,950 quarterly on producing and distributing the newsletter, this has been reduced to three times a year.

The Trust understands the importance of having an engaged and active membership and has focussed on ways of achieving this throughout the year, as detailed in the Membership section.

Board Roles and Structures

Following the Board Effectiveness Review in 2010/11, the purpose of which was to review the Board's working and governance arrangements to ensure that the Board is appropriate and effective in undertaking its role, both KPMG and Deloitte LLP issued a detailed report and action plan. During 2011/12, the Board of Directors has implemented the recommendations from the KPMG and Deloitte LLP reports and has been monitoring progress on a monthly basis to ensure compliance.

A follow-up review was undertaken by Deloitte LLP in December 2011/ January 2012 to ascertain whether the recommendations contained in Deloitte's detailed action plan had been implemented. The outcome of the follow-up review was that "the Board has responded positively and promptly to the points raised and significant improvements in the effectiveness of the Board have been made and that decision making is effective with no material concerns noted."

There were a number of changes to the membership of the Board of Directors during 2011/12 as follows:-

- Pat Oliver was appointed Director of Operations in April 2011 following the resignation of Harry Clarke.
- Doug Garrett and Karen Crowshaw were appointed as Non-Executive Directors in June 2011, following the resignation of Christine Breene and Bill Robinson in March 2011.
- Alan Roff was appointed as a Non-Executive Director in December 2011 following the resignation of Michael Brown in July 2011.
- Wendy Swift was appointed as Managing Director of Community Services and Transformation in November 2011 to lead the Project Team for ToPP.
- Ian Johnson was appointed to the post of Trust Chairman in February 2012 following a selection process during January/February 2012. Ian Johnson took up post from 16th April 2012, following Beverly Lester's retirement on 31st March 2012.
- Dr Mark O'Donnell was appointed to the post of Medical Director in March 2012 following a selection process. Dr O'Donnell took up post from 9th April 2012, following Dr Paul Kelsey's retirement from his Medical Director role on 31st March 2012.

In the event of any changes to the Executive Directors of the Board, appropriate deputising arrangements are in place to ensure continuity.`

Service Performance against Targets and the Care Quality Commission (CQC) Essential Quality and Safety Standards

The Board is confident that its systems for managing performance against targets and the Care Quality Commission's (CQC) essential quality and safety standards are robust and will promptly identify potential problems and appropriate action to respond.

An unannounced visit took place on 27th September 2011. This consisted of visits to the Surgical Department, during which a review of local performance data, Clinical Governance and Risk Management processes, such as, serious untoward incidents (SUI's) and Risk Registers was undertaken. The outcome of the visit was very positive, a continuously refreshed action plan is in place to ensure that the Trust will remain compliant with the essential quality and risk standards within the CQC Framework and performance management arrangements are in place to deliver all national targets.

The final report was received by the Trust on the 17th January 2012. The report overall provided positive feedback, and demonstrated compliance with 15 standards of quality and safety. However, the Trust had been asked to provide a compliance action against Outcomes 2: Consent to care and treatment, as this essential standard of quality and safety had been identified as not being met.

An action plan had been developed and implemented to achieve compliance with the identified standard. The action plan and a progress report demonstrating compliance was submitted to the CQC following approval by the Board.

The Trust was successful in achieving Clinical Negligence Scheme for Trusts (CNST) Maternity Level 2 on the 28th February 2012. Assessors assessed the implementation of the approved documents provided at Level 1. This was performed using a variety of evidence provided by the maternity service. In the majority of criteria, the assessment was performed using health records and training data. Other evidence that demonstrated implementation such as, action plans, audits and business plans were considered. A score was only awarded if the evidence indicated that implementation was occurring in at least of 75% of cases. The assessors reviewed between 300 – 350 sets of case notes.

The maternity service was assessed against five standards each containing ten criteria giving a total of 50 criteria. In order to gain compliance at Level 2 the maternity service was required to pass at least 40 of these criteria, with a minimum of seven criteria being passed in each individual standard. The maternity service scored as follows:

Organisation	**10/10**	**Compliant**
Clinical Care	**8/10**	**Compliant**
High Risk Conditions	**10/10**	**Compliant**
Communication	**8/10**	**Compliant**
Postnatal & Newborn Care	**9/10**	**Compliant**
Overall Compliance	**45/50**	**Compliant**

The Trust achieved CNST Level 2, which helps the maternity service to improve the quality of care provided to the women and gives the Trust a 20% discount on the NHSLA CNST premium, an approximate saving of £480,000 per year.

The Trust achieved NHSLA General Risk Management Standards Level 3 in February 2011, after which an action plan was developed to ensure the Trust continues to maintain Level 3 in 2012/13. Attaining Level 3 status provides a reduction in NHSLA contributions of 30%. In accordance with the 2011/2012 figures the savings equate to £664,000.

The Board receives a monthly Business Monitoring Report, covering all aspects of quality, patient safety and operational performance, and a quarterly CQC Assurance Report as part of the Performance Management Framework. The Board receives patient stories via a DVD, where patients are encouraged to share their experiences in order to inform Board discussion and drive improvements in the quality of care. The Divisions also deliver presentations to the Board on a regular basis regarding a number of clinical redesign projects that they have embarked on to improve the effectiveness of patient care. The Board also participate in weekly informal patient safety walkabouts and two monthly formal patient safety walkabouts, which are a critical factor in developing a safer culture and improving patient safety. The Trust is working with John Ormand Consultancy (JOMC) on a Safety Culture Change Project, which involves training some 200 staff, across the organisation, to encourage them to carry out face to face non-confrontational conversations with other staff members about safety aspects of their work, which is an extension of the Executive led patient safety walkabouts that have been underway for some years.

The Healthcare Governance Committee considers high/significant risks and if appropriate, commends their inclusion on the Corporate Risk Register and/or Board Assurance Framework. This is presented to the Board of Directors for formal ratification. Risk prioritisation and action planning is informed by the Trust's Corporate Objectives, risks also derive from the need to comply with national requirements and guidance, themes from complaints, claims, incident reports and risks identified by internal audit reports. Further sources of risks include; proactive risk assessments from the Wards, Departments and Divisions. Action plans are developed for each risk and the rating of risks is adapted from the Australian Risk Management Process, which defines the chance of something happening that may have an adverse impact on patients, staff or the organisation. Risk is measured in terms of consequence and likelihood combined to arrive at a risk rating from low to very high. Lead Executive Directors and Lead Managers are identified to address the gaps in control and assurance and are responsible for developing action plans to address the gaps.

The Board Assurance Framework is fully embedded within the organisation, this assurance framework:

- Covers all of the Trust's main activities.
- Identifies the Trust's Corporate Objectives and the targets the Trust is striving to achieve.
- Identifies the risks to the achievement of the objectives and targets.
- Identifies the system of internal control in place to manage the risks.
- Identifies and examines the review and assurance mechanisms, which relate to the effectiveness of the system of internal control.
- Records the actions taken by the Board of Directors and Officers of the Trust to address control and assurance gaps; and
- Covers the CQC quality and safety standards.

The Board Assurance Framework is presented to the Board of Directors on a quarterly basis. In preparation for the Transfer of Community Health Services into Blackpool Teaching Hospitals NHS Foundation Trust on 1st April 2012, NHS Blackpool and NHS North Lancashire have been shadow reporting their Board Assurance Framework risks since the 15th July 2011. This outlines the key risks to the organisation and the mitigation being undertaken to minimise these risks.

The Board Assurance Framework serves to assure the Board of Directors that the organisation is addressing its strategic risks. The elements of the Board Assurance Framework are monitored and reviewed on a quarterly basis by the Healthcare Governance Committee and the Audit Committee and then by the Board of Directors. This demonstrates that the document is live and continuous and provides evidence to support the Annual Governance Statement.

The Board is sufficiently aware of potential risks to quality through a system of robust, formal and devolved reporting structures, for example, through the Corporate Governance Structure and Divisional structure. Overall this system provides a strong focus on evaluating and managing risk as described in our risk management strategy. The strategy has recently been updated in conjunction with Community Health Services in preparation for the enlarged organisation.

The Risk Management Strategy applies to all employees and requires an active lead from managers at all levels to ensure risk management is a fundamental part of the total approach to quality, safety, corporate and clinical governance, performance management and assurance. Employees, contractors and agency staff are required to report all adverse incidents and concerns. Blackpool Teaching Hospitals NHS Foundation Trust supports a learning culture, ensuring that an objective investigation or review is carried out to continually learn from incidents, only assigning blame to individuals where it is clear that policies and procedures have not been appropriately followed.

The Risk Management Strategy is validated by the Healthcare Governance Committee and approved by the Board of Directors and covers all risks and is subject to an annual review to ensure it remains appropriate and current. Staff are both accountable and responsible for risk management to ensure it is clearly identified as well as implementing the system for identifying, managing, evaluating and controlling individual risk.

Clinical Quality

The Trust has strengthened its performance management structure in relation to delivering the Care Quality Commission (CQC) standards and has maintained progress to deliver top 10% performance for clinical quality. Over the next 12 months, the Trust will continue to focus on the quality of services that we are offering to our patients and the implementation of our Quality Framework. The Quality Framework sets out the approach that this will take and the measures that the Board of Directors have identified as being key to delivering quality care and how success in these areas will be measured.

The Trust registered with the CQC on 6th February 2009, making a statement about our current and future compliance with the new Healthcare Acquired Infection (HCAI) regulations and arrangements for meeting the compliance criteria of the hygiene code. The CQC Registration Panel granted our application for registration unconditionally on 1st April 2009. The Trust continues to maintain compliance with the HCAI regulations and compliance with the criteria of the hygiene code.

The Trust has continued to implement the Methicillin Resistant Staphylococcus aureus (MRSA) Screening Operational Assurance Framework for elective admissions since 31st March 2009, for relevant emergency admissions since 31st December 2010, and is currently compliant with both. Actions to improve performance are continually being sought and implemented.

Co-operation with NHS bodies and local authorities

The Trust will continue to work closely with key commissioners, stakeholders and Local Authorities. Alliances have been made with Blackpool and Lancashire Local Involvement Networks (LINks). Regular meetings are held with our main commissioners, NHS Blackpool and NHS North Lancashire, in relation to the monitoring of in-year performance.

Mandatory Services Risk

There are no foreseeable service changes that threaten the delivery of mandatory services provided by the Trust, nor are there any issues of accreditation that threaten the viability of a service in 2012/13.

The Trust has developed a robust set of business continuity and contingency arrangements integrating Community Health Services over the last twelve months. This ensures that services can continue to be provided during a catastrophic event that impacts upon patient services. These plans have been cascaded throughout the organisation and where appropriate have been fully tested. There are Major Incident and Pandemic Influenza Plans in place, which dovetail with regional and other local arrangements. These plans have been thoroughly tested through six monthly mandatory communication callouts, 'live' regional and other local desktop exercises. The Trust also has arrangements for decontaminating patients, which were enacted in September 2010, and are exercised every two months to ensure the departments keep staff up to date.

Further information where quality governance and quality are discussed in more detail in the Annual Report can be found in the Quality Report (Annex A) and in the Annual Governance Statement (Annex E).

'Following the recent replacement of my pacemaker, I feel that I should record the absolute first class attention I have received at entry level from the pacemaker team and associates. My previous routine visits to the hospital have been a pleasure and the friendly lively staff are always highly professional and a real tonic. However in this most recent surgery I have been particularly appreciative of the high level of communication that has been achieved, ensuring that patients don't just feel like a number'.

Mr C Gleave, Poulton-le-Fylde

Board of Directors' Report

The business of the Foundation Trust is managed by the Board of Directors which is collectively responsible for the exercise of the powers and the performance of the NHS Foundation Trust subject to any contrary provisions of the NHS Act 2006 as given effect by the Trust's Constitution. These have changed slightly after the Health and Social Care Act, which was introduced on 27th March 2012.

Management Commentary and Principal Activities

The Board of Directors is responsible for providing strong leadership to the Trust. Responsibilities include:

- Setting strategic aims and objectives, taking into account the views of the Council of Governors.
- Ensuring robust assurance, governance and performance management arrangements are in place to ensure the delivery of identified objectives.
- Ensuring the quality and safety of healthcare services, education, training and research and applying the principles and standards of robust clinical governance.
- Ensuring that the Trust complies with its Terms of Authorisation, its Constitution, mandatory guidance as laid down by Monitor and other relevant contractual or statutory obligations.
- Ensuring compliance with the Trust's Constitution which sets out the types of decisions that are required to be taken by the Board of Directors. The assurance framework identifies those decisions that are reserved by the Board of Directors and those that can be delegated to its Trust Managers. The Constitution also describes which decisions are to be reserved for the Council of Governors.

The Board of Directors comprises seven Non-Executive Directors (including the Chairman) and six Executive Directors (including the Chief Executive). In addition, there are two non-voting Executive Directors. The names of the Board of Directors during the financial year are outlined in the Profile of the Board section.

There were a number of changes to the membership of the Board of Directors during 2011/12 as detailed under 'Board Roles and Structures' on page 65.

As a self-governing Foundation Trust, the Board of Directors has ultimate responsibility for the management of the Trust, but is accountable for its stewardship to the Trust's Council of Governors and Foundation Trust Members. In addition, the Trust's performance is scrutinised by Monitor and CQC.

In order to understand the roles and views of the Council of Governors and Foundation Trust Members, members of the Board of Directors undertake the following:

- Attend Council of Governors meetings – the Chairman, Chief Executive, Deputy Chief Executive and Director of Operations attend all meetings and two Non-Executive Directors attend on a rotational basis.
- Attend meetings of the Membership Committee - One nominated Non-Executive Director
- Two nominated Governors are invited to attend Board of Directors meetings on a rotational basis.

The Non-Executive Directors are appointed by the Trust's Council of Governors and, under the terms of the Trust's Constitution, they must form the majority of the Directors.

The Chairman is committed to spend a minimum three days per week on Trust business. The Chairman's other significant commitments are outlined in the Profile of the Board section of the Annual Report. There have been no changes to these commitments during the past 12 months. The Non-Executive Directors are committed to spend a minimum of four days per month on Trust business. Both the Chairman and the Non-Executive Directors routinely spend in excess of their commitment of three days per week and four days per month respectively on Trust business.

The Board of Directors meets a minimum of once per month and the Board Agenda is produced to ensure that sufficient time is devoted to matters relating to patient safety and quality, finance and workforce. In addition, Board Seminars are held bi-monthly to ensure that sufficient time is devoted to strategic issues.

The composition of the Board of Directors is regularly reviewed. As part of the work undertaken by KPMG and Deloitte, the skills profile of the Board was undertaken to ensure that the membership of the Board was balanced, complete and appropriate. As a result, there were two changes to the Non-Executive Director composition in June 2011.

The performance of the Board of Directors in its entirety, and the Directors of which it is comprised, is regularly reviewed. Following the Board Effectiveness Review in 2010/11, the purpose of which was to review the Board's working and governance arrangements to ensure that the Board is appropriate and effective in undertaking its role, both KPMG and Deloitte issued a detailed report and action plan. During 2011/12, the Board of Directors has implemented the recommendations from the KPMG and Deloitte reports and has been monitoring progress on a monthly basis to ensure compliance. A follow-up review was

undertaken by Deloitte in December 2011/January 2012 to ascertain whether the recommendations contained in Deloitte's detailed action plan had been implemented. The outcome of the follow-up review was that "the Board has responded positively and promptly to the points raised and significant improvements in the effectiveness of the Board have been made and that decision making is effective with no material concerns noted."

There have been 12 formal Board Meetings, six Board Seminars and 10 Extraordinary Board Meetings during 2011/12.

There are seven sub-committees of the Board as follows:

- Finance and Business Monitoring Committee
- Audit Committee
- Charitable Funds Committee
- Healthcare Governance Committee
- Human Resources, Organisational Development and Teaching Governance Committee
- Remuneration Committee
- Marketing Strategy Committee

Attendance at the Board of Directors meetings and Board sub-committees is summarised in the following table:-

Board Members	Board of Directors	Extra-Ordinary Board of Directors	Finance & Business Monitoring Committee	Audit Committee	Charitable Funds Committee	Healthcare Governance Committee	HR, OD & Teaching Governance Committee *	Remuneration Committee	Marketing Strategy Committee
Number of Meetings	12	10	12	6	4	4	6	1	1
Beverly Lester (until 31.3.12)	12	7	9	N/A	3	2	3	1	N/A
Paul Olive	11	7	10	6	N/A	N/A	N/A	1	N/A
Michael Brown (until 31.7.11)	4	2	2	2	2	N/A	N/A	1	N/A
Malcolm Faulkner	11	9	10	6	N/A	N/A	N/A	1	1
Tony Shaw	12	10	11	5	N/A	3	N/A	1	N/A
Doug Garrett (from 1.6.11)	8	4	7	3	2	N/A	N/A	0	N/A
Karen Crowshaw (from 1.6.11)	9	8	9	4	N/A	N/A	4	0	1
Alan Roff (from 1.12.11)	4	2	4	1	1	N/A	N/A	N/A	N/A
Aidan Kehoe	10	10	10	N/A	N/A	3	3	N/A	0
Tim Welch	12	9	11	6	1	4	3	N/A	N/A
Marie Thompson	11	9	10	N/A	2	2	2	N/A	N/A
Dr Paul Kelsey (until 31.3.12)	11	7	10	N/A	0	3	N/A	N/A	0
Nick Grimshaw	11	7	10	N/A	N/A	1	5	N/A	N/A
Robert Bell	12	9	11	N/A	2	1	N/A	N/A	N/A
Harry Clarke (until 31.5.11)	1	1	1	N/A	N/A	N/A	N/A	N/A	0
Pat Oliver (from 26.4.11)	10	9	12	N/A	N/A	1	5	N/A	0
Liz Holt (until 31.10.11)	6	5	0	N/A	N/A	N/A	1	N/A	0
Wendy Swift (from 1.11.11)	4	3	2	N/A	N/A	N/A	N/A	N/A	0

* Human Resources, Organisational Development and Teaching Governance Committee

The work of the Board sub-committees is evaluated on an annual basis against agreed work programmes with summary reports and minutes provided to the Board of Directors.

Compliance with the NHS Foundation Trust Code of Governance

The creation of Foundation Trusts has led to the requirement for a framework for corporate governance, applicable across the Foundation Trust Network. This is to ensure that standards of probity prevail and that Boards operate to the highest levels of corporate governance.

Monitor has produced the NHS Foundation Trust Code of Governance. This code consists of a set of Principles and Provisions and may be viewed on Monitor's website at: www.monitor.nhsft.gov.uk/publications.php?id=930.

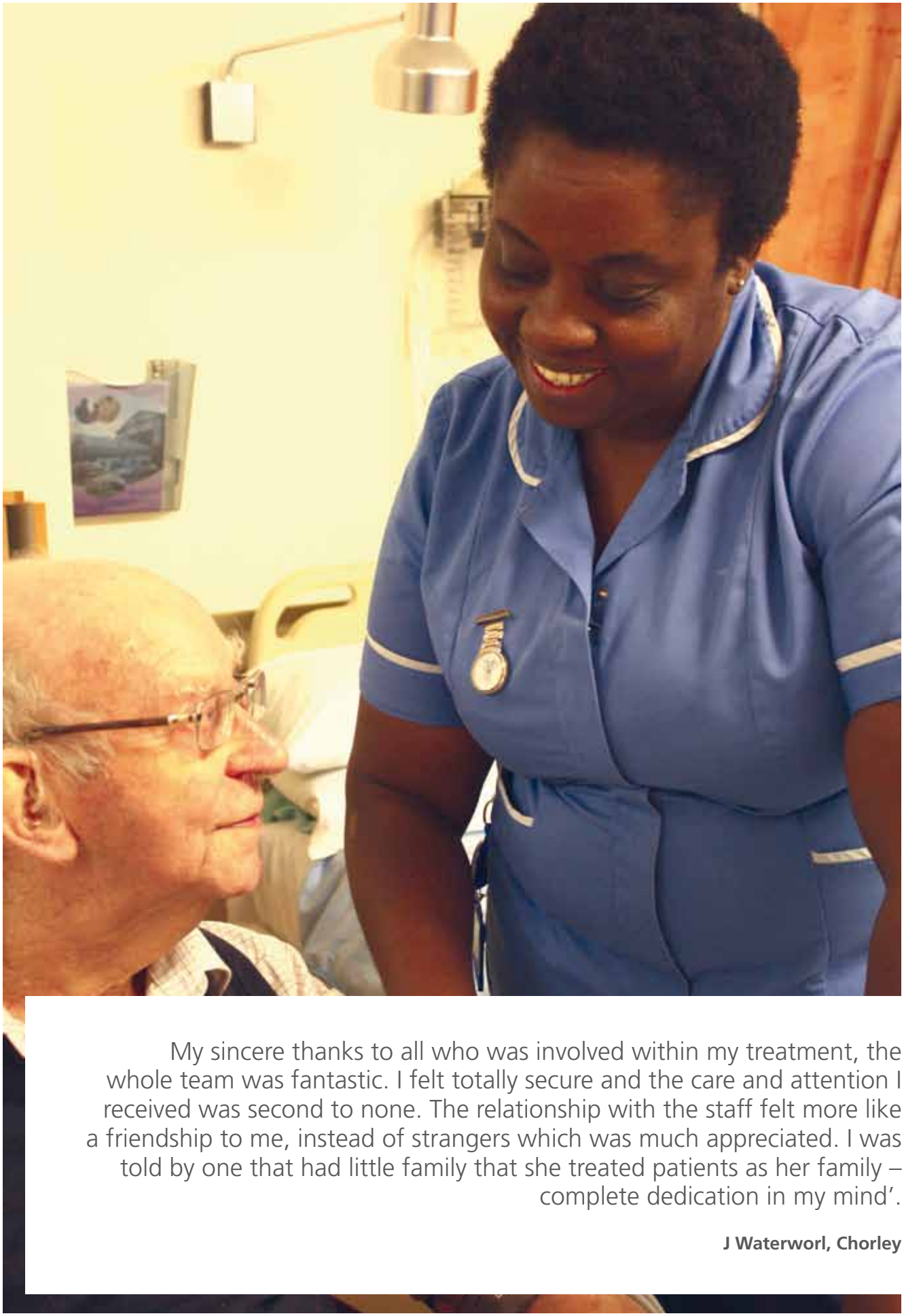
The Board of Directors has established governance policies in the light of the main and supporting principles of the Code of Governance, these include:

- Corporate Governance Framework - incorporating the Standing Orders of the Board of Directors, Standing Orders of the Council of Governors, Scheme of Reservation and Delegation of Powers, and Standing Financial Instructions
- Established the role of Senior Independent Director
- Regular private meetings between the Chair and the Non-Executive Directors
- Non-Executive Director Performance Appraisal process developed
- Formal induction programme for Non-Executive and Executive Directors
- Attendance records for Directors and Governors at key meetings
- Induction Programme for Governors
- Register of Interests - Directors, Governors and Senior Staff
- Established role of Link Governor
- Comprehensive Assurance Briefing Report to all meetings of the Council of Governors
- Effective Council of Governors' sub-committee structure
- Council of Governors' Agenda setting process
- Membership Strategy
- Implementation Plan and Key Performance Indicators
- Agreed recruitment process for Non-Executive Directors

- Remuneration Committee of the Board of Directors
- Nominations Committee of the Council of Governors
- High quality reports to the Board of Directors and Council of Governors
- Council of Governors' presentation of performance and achievement at the Annual Members Meeting
- Robust Audit Committee arrangements
- Council of Governor-led appointment process for External Auditor
- Raising Concerns Policy and Counter Fraud Policy and Plan.

Report on the basis of either compliance with the Code provisions or an explanation where there is non-compliance. The compliance statement below reflects the Trust's declaration regarding compliance with the Code as stated in the latest Annual Report 2011/12.

The Board of Directors considers that, throughout the 2011/12 reporting year, the Trust has applied the principles and met all of the provisions and the requirements of the Code of Governance. A report was submitted to the Audit Committee on 1st May 2012 and the Board of Directors on 24th May 2012 to provide assurance of compliance with the Code of Governance.



My sincere thanks to all who was involved within my treatment, the whole team was fantastic. I felt totally secure and the care and attention I received was second to none. The relationship with the staff felt more like a friendship to me, instead of strangers which was much appreciated. I was told by one that had little family that she treated patients as her family – complete dedication in my mind'.

J Waterworl, Chorley

Profile of the Board

Voting members of the Board of Directors:-

Beverly Lester (Chairman) – Term of Office from 1.11.09 to 31.10.12 (Third Term) (until 31.3.12)

Experience:

- Former Chairman of Blackpool, Wyre and Fylde Community Health Services NHS Trust
- Former Partner in Law Firm
- Former Deputy District Judge
- Part Time Tribunal Judge of the Tribunals Judiciary
- Trustee of the Ladies Sick Poor Association
- Governor of Carters Primary School
- Member of Blackpool Council's Children's Trust Board
- Member of the Court – University of Central Lancashire
- Former Treasurer and President of Blackpool and Fylde Law Society

Qualification:

- Qualified Solicitor – LL.B

Paul Olive (Non-Executive Director and Deputy Chairman) – Term of Office from 20.5.10 to 19.5.13 (Third Term)

Experience:

- Former Finance Director of Stanley Leisure plc
- Former Non-Executive Director of Crown Leisure plc
- Former Governor of Blackpool Sixth Form College
- Former Trustee of Age Concern
- Trustee of the Ladies Sick Poor Association

Qualification:

- Chartered Accountant – Fellow of the Institute of Chartered Accountants

Michael Brown (Non-Executive Director/Senior Independent Director) – Term of Office from 1.12.08 to 30.11.11 (Second Term) (until 31.7.11)

Experience:

- Former Chief Executive of Wyre Borough Council
- Chairman of Regenda Group of Housing Associations
- Director of Eccleston Services
- Director of AS Associates Ltd

Qualification:

- Qualified Solicitor – LL.B

Malcolm Faulkner (Non-Executive Director) (Senior Independent Director) – Term of Office from 1.12.11 to 30.11.14 (Second Term)

Experience:

- Former Independent Consultant
- Former Director of United Utilities
- Former Chairman of Norweb
- Former MD of Norweb Energy and Telecommunications Division
- Former Commercial Director of Norweb plc
- Director of Great Places Housing Group
- Former Pro Chancellor and Chair of the Board of the University of Central Lancashire (UCLAN)
- Member of the Court of UCLAN
- Community Governor of Holme Primary School

Qualification:

- B.Sc. (Hons) M.Sc. Electrical Engineering
- Diploma in Management Studies
- Chartered Engineer (FIET)
- Companion of the Chartered Management Institute (CCMI)

Alan Roff (Non-Executive Director) – Term of Office from 1.12.11 to 30.11.14 (First Term)

Experience:

- Former Deputy Vice Chancellor, University of Central Lancashire
- Former Chair of North West Regional Action Plan (ERDF)
- Former Chair of Lancashire Economic Partnership Board
- Former Chair of Preston Strategic Partnership Executive
- Former Council Member of North West Region Learning and Skills Council
- Former Board Member of North West Business Link
- Former Head of Computing Services, UCLAN
- Higher Education and IT Consultant

Qualification:

- BA (Hons) Mathematics
- MA Quantitative Social Science
- Fellow of Royal Statistical Society

Karen Crowshaw (Non-Executive Director) – Term of Office from 1.6.11 to 31.5.14 (First Term)

Experience:

- Director, Crowshaw Consulting
- Former Managing Director (Regulated Sales), Lloyds Banking Group
- Former Regional Director, HBOS PLC
- Former Project Manager, National Sales Conference
- Former HR Director, Halifax Retail

Qualification:

- Masters in Business Administration (MBA)
- Post Graduate Diploma in Personnel (CIPD)
- Chartered Institute of Bankers (CIB)

Doug Garrett (Non-Executive Director) – Term of Office from 1.6.11 to 31.5.14 (First Term)

Experience:

- CEO/Director - private businesses
- National and international trade in antiques, sport and leisure, property investment - via companies such as Rackhall and Closelink
- Regeneration in Blackpool and Belfast - £1.5 billion of investment and 25,000 jobs
- Operations management, marketing and advertising
- Chairman of Groundwork Trust for Lancashire West and Wigan
- Chairman of the Blackpool Enterprise Board
- Trustee Curious Minds (Arts Charity)
- Trustee of the St Anne's Community Trust
- Board Member of Blackpool Fylde and Wyre Economic Development Company

Qualification:

- Post Graduate Diploma in Marketing
- International Business Degree, BA (Honours)
- Fellow of the Royal Society for the Arts
- Fellow of the Chartered Institute of Marketing
- Fellow of the Institute of Direct Marketing
- Member of Real Estate body CORENET Global

Tony Shaw (Non-Executive Director) – Term of Office from 1.7.10 to 30.6.13 (First Term)

Experience:

- Former Managing Director Business Link Fylde Coast
- Former General Manager at Blackpool Gazette and Herald
- Former Managing Director at Blackpool Gazette and Herald
- Former Director of United Provincial Newspapers
- Former Non-Executive Director of Blackpool, Wyre and Fylde Community Health Services NHS Trust
- Former Chairman of Blackpool PCT

Qualification:

- Certified Accountant (Retired)

Aidan Kehoe (Chief Executive) – appointed in July 2009 (formerly Deputy Chief Executive from March 2008)

Experience:

- Former Deputy Chief Executive at Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust
- Over 20 years general management experience in the NHS including senior posts at University Hospital Birmingham, Salford Royal Hospital, Rampton Special Hospital and Salisbury Community and Mental Health Services
- Joined NHS as National Trainee of the NHS General Management Training Scheme

Qualification:

- Qualified Chartered Accountant – Institute of Chartered Accountants (ACA)
- Diploma in Health Service Management (Dip HSM)
- B.Sc (Hons) – Managerial and Administrative Studies

Tim Welch (Deputy Chief Executive) - appointed in July 2009 (formerly Director of Finance from August 2005)

Experience:

- Former Director of Finance at Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust
- Former Director of Finance at City and Hackney Teaching PCT
- Former Deputy Director of Finance at City and Hackney Teaching PCT
- Joined NHS as Financial Management Trainee

Qualification:

- Chartered Public Finance Accountant
- BSc (Hons) – Biochemistry

Harry Clarke (Director of Operations) – appointed in October 2009 (until May 2011)

Experience:

- Former Associate Director for Performance Improvement at Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust
- Former Head of Service Improvement at Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust.
- Appointed to various Directorate Manager Posts between 1998 and 2004.
- Joined the NHS in 1991 as Project and Commissioning Manager at Royal Lancaster Infirmary

Qualification:

- Post Graduate Certificate in Human Resources (HR) Leadership.
- Master of Business Administration.
- Post Graduate Diploma in Public Administration

Pat Oliver (Director of Operations) – appointed in April 2011

Experience:

- Former Interim General Manager for the Surgical Division at the University Hospitals of South Manchester NHS Foundation Trust (seconded from the Trust)
- Former Associate Director of Operations (Surgery) at Blackpool Teaching Hospitals NHS Foundation Trust
- Former General Manager of the Musculo-Skeletal Division at Wrightington, Wigan & Leigh NHS Trust
- Former General Manager of Rehabilitation and Elderly Care at Wrightington, Wigan & Leigh NHS Trust
- Acting Deputy Director of Nursing and Patient Services at Wrightington, Wigan & Leigh NHS Trust
- Acting Director of Nursing and Patient Services at Wrightington, Wigan & Leigh NHS Trust

Qualification:

- Registered General Nurse
- Diploma in Nursing Studies
- BSc (Hons) (incorporating management module)
- LLB (Hons)
- PRINCE 2
- Chartered Institute of Marketing Certificate

Dr Paul Kelsey (Medical Director) – appointed in June 2006 (until 31st March 2012)

Experience:

- Consultant Haematologist at Blackpool, Fylde and Wyre Hospitals NHS Trust since 1988
- Former Senior Registrar in Haematology – North West Rotational Training Scheme

Qualification:

- M.B.,B.Sc. (Hons) – Pathology
- MRCP (UK)
- FRCPath

Nick Grimshaw (Director of Human Resources and Organisational Development) – appointed in May 2007

Experience:

- Former Director of HR at Tameside and Glossop Acute Services NHS Trust
- Former Director of HR at Greater Manchester Workforce Development Confederation
- Former Director of HR at North Manchester Healthcare NHS Trust

Qualification:

- BA - English and History
- Post Graduate Diploma in Management
- Post Graduate Diploma in Personnel (MCIPD)

Marie Thompson (Director of Nursing and Quality) - appointed in February 2009

Experience:

- Registered General Nurse
- Over 20 years experience in a variety of clinical, practice development and managerial roles
- Responsibility for the Trust's Nursing and Midwifery Workforce and delivery of the Trust's Quality Improvement Objectives
- Responsibility for Nursing standards, Patient Experience, Infection Prevention, Safeguarding Children, Young People and Adults, and Emergency Planning
- Former Deputy Director of Nursing and Governance for Wrightington, Wigan and Leigh Hospitals NHS Trust
- Deputy Director of Nursing North East Lancashire Hospitals

Qualification:

- Registered General Nurse
- MSc Human Resource Leadership
- BSc Hons Nursing Studies
- Post Graduate Certificate in Education
- Post Graduate Diploma Management Studies

Non-voting member of the Board of Directors:-

Robert Bell (Director of Facilities and Clinical Support) – appointed in March 2009 (formerly Director of Facilities and Estates from March 2009)

Experience:

- Former Director of Facilities and Estates at Blackpool Teaching Hospitals NHS Foundation Trust
- Head of Technical Services for Ocado (Waitrose) Ltd
- Technical Services Director for Tibbett & Britten Ltd
- Principal Technical Officer for Merseyside Police Authority

Qualification:

- Bachelor of Science Degree in Mechanical Engineering
- Chartered Engineer
- Member of the Chartered Institute of Building Services Engineers
- Associate Member of the Institute of Mechanical Engineers

Liz Holt (Designate Director of Community Health Services) – appointed January 2010 (until October 2011)

Experience:

- Former Director of Community Health Services, NHS Blackpool
- Former Assistant Director - Patient & Public Involvement / Performance Improvement, Cumbria & Lancashire SHA
- Over 12 years experience at director level leading, managing and developing community health services

Qualification:

- BA - Open University
- Certificate in Management Studies
- City & Guilds Further Education Teaching Certificate
- CPSM Registration
- Diploma in Chiropody

Wendy Swift (Managing Director of Community Services and Transformation) – appointed November 2011

Experience:

- Former Chief Executive of Blackpool Primary Care Trust
- Chair of the NHS North West 111 Programme Board.
- Lead commissioner role for the North West Ambulance Service.
- Former Deputy Chief Executive of Blackpool Wyre and Fylde Community Health Services Trust
- Former Director of Planning and Operations in East Lancashire Hospitals.
- 32 years extensive experience of working in Acute, Community and Primary Care services.

Qualification:

- Diploma in Health Service Management (Dip HSM)
- B.A. (Hons) – Business Studies

Ian Johnson (Chairman Designate 20th February) - appointed 13th February 2012 – commenced 16th April 2012

Experience:

- Chief Counsel and Member of the Management Board of Alstom Power-Gas
- 30 years experience as a qualified solicitor
- Non Executive Director of the University of Cumbria
- Trustee of the Crossfield Housing (Arnside) Society Limited, Lancashire
- Member of the Law Society and Institute of Directors

Qualification:

- M.A.
- LL.M.

Dr Mark O'Donnell - (Medical Director) – appointed 3rd April 2012 – commenced 10th April 2012

Experience:

- Consultant Physician in Stroke Medicine at Blackpool, Fylde and Wyre Hospitals NHS Trust since 2007
- Consultant Geriatrician at Blackpool, Fylde and Wyre Hospitals NHS Trust from 1994

Qualification:

- MB ChB 1980 University of Liverpool
- MD 1993 University of Birmingham
- Diploma in Rehabilitation Medicine 1993 RCP London
- FRCP London 1998

All Board members have declared their relevant and material interests and the Register of Directors' Interests is available for inspection by members of the public via the Foundation Trust Secretary at the following address:-

Address: Trust Headquarters
Victoria Hospital
Whinney Heys Road
Blackpool
FY3 8NR

Telephone: 01253 306856
Email: judith.oates@bfwhospitals.nhs.uk

'I would like to thank everyone on Ward 35 for the wonderful care and attention I received during my 4 day stay. I have nothing but praise for everyone at Victoria Hospital and would like to thank you all from the bottom of my heart'.

Mrs J Holmes, Blackpool

Council of Governors

The Council of Governors was formed on 1st December 2007 in accordance with the NHS Act 2006 and the Trust's Constitution. The Council of Governors is responsible for representing the interests of NHS Foundation Trust members and partner organisations in the local health economy.

The roles and responsibilities of the Council of Governors, which are to be carried out in accordance with the Trust's Constitution and the Foundation Trust's Terms of Authorisation, are as follows:-

- To appoint or remove the Chairman and the other Non-Executive Directors.
- To approve the appointment (by the Non-Executive Directors) of the Chief Executive.
- To decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors.
- To appoint or remove the Foundation Trust's External Auditor.
- To appoint or remove any other External Auditor appointed to review and publish a report on any other aspect of the Foundation Trust's affairs.
- To be presented with the Annual Accounts, any report of the External Auditor on the Annual Accounts and the Annual Report.
- To provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Foundation Trust's forward planning.
- To respond as appropriate when consulted by the Board of Directors in accordance with the Constitution.
- To undertake such functions as the Board of Directors shall from time to time request.
- To prepare and, from time to time review the Foundation Trust's Membership Strategy and its policy for the composition of the Council of Governors and of the Non-Executive Directors and, when appropriate, to make recommendations for the revision of the Trust's Constitution.

The Council of Governors and the Board of Directors continue to work together to develop an effective working relationship. Board members including the Non-Executive Directors have regular attendance at Council of Governors Meetings to ensure that members of the Board develop and gain an understanding of the Governors' and Members' views about the Trust.

The Council of Governors comprises a total of 33 Governors, including 17 Public Governors (elected from the constituencies of Blackpool, Fylde, Wyre, Lancashire and South Cumbria and North Lancashire), six Staff Governors (elected from the staff groups of Medical & Dental, Nursing & Midwifery, Clinical Support, Non-Clinical Support and Community Health Services) and 10 Appointed Governors (from a range of key stakeholder organisations).

The initial Elected Governors were appointed for either two years or three years (in December 2007). All Elected Governors are eligible for re-election at the end of their initial term of office for a further six years, i.e. two terms of office. However, Elected Governors are not eligible for subsequent re-election, i.e. in excess of nine years.

The Appointed Governors are appointed for three years and are eligible for re-appointment at the end of their three year term for a further six years, i.e. two terms of office. However, Appointed Governors are not eligible for further re-appointment, i.e. in excess of nine years.

The Trust's Constitution sets out the composition for the Council of Governors as follows:-

APPOINTED GOVERNORS	ROLE
Principal Commissioning Primary Care Trusts – 2: NHS Blackpool (1) NHS North Lancashire (1)	To represent main Trust commissioners and key NHS economy partners.
Principal Local Councils – 2: Blackpool Council (1) Lancashire County Council (1)	To represent key local non-NHS Local Health Economy partners.
Principal University – 1: University of Central Lancashire	To ensure strong teaching and research partnership and to represent other University interests.
Voluntary Sector – 1: Council for Voluntary Services	To engage and assist the Trust in identifying needs of local community.
Lancashire Care Foundation Trust - 1	To engage and assist the Trust in identifying needs of local community.
North and Western Lancashire Chamber of Commerce – 1 *	To engage and assist the Trust in dialogue with the wider catchment population of North and Western Lancashire.
Blackpool Youth Council – 1 *	To engage and assist the Trust in dialogue with the younger catchment population.
University of Liverpool – 1	To ensure strong teaching and research partnership and to represent other University interests.
Total Appointed Governors – 10	

ELECTED STAFF GOVERNORS	ROLE
Class 1 – Medical Practitioners – 1	To assist the Trust in developing its services and ensure active representation from those who deliver the services.
Class 2 - Nursing and Midwifery – 2	As above.
Class 3 - Clinical Support Staff – 1	As above.
Class 4 - Non-Clinical Staff – 1	As above.
Class 5 – Community Health Services – 1 **	As above.
Total Elected Staff Governors – 6	

ELECTED PUBLIC AND PATIENT GOVERNORS To represent:-	ROLE
Area 1 - Blackpool – 8	To represent patients who are resident in Blackpool.
Area 2 - Wyre – 4	To represent patients who are resident in Wyre.
Area 3 - Fylde – 3	To represent patients who are resident in Fylde.
Area 4 - Lancashire & South Cumbria – 1	To represent of patients who are resident in the wider environs of South Cumbria and Lancashire.
Area 5 - North Lancashire – 1 **	To represent patients who are resident in the wider environs of North Lancashire.
Total Elected Public and Patient Governors – 17	

TOTAL MEMBERSHIP OF COUNCIL OF GOVERNORS
Appointed Governors – 10 (currently one vacancy)
Staff Governors (elected) – 6
Public and Patient Governors (elected) - 17
Total membership of Council of Governors – 33

* The North & Western Lancashire Chamber of Commerce and Blackpool Youth Council nominated Denys Smith-Hart and Nicole Burke as Appointed Governors in November 2011 and December 2011 respectively.

** As part of the Transformation of Patient Pathways transaction, a North Lancashire Public Constituency and a Community Health Services Staff Constituency were established and a Public Governor (Christopher Lamb) and a Staff Governor (Claire Lewis) were elected to represent these areas respectively. Both Governors acted in shadow form until the successful transaction on 1st April 2012.

There have been a number of changes to the Council of Governors during 2011/12 as follows:-

The following Governors were re-elected unopposed with effect from 27th September 2011:-

John Longstaff (Public – Fylde)
Anne Smith (Public – Fylde)
Peter Askew (Public – Wyre)
Dr Tom Kane (Staff – Medical & Dental)
Tina Daniels (Staff – Non-Clinical Support)
Samantha Woodhouse (Staff – Nursing & Midwifery)

The following Governors were elected unopposed with effect from 27th September 2011:-

Anthony Winter (Public – Fylde)
Lynden Walthew (Public – Wyre)
Joanne MacDonald (Public – Lancashire & South Cumbria)

The following Governors were re-elected or elected to the Blackpool Constituency following a Public Ballot with effect from 27th September 2011:-
John Butler (re-elected)
Cliff Chivers (re-elected)
George Holden (elected)
Chris Smith (elected)

The following Appointed Governors were re-appointed for a further term commencing 27th September 2011:-

Jean Taylor (UCLAN)
Paul Rigby (Lancashire County Council)
Dr Tom Kennedy (University of Liverpool)
Brian Rowe (NHS North Lancashire)

The following Appointed Governors have been replaced during 2011/12:-

Mike Wistow (Lancashire Care NHS Foundation Trust) - replaced by Susan Rigg (Associate Director of Performance Management and Planning at Lancashire Care NHS Foundation Trust).
Councillor Roy Haskett (Blackpool Council) – replaced by Councillor John Broughton (Blackpool Council).
Richard Emmess (NHS Blackpool) – replaced by Roy Fisher (NHS Blackpool).

The following Appointed Governors joined the Council of Governors in November 2011 and December 2011 respectively:-

Denys Smith-Hart (North & Western Lancashire Chamber of Commerce).
Nicole Burke (Blackpool Youth Council)

The term of office for the following Governors expired in September 2011 and they did not wish to be re-elected/re-appointed.

Arthur Roe (Public Governor – Blackpool)
Austin McNally (Public Governor – Wyre)
David Slater (Appointed Governor – Business Link North West)

All elections to the Council of Governors are conducted by the Electoral Reform Services Limited on behalf of the Trust and in accordance with the Model Election Rules.

Membership of the Trust's Council of Governors is set out below:

Name	Constituency/Organisation	Term of Office
Public Governors		
John Butler (from September 2011) *	Blackpool	3 years
Clifford Chivers (from September 2011) *	Blackpool	3 years
Hannah Harte (from December 2010)	Blackpool	3 years
Chris Thornton (from December 2010)	Blackpool	3 years
Eric Allcock (from December 2010)	Blackpool	3 years
Mark Chapman (from December 2010)	Blackpool	3 years
Chris Smith (from September 2011) **	Blackpool	3 years
George Holden (from September 2011) **	Blackpool	3 years
Anne Smith (from September 2011) *	Fylde	3 years
John Longstaff (from September 2011)**	Fylde	3 years
Tony Winter (from September 2011) **	Fylde	3 years
Peter Askew (from September 2011) *	Wyre	3 years
Ramesh Gandhi (from December 2010)	Wyre	3 years
John Bamford (from December 2010)	Wyre	3 years
Lynden Walthew (from September 2011) **	Wyre	3 years
Joanne MacDonald (from September 2011) **	Lancashire and South Cumbria	3 years
Chris Lamb (from 1st April 2012) ***	North Lancashire	3 years
Staff Governors		
Dr Tom Kane (from September 2011) *	Medical and Dental	3 years
Sam Woodhouse (from September 2011) *	Nursing and Midwifery	3 years
Andrew Goacher (from September 2010 *	Nursing and Midwifery	3 years
Tina Daniels (from September 2011) *	Non-Clinical Support	3 years
Cherith Haythornthwaite (from September 2011) **	Clinical Support	3 years
Claire Lewis (from 1st April 2012) ***	Community Health Services	3 years
Appointed Governors		
Roy Fisher	NHS Blackpool (PCT)	3 years
Brian Rowe	NHS North Lancashire (PCT)	3 years
Councillor John Boughton	Blackpool Council	3 years
County Councillor Paul Rigby	Lancashire County Council	3 years
Vacant Post	Council for Voluntary Service	3 years
Susan Rigg	Lancashire Care Trust	3 years
Jean Taylor	University of Central Lancashire	3 years
Dr Tom Kennedy	University of Liverpool	3 years
Denys Smith-Hart	North & Western Lancashire Chamber of Commerce	3 years
Nicole Burke	Blackpool Youth Council	3 years

* Re-elected Governors
** Newly elected Governors
*** Newly elected Governors (in shadow form until the transfer of community services on 1st April 2012)

Attendance at Council of Governors Meetings:
Governor Attendance

Governors	Number of Meetings (4)
John Butler	4
Clifford Chivers	3
Hannah Harte	4
Chris Thornton	2
Eric Allcock	3
Arthur Roe *	1
Mark Chapman	3
Chris Smith **	1
George Holden **	2
Anne Smith	4
John Longstaff	2
Janice Dickson *	0
Tony Winter **	1
Peter Askew	4
Ramesh Gandhi	4
John Bamford	3
Austin McNally *	2
Lynden Walthew **	1
Joanne MacDonald **	1
Chris Lamb ***	2
Dr Tom Kane	4
Sam Woodhouse	2
Andrew Goacher	3
Tina Daniels	2
Cherith Haythornthwaite **	2
Claire Lewis ***	1
Richard Emmess *	1
Roy Fisher **	2
Brian Rowe	1
Councillor Roy Haskett *	0
Councillor John Boughton **	1
County Councillor Paul Rigby	2
Doug Garrett *	1
Nicole Burke **	1
David Slater *	1
Denys Smith-Hart **	2
Jean Taylor **	3
Mike Wistow *	2
Susan Rigg **	1
Dr Tom Kennedy	1

Meetings of the Council of Governors took place on the following dates in 2011/12:-

16th May 2011
15th August 2011
14th November 2011
13th February 2012

* Resigned during 2011/12.
** Elected/Appointed during 2011/12.
*** Newly elected Governors (in shadow form until the transfer of community services on 1st April 2012)

Governor sub-groups were established in respect of the following:-

- The Annual Report and Accounts and the Quality Report.
- The Annual Plan 2012/13.
- The Governors' Objectives for 2012/13.
- The Governors' Election Process.

The Chief Executive, Deputy Chief Executive and Director of Operations routinely attend meetings of the Council of Governors. The Non-Executive Directors attend the Council of Governors Meetings on a rotational basis.

During 2011/12, the Council of Governors received regular updates from the Chief Executive plus regular performance, finance and membership reports.

Presentations were also given to the Council about the Vision Programme, Waste Management, the Annual Report and Accounts, the External Auditor's Opinion on the Quality Accounts, Developing the Role of Governors, Capital Developments and the Mortality Collaborative.
Other items discussed at the Council of Governors Meetings included the Report and Action Plan from KPMG Management Consultants, Corporate Objectives, Serious Untoward Incidents, Complaints and Patient And Liaison Service Reports, Chairman's and Non-Executive Directors' Appraisals/Objectives/Remuneration, Membership Strategy, Annual Plan, Deloitte Report and Action Plan, Annual Report and Accounts, Quality Accounts, Divisional Management Structure, Governors' Objectives, Intelligent Board Workshop, Declarations of Interests, Governor Elections, Board Composition, Trust Constitution, Governors' Induction Pack, Membership of the Foundation Trust Governors' Association, Monitor's Results of the Governors' Survey, Clinical Audit, Board Assurnace Framework, Corporate Risk Register, Transforming Community Services, Audit Fee Proposal and Re-Appointment of External Auditors, Proposals for the Replacement of the Trust Chairman, Annual Self Assessment.

Governors have also been involved in the following meetings/events:-

- Trust Committees, i.e. Charitable Funds Committee, Marketing Strategy Committee.
- Governors' Patient Experience Committee.
- Formal Patient Safety Walkabouts.
- Patient Experience Revolution Initiative.
- Attendance at Board Meetings as observers.
- Governors' Informal Meetings.
- Governors' Workshops.
- Hand Hygiene Training.
- Investors in People Assessment.

In addition, Governors have participated in external events as follows:-

- Foundation Trust Governors Association Forums.
- Foundation Trust Network Annual Governance Conference.
- HFMA E-Learning Modules.

There are currently two Governor Sub-committees, namely the Nominations Committee and the Membership Committee, comprising three and nine Governors respectively, details of which are identified in the tables below:

Governor Attendance at Nominations Committee Meetings:

Committee Members (4)	Number of Meetings (3)
Beverly Lester (Chairman)	3
Peter Askew	3
Eric Allcock	2
Doug Garrett (until 31st May 2011)	1
Roy Fisher (from 1st September 2011)	1

Governor Attendance at Membership Committee Meetings:

Committee Members (9)	Number of Meetings (4)
Anne Smith (Chairman)	3
John Boughton *	0
John Butler	4
Clifford Chivers	4
Hannah Harte	0
George Holden *	2
John Longstaff	3
Chris Smith *	2
Lynden Walthew *	2
Sam Woodhouse	1

* Resigned or elected/appointed during 2011/12.

Governors are also involved in a number of Trust Committees, namely the Marketing Strategy Committee, IG Committee, Charitable Funds Committee, PEAT, Healthy Transport Committee, Waste Management Committee, E&D and Human Rights Committee, ToPP Committee, R&D Committee, Staff Car Parking Working Group and Fire Committee.

In addition, a Governors' Patient Experience Committee has been established during 2011/12 and the inaugural meeting took place on the 5th August 2011. The meetings, which take place on a quarterly basis, include hospital visits to selected wards.

Governors are required to comply with the Trust's Code of Conduct and to declare interests that are relevant and material to the Council of Governors.

All Governors have read and signed the Trust's Code of Conduct which includes a commitment to actively support the NHS Foundation Trust's Vision and Values and to uphold the Seven Principles of Public Life, determined by the Nolan Committee.

All Governors have declared their relevant and material interests and the Register of Interests is available for inspection by members of the public via the Trust's website www.bfwhospitals.nhs.uk or the Foundation Trust Secretary at the following address:-

Address: Trust Headquarters
Victoria Hospital
Whinney Heys Road
Blackpool
FY3 8NR

Telephone: 01253 306856

Email: judith.oates@bfwhospitals.nhs.uk

Any member of the public wishing to make contact with a member of the Council of Governors should, in the first instance, contact the Foundation Trust Secretary.

I would like to send thanks to the consultants and nursing staff on Ward 14 for their excellent attention during my short stay. The meals were surprisingly very satisfactory and piping hot, all credit to the management of the NHS at Blackpool Victoria Hospital.

Ian Brailsford, Lytham St Annes

Membership

Over the past 12 months, the Trust's membership has decreased slightly.

Public Members

All members of the public who are aged 16 or over and who live within the boundaries of Blackpool, Fylde and Wyre Borough Councils, or the wider catchment area of Lancashire and South Cumbria for which we provide tertiary cardiac and haematology services, are eligible to become members. Other members of the public who do not fall into these categories, either due to age or place of residence, are eligible to become affiliate members of the Trust.

Staff Members

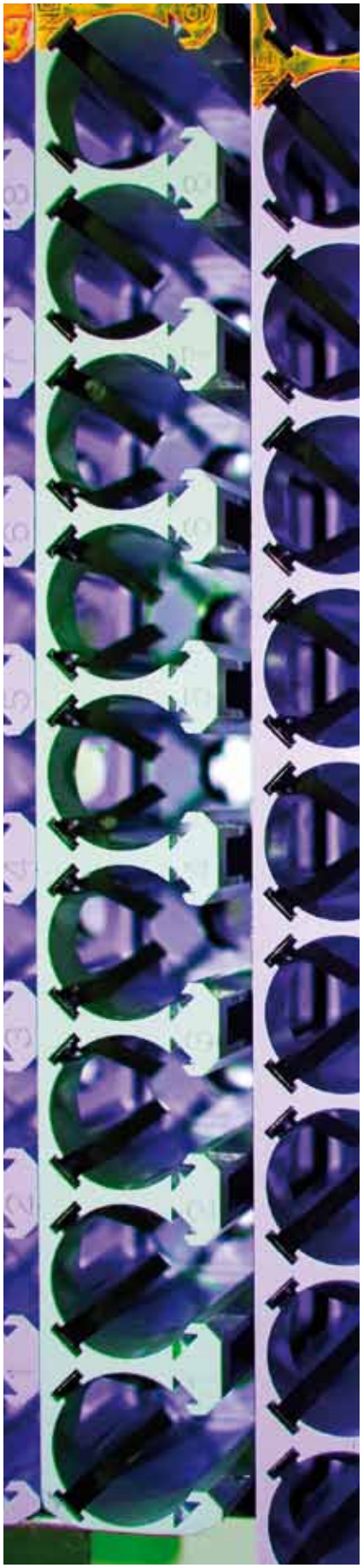
Staff who work for the Trust automatically become members unless they choose to opt out. These include:

- Staff who are employed by the Foundation Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months, and
- Staff who have been continuously employed by the Foundation Trust under a contract of employment.

Trust volunteers are eligible to become members under the public constituency.

Growth of Public Members

The number of public members has decreased slightly over the last 12 months, with 294 being recruited in total, although we have lost 330 members who have either died or been made inactive members. The Trust's public membership currently stands at 5,885.



Membership Report for Blackpool Teaching Hospitals from 01/04/2011 to 31/03/2012	
Public constituency	**Number of members**
As at start (1st April)	5,921
New Members	294
Members leaving	330
At year end (31st March)	5,885
Staff constituency	**Number of members**
As at start (1st April)	4,514
New Members	213
Members leaving	18
At year end (31st March)	4,709
Patient constituency	**Number of members**
As at start (1st April)	0
New Members	0
Members leaving	0
At year end (31st March)	0
Public constituency	**Number of members**
Age (years):	
0-16	8
17-21	245
22+	4,756
Ethnicity:	**Number of members**
White	4,692
Mixed	15
Asian	64
Black	14
Other	13
Socio-economic groupings:	**Number of members**
ABC1	4,713
C2	734
D	109
E	302
Gender analysis:	**Number of members**
Male	3,029
Female	2,818
Patient constituency	**Number of members**
Age (years):	
0-16	0
17-21	0
22+	0

Recruitment of Members

In order to maintain our membership level and in order to recruit new public members, we have implemented various initiatives over the past year. These include:

- Membership information displayed at entrances to hospitals and in outpatients departments.
- Recruitment stands at events for the public and community meetings, such as Area Forums in conjunction with Blackpool Council.
- Radio and newspaper advertising campaigns.
- Further development of the online membership section of the website - the amount of members joining via the website is steadily increasing.
- Distribution of recruitment posters and leaflets to GP surgeries throughout the Fylde Coast.
- A re-design of recruitment materials to modernise, freshen and update, in order to make them more user friendly.
- Presentations at meetings of community groups about the benefits of membership.
- Targeting of under-represented areas such as younger members and ethnic minority groups.
- The Trust has implemented a youth forum, 'Victoria's Voice' to provide a voice for young people to express their thoughts on the hospital's services and other health topics that are important to them.
- Liaised with public health organisers from Primary Care in order to attend health road shows held within local companies.
- Recruitment stands at Fresher's Fayres at Blackpool and the Fylde College, Blackpool Sixth Form College and the Blackpool University Campus.
- The Trust's Facebook social network site in now fully up and running engaging and informing members and the wider public of developments and events at the Trust.
- The Trust also has a Twitter social network page to attract new members, in particular to target young members and currently has over 600 followers.
- Membership now has its own dedicated Membership Volunteer who comes in two afternoons a week and helps out in the recruitment and engagement of members.

Over the next 12 months we will continue to look at new and fresh ways of promoting the benefits of membership in order to maintain and increase our total membership. These include:

- Membership Officer and Membership Volunteer going into outpatients recruiting members on a one-to-one basis, this has previously proven to be a good way of recruiting members.
- Increasing the number of membership stands and boards in areas where the public directly attend the hospitals, and make them more prominent.
- Manning these stands and discussing the benefits of membership with the public on a one-to-one basis, encouraging them to sign up.
- To continue to work with the colleges' focus groups and student council to develop information designed for young people and to promote the ways in which young people can actively contribute to the Trust.
- Arranging talks with health and care students at Blackpool and the Fylde College and the Blackpool Sixth Form College.
- Attend meetings in the community to discuss membership, focussing on ethnic minority groups, mother and toddlers groups and health clubs.
- Extending the use and access to the social networking site on Facebook and Twitter to continue to attract new members, in particular young members.
- Emailing Membership information to local companies and organisations in order to be advertised in their own staff publications
- Encouraging members of the public to see the benefit of being part of the Trust, through bigger and more varied recruitment events.

Retention of Members

The Trust recognises the importance and value of a representative membership and has continued to focus on and progress opportunities for the engagement and retention of existing members.

It is particularly important to the Trust to not only build its membership, but to ensure that the membership is being fully utilised.

Numerous and varied initiatives have taken place over the last year to retain our existing members.

- We continue to produce and expand the newsletter 'Your Hospitals', which keeps members informed on current developments within the Trust, gives information on the Council of Governors, keeps members up to date with Fundraising activities and asks members their opinions on a wide range of topics through consultations. The newsletter also gives details of a wide variety of local services and businesses that provide discounts for members, on production of their membership card. Copies of 'Your Hospitals' are also available on the Trust's website from Issue 1 to Issue 14.

- A section of the newsletter has been named 'Consultation Corner' and this gains valuable opinions from members on a wide variety of topics. The information is collated and used to influence decisions that are made about the Trust services. Consultations have been held on 'the Trust website', 'Improving the Patient Experience' and 'the Nurse Led Therapy unit'.
- Membership seminars have been held every month which have been popular and have included a range of topics from rheumatoid arthritis, bereavement care, healthcare acquired infections and bowel cancer screening.
- The Membership Committee, which consists of a group of Governors from staff, public and appointed constituencies, regularly discuss and put into action ideas to involve our current membership and make members feel a valued and influential part of the Trust.
- Members are able to contact the Membership Office with any queries or ideas via a dedicated membership hotline and email address.
- All members were invited to the Annual Members' and Public Meeting which was a formal meeting to discuss the Trust, its developments, future services and membership. This was attended by around 300 staff and public members.
- Following the monthly health seminars, Governors have held several 'Meet Your Governor' meetings to deal with any queries or issues members may have.
- The Trust continues to keep members informed of events held at the hospital such as the health seminars, open days and official openings of new facilities by email.

The Trust has implemented various new ways of engaging with its members over the past year to encourage members to become more actively involved in the work at the Trust.

The following initiatives have taken place:

- Increased opportunities for members to become volunteers, in a variety of different roles across the Trust, including roles on the wards and in administration.
- Our Research and Development (R&D) Team invited public members to become representatives on the R&D Committee to give advice on research and promote its importance to staff, patients and public.
- As part of our revamped membership application form we are asking our members to indicate their level of participation, i.e. Level 1 – to receive newsletters and voting information only; Level 2 – as Level 1 and to take part in consultations, surveys etc; Level 3 – as Level 1 and 2 and involvement opportunities, such as attending seminars, discussion groups, volunteering and standing for election.

The Trust recognises the need to understand the level of involvement members wish to have and link this to member activities. This ensures that we fully harness the experience, knowledge and skills of our members, recognising and using them to add value to the decision making process and supporting effective governance and delivery of the Trusts objectives. We wish to encourage a partnership approach between the Trust, its membership and other like-minded organisations, working together for the benefit of our organisations, our members and the community served.

Membership Representation

One of the key elements that we want to bring to our membership is that it is representative of the community that we serve. We have been focussing on ways of growing our young membership, as this remains under-represented. We shall also be concentrating on recruiting from ethnic minority groups, which also remains under-represented, by attending community groups. Another key element we want to bring to our membership is that we are actively engaging our members, and using their skills and expertise to add value to the services the Trust offers for the benefit of the whole community which it serves.

'On the 21st May 2011 our daughter was born 7 weeks premature, she is home now and doing extremely well. This is totally due to the team on the Special Care Baby Unit and their expertise in this field. I cannot praise them highly enough for their dedication, superb teamwork, patience in dealing with our questionable fears and a level of service which deserves the highest of accolades. Immense thanks'.

Mr & Mrs Shanagher, St Annes

Audit Committee

The role of the Audit Committee is to provide to the Board of Directors an independent and objective review over the establishment and maintenance of effective systems of integrated governance, risk management and internal control across the organisation's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives.

Role of Audit Committee

It also provides assurance on the independence and effectiveness of both external and internal audit and ensures that standards are set and compliance with them is monitored in the non-financial and non-clinical areas of the Trust that fall within the remit of the Committee. The Audit Committee is significantly instrumental in reviewing the integrity of the Annual Financial Accounts and related External Auditor's Reports thereon. In addition it reviews the Annual Governance Statement prepared by the Chief Executive in his role as the Accountable Officer.

The Council of Governors has approved the continued appointment of PricewaterhouseCoopers as the Trust's external auditors until 31st March 2013. PricewaterhouseCoopers will be paid £53,000 (excluding VAT) for 2011/12 and £50,500 (excluding VAT) for 2012/13 in respect of statutory audit fees. An additional annual fee of £12,500 (excluding VAT) will be charged for work on the Quality Report.

The Trust limits work done by the external auditors outside the audit code to ensure independence is not compromised. In 2011/12 additional work was carried out by the External Auditors outside of normal audit requirements. The main area was due diligence and independent reporting accountants work in relation to the Transforming Community Services transaction, for which the fees were £161,500.

Composition of the Audit Committee

The Committee operates in accordance with the revised Terms of Reference (as per the new Audit Committee Handbook) agreed by the Board of Directors on 28th September 2011 and has met on six occasions during the year ended 31st March 2012. Each member's attendance at these meetings complied with the criterion for frequency of attendance as set out in the Audit Committee's Terms of Reference. The Committee Membership comprises of all the Non-Executive Directors of the Board (with the exclusion of the Chairman) and is chaired by Paul Olive, FCA. The Board considers Paul Olive to have relevant financial experience following his role as a former Finance Director of a FTSE listed company. In addition to the Committee members, standing invitations are extended to the Finance Director (who also acts as the Deputy Chief Executive), External and Internal Audit representatives, the Local Counter Fraud Officer, the Deputy Director of Corporate Affairs and Governance and the Assistant Finance Director. In addition other officers have been invited to attend the Audit Committee where it was felt that to do so would assist the Committee to effectively fulfil its responsibilities; these included the Chief Executive, Deputy Director of Human Resources and Organisational Development, the Financial Accountant, the Clinical Governance Risk Manager, the Director of Nursing and Quality, the Director of Operations, the Clinical Audit Lead and Clinical Improvement Coordinator and the Head of Procurement. Administrative support has been provided by Miss Kayleigh Briggs, PA to the Finance Director and Deputy Chief Executive.

Audit Committee Financial Activities

The Committee reviewed the Draft Annual Report and Accounts and Quality Report for the year ended 31st March 2011 at its meeting on 3rd May 2011 and the final Audited Accounts and Quality Report at its subsequent meeting on 2nd June 2011 and formally recommended to the Board that the Accounts be approved at the Board meeting held on 2nd June 2011. The initial draft of the Annual Report and Quality Accounts for the year ending 31st March 2012 was discussed at the Committee meeting held on 7th February 2012. The continuing development and improvement of the Quality Accounts was also considered at a number of meetings and presentations made thereon by the External Auditors.

As stated in last year's Audit Committee report, the Trust is continuing to monitor its performance against the Auditors Local Evaluation standards and the progress of this review was considered throughout the current year.

Internal Control and Risk Management Systems

Throughout the year the Committee has received regular reports from both Internal and External Auditors in relation to the adequacy of the systems of internal control and also received regular reports from the Deputy Director of Corporate Affairs and Governance on the robustness of risk management arrangements throughout the Trust. Specifically the Committee has gained assurance by reviewing the Governance Briefing Report, Care Quality Commission essential Standards, Divisional Risk Registers, the Corporate Risk Register and the Board Assurance Framework. The Trust Annual Governance Statement was considered at the meeting held on 3rd May 2011 in relation to the year ended 31st March 2011 and recommended to the Board for approval. Significant Assurance was also given that there is generally a sound system of internal control at the meeting held on 1st May 2012 in relation to the year ended 31st March 2012. Presentations by the Clinical Audit team were made on two occasions throughout the year reflecting the continuing development and refinement of this important function.

External Audit

The Trust's External Auditors, PricewaterhouseCoopers (PwC) were re-appointed as Auditors of the Trust for the financial years 2011/12 and 2012/13 at the Council of Governors Meeting held on 14th November 2011 and their audit fee for those years approved. The Committee has reviewed the work and findings of the External Auditors by:-

- Discussing and agreeing the scope and cost of audit detailed in the Annual Plan for 2011/12 and the audit fees for the following year.
- Considering the extent of co-ordination with, and reliance on, Internal Audit.
- Considering alternative mechanisms regarding self assessment of the Audit Committee's effectiveness, and the results of the self assessment results at the meeting on 7th February 2012.
- Considering a number of accounting treatments under IFRS and the impact thereon in relation to the Annual Accounts.
- Considering of matters in relation to Fraud Responsibilities.
- Receiving and considering the Annual Audit Letter at its meeting on 2nd June 2011, which was presented to the Board of Directors at its meeting on 2nd June 2011.
- Receiving and considering reports in relation to going concern matters, the position in relation to the Trust breach situation with Monitor and on the matter of Transforming Community Services. Members of the Audit Committee have also met in private with External Audit representatives on 12th July 2011 so as to allow discussion of matters in the absence of executive officers.

Internal Audit

The Committee has reviewed and considered the work and findings of Internal Audit by:

- Discussing and agreeing the nature and scope of the Annual Internal Audit Plan.
- Receiving and considering progress against the plan presented by the Chief Internal Auditor and Internal Audit Manager.
- Receiving reports on the Assurance Framework, Risk Management System and Care Quality Commission Standards. At its meeting on 1st May 2011, the Committee received the Head of Internal Audit Opinion which gave "significant assurance" that there was a generally sound system of internal control for the year ended 31st March 2011.

In addition, the Chief Internal Auditor gave a presentation to the Committee on the new Audit Committee Handbook. The Committee also met in private with Internal Audit representatives on 12th July 2011 so as to allow discussion of matters in the absence of Executive Officers.

Other Matters

In addition to the matters outlined in this report, the following areas/issues were reviewed by the Committee during the year:

- Adoption of a policy covering provision of non audit work by Trust auditors.
- Continuing review of Clinical Audit both in terms of staffing levels and functional development.
- Review of 2010/11 Audit Committee Report.
- Local Counter Fraud Specialist Report and Annual Report, together with a formal review of the Local Counter Fraud Service.
- Presentations on and reviewing progress of the implementation of the Trust electronic rostering system.
- Presentation on Quality Governance and latest trends in Quality Reporting.
- Adoption of Revised Standing Orders, Scheme of Reservation and Delegation of Powers and Standing Financial Instructions, incorporating Community Services.
- Consideration of alternative mechanisms regarding self assessment of Audit Committees Effectiveness and adopting the process laid down in the new Audit Committee Handbook. The results of this assessment were considered at the committee meeting held on 7th February 2012.
- Presentation and discussions on the working of the PMO office regarding QuIPP.
- Review of "Key Considerations for Foundation Trust Audit Committees".
- Consideration of the process for consolidation, or otherwise, of the Trust's Charitable Funds.
- Discussion regarding system for presentation of information regarding waivers to standing orders and the finalisation of an approved system.
- Review of current legal updates.
- Continuous review of training needs for Audit Committee members and attendance at relevant courses.
- Matters for consideration by the Board.

Conclusion

2011/12 has been a challenging year for the Trust in relation to its continued failure to meet its Financial Risk Ratings as a Foundation Trust. However financial performance has improved along with enhanced liquidity and approval has been recently given for the Community Services acquisition with effect from 1st April 2012.

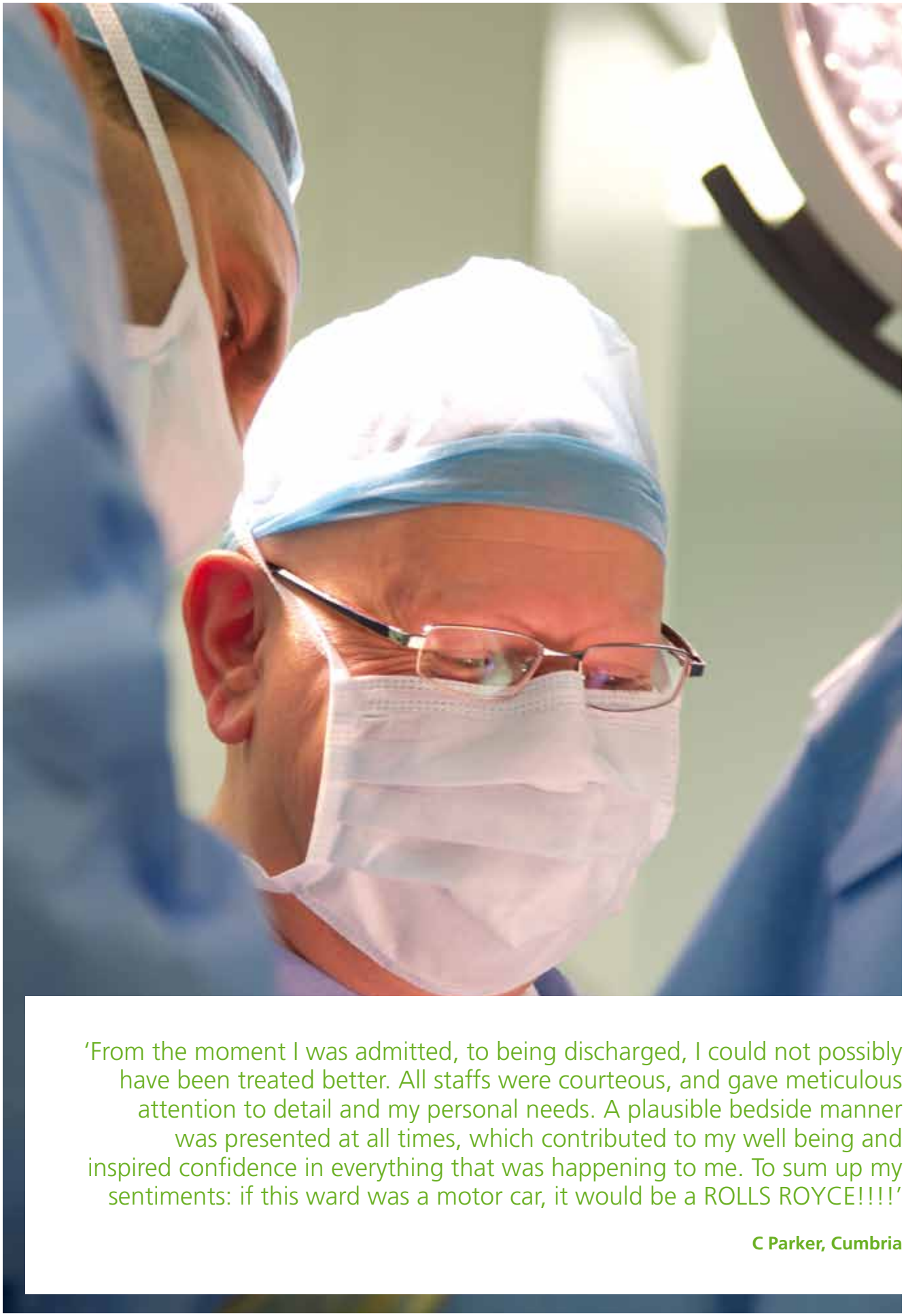
Looking Ahead

2012/13 and beyond present many challenges both to the NHS and Acute Trusts in particular increased efficiencies, improved patient care and the backcloth of Governmental changes all present their particular challenges. The Committee will need to be strong and vigilant in its role to ensure that the Trust returns to its agreed ratings with Monitor, particularly having regard to the economic climate and its need to make consistent and substantial cost savings and at the same time ensure that it delivers continuing and improving patient care. The Committee will also have to ensure that the forthcoming acquisition of Community Health Services goes smoothly and the necessary governance arrangements, both clinical and financial, are in place. The year ahead therefore looks challenging and I take this opportunity to thank my fellow Audit Committee Members for their help and assistance during the year covered by this report.

Signed

Paul Olive
Audit Committee Chairman

24th May 2012



'From the moment I was admitted, to being discharged, I could not possibly have been treated better. All staffs were courteous, and gave meticulous attention to detail and my personal needs. A plausible bedside manner was presented at all times, which contributed to my well being and inspired confidence in everything that was happening to me. To sum up my sentiments: if this ward was a motor car, it would be a ROLLS ROYCE!!!!'

C Parker, Cumbria

Remuneration Report

The membership of the Trust's Remuneration Committee comprises all six Non-Executive Directors, plus the Chairman.

The committee was chaired by Mr Michael Brown, Non-Executive Director, until 31st July 2011. Mr Malcolm Faulkner, Non-Executive Director, has been the Chairman of the Committee since 1st August 2011.

Membership of the Remuneration Committee is as follows:-

Mr Michael Brown – Chairman of the Committee (until 31st July 2011)
Mr Malcolm Faulkner – Chairman of the Committee (from 1st August 2011)
Miss Beverly Lester
Mr Paul Olive
Mr Tony Shaw
Mr Doug Garrett (from 1st June 2011)
Mrs Karen Crowshaw (from 1st June 2011)
Mr Alan Roff (from 1st December 2011)
Mr Nick Grimshaw – Secretary

One meeting of the committee took place during 2011/12 (27th July 2011) with attendance as follows:-

Committee Members (7)	Number of Meetings (1)
Mr Michael Brown (until 31st July 2011)	1
Mr Malcolm Faulkner (from 1st August 2011)	1
Miss Beverly Lester (until 31st March 2012)	1
Mr Paul Olive	1
Mr Tony Shaw	1
Mr Doug Garrett (from 1st June 2011)	1
Mrs Karen Crowshaw (from 1st June 2011)	1
Mr Alan Roff (from 1st December 2011)	0
Mr Nick Grimshaw – Secretary	1

The committee establishes pay ranges, progression and pay uplifts for the Chief Executive, Executive Directors and other Senior Manager posts.

The Committee undertakes its duties by reference to national guidance, pay awards made to other staff groups through national awards and by obtaining intelligence from specialists in pay and labour market research.

At the meeting in July 2011, the committee agreed, for the second consecutive year, that there would be no annual uplift from April 2011 in salaries payable to any of the directors or other senior posts that are reviewed by the committee. The Committee also formally ratified the appointment of Mrs Pat Oliver as the Director of Operations and agreed appointments to the newly comprised Divisional management structure, namely two Deputy Directors of Operations and two Divisional Directors.

All Executive Directors are on permanent contracts. Notice and termination payments are made in accordance with the provisions set out in the standard NHS conditions of service and NHS pension scheme as applied to all staff.

The following tables provide details of the remuneration and pension benefits for senior managers for the period 1st April 2011 to 31st March 2012. These tables are subject to audit review.

Signed: Date: 24th May 2012

Aidan Kehoe
Chief Executive

A) Remuneration

Name and title	Year ended to 31st March 2012					2011
	Salary (bands of £5000)	Bonuses	Other Remu-neration (bands of £5000)	Benefits in Kind rounded to the nearest £100	Total (bands of £5000)	Total (bands of £5000)
	£000	£000	£000	£	£000	£000
B Lester - Chairman	45 - 50				45 - 50	45 - 50
A Kehoe - Chief Executive	165 - 170			*4,000	170 - 175	170 - 175
T Welch - Deputy Chief Executive	120 - 125				120 - 125	125 - 130
H Clarke - Director of Operations (to 31/05/2011)	15 - 20				15 - 20	105 - 110
P Oliver - Director of Operations (from 26/04/2011)	105 - 110				105 - 110	80 - 85
PR Kelsey - Medical Director	80 - 85	30 - 35	75 - 80		190 - 195	190 - 195
M Thompson - Director of Nursing and Quality	105 - 110				105 - 110	105 - 110
R Bell - Director of Facilities	105 - 110				105 - 110	105 - 110
N Grimshaw - Director of Human Resources	105 - 110				105 - 110	105 - 110
PA Olive - Non Executive	15 - 20				15 - 20	15 - 20
C Breene - Non Executive (to 31/03/2011)	0				0	10 - 15
W Robinson - Non Executive (to 31/03/2011)	0				0	10 - 15
M Brown - Non Executive (to 31/07/2011)	0 - 5				0 - 5	10 - 15
MG Faulkner - Non Executive	10 - 15				10 - 15	10 - 15
RA Shaw - Non Executive	10 - 15				10 - 15	5 - 10
P Hosker - Non Executive (to 30/06/2010	0				0	5 - 10
K Crowshaw - Non Executive (from 01/06/2011)	10 - 15				10 - 15	0
D Garrett - Non Executive (from 01/06/2011)	10 - 15				10 - 15	0
A Roff - Non Executive (from 01/12/2011)	0 - 5				0 - 5	0

Band of Highest Paid Directors Total Remuneration (£'000)	190 - 195	190 - 195
Median Total Remuneration	23,589	22,663
Ratio	8.2	8.5

*The non-cash payments relate to lease cars.

Pension Benefits -Values subject to audit review

B) Pension benefits

Name and title	Real increase in pension at age 60 (bands of £2500)	Total accrued pension at age 60 at 31st March 2012 (bands of £5000)	Real increase in pension lump sum at age 60 (bands of £2500)	Lump sum at age 60 related to accrued pension at 31st March 20112 (bands of £5000)	Cash Equivalent Transfer Value at 31st March 2012	Real increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000
A Kehoe Chief Executive	0 - 2.5	40 - 45	0 - 2.5	135 - 140	816	102
T Welch Deputy Chief Executive	0 - 2.5	25 - 30	2.5 - 5	85 - 90	396	89
P Kelsey Medical Director	(0 - 2.5)	70 - 75	(0 - 2.5)	215 - 22 0	1,576	66
H Clarke Director of Operations (to 31/05/2011)	(0 - 2.5)	45 - 50	(0 - 2.5)	135 - 140	880	(3)
C Siddall Director of Operations (to 26/04/2011)	0 - 2.5	30 - 35	0 - 2.5	100 - 105	572	6
P Oliver - Director of Operations (from 26/04/2011)	5 - 10	35 - 40	25 - 30	105 - 110	578	127
M Thompson Director of Nursing and Quality	0 - 2.5	35 - 40	0 - 2.5	105 - 110	554	82
N Grimshaw Director of Human Resources	0 - 2.5	35 - 40	0 - 2.5	105 - 110	609	78
R Bell Director of Clinical Support and Facilities Management	0 - 2.5	5 - 10	0 - 2.5	0 - 5	3085	31

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's and any other contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional years of pension service in the scheme at their own cost. CETV's are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV – this reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

During the 2011/12 year, there was a change to the Government Actuary Department factors for the calculation of CETV's. This will have affected transfer values shown in the table above.

'From a consultant level down to the secretarial level we could not have been happier with the staff's management and we always felt comfortable in the knowledge that Brian was at all times in great hands. We trust that Blackpool Victoria and the Cardiac Centre in particular continue to go from strength to strength'.

Brian and Elaine Gowlding, Blackpool

Nominations Committee

The Nominations Committee is a formally constituted sub-committee of the Council of Governors and comprises the Trust Chairman (Chair of the Committee) and three Governors.

Membership of the Nominations Committee:-

Miss Beverly Lester – Trust Chairman (Chairman)

Mr Peter Askew – Elected Governor (Wyre Constituency)

Mr Eric Allcock – Elected Governor (Blackpool Constituency)

Mr Doug Garrett – Appointed Governor (Blackpool, Fylde and Wyre Economic Development Company) (until 31st May 2011)

Mr Roy Fisher – Appointed Governor (NHS Blackpool) (from 1st September 2011)

There have been three meetings of the Nominations Committee during 2011/12.

The Nominations Committee has the following responsibilities:-

Recruitment and Appointment of Non-Executive Directors:-

- To agree the skill mix and process for the appointment of Non-Executive Directors, in accordance with the Trust's Terms of Authorisation and Monitor's requirements.
- To draw up person specifications for each of these posts to take account of general and specific requirements in terms of roles and responsibilities.
- To determine a schedule for advertising, shortlisting, interview and appointment of candidates with requisite skills and experience. This will include identification of appropriate independent assessors for appointment panels.
- To recommend suitable people for appointments to be ratified by the Council of Governors.

Terms and Conditions – Chair and Non-Executive Directors:-

- To recommend salary arrangements and related terms and conditions for the Chairman and Non-Executive Directors for agreement by the Council of Governors.

Performance Management and Appraisal:-

- To agree a process for the setting of objectives for Non-Executive Directors, subsequent appraisal by the Trust Chairman and feedback to the Council of Governors.
- To agree a mechanism for the evaluation of the Trust Chairman, led by the Senior Independent Director.
- To address issues related to Board development and to ensure that plans are in place for succession to posts as they become vacant so that a balance of skills and experience is maintained.

'I cannot describe the wonderful care I received during my stay at Blackpool Victoria Hospital with dignity and respect from all. The ward was spotless, the cleaners were in early cleaning every available knob and ledge, they were quiet whist doing their tasks and respectful of all patients. I appreciated the privacy given by the bed screens during toilet and washing, and also my individual nursing care. With many thanks'.

Hannah Taylor, Thornton

Annex A - Quality Report

1st April 2011 to 31st March 2012

Part 1: Statement On Quality From The Chief Executive Of The NHS Foundation Trust

NHS Foundation Trusts' each year have to include a report on the quality of care we promote within our annual report. The aim of the quality report is to improve public accountability for the quality of care.

The quality report provides a quality account about the quality of services provided by the Trust, the improvements we have made during 2011/2012 and sets out our key priorities for the next year 2012/13. The quality report also includes feedback from our patients, governors and Commissioners on how well they think we are doing.

I am delighted to introduce the Trust's third Quality Report for the 2011/12 period, which highlights the work we have been doing over the past 12 months to ensure our patients receive the highest quality and safest care possible.

We aim to provide services that consistently deliver the best clinical outcomes for our patients, which are safe, accessible and responsive to patients' needs. This Quality Report sets out how we are progressing with this ambition and where we are focusing our attention to make further progress.

During 2011/12 we made a number of improvements in key areas of quality and safety and received national recognition for some of our work.

The Trust was proud to be shortlisted in three award categories – Enhancing Patient Dignity, Rising Star of the Year and Cancer Nurse Leader of the Year - highlighting our staff's commitment to improving quality of patient care.

Our work in respect of our ongoing investment in our staff was recognised with the award as an Investor In People Gold employer, we are one of a very small number of organisations nationally who have achieved this level of award.

Our work to drive down hospital acquired infections has continued. We have maintained the achievements we have seen over recent years in reducing Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia with just two cases for the period 2011/2012. We also saw the number of cases of Clostridium Difficile infection fall from 101 in 2010/2011 to 53 in 2011/2012 – a reduction of 47.52%. We have also made progress in other important areas of safety including falls, pressure ulcers and medication errors.

We have continued to make progress in improving the patient experience, scoring above the national average in the 2011 National Inpatient Survey in areas including privacy and dignity, cleanliness and hospital food.

We were once again recognised for the high quality of information we provide for patients as we were one of the first organisation's to be awarded the National Information Standard Accreditation for the second year running. The Trust has also maintained compliance with Level 3 National Health Service Litigation Authority (NHSLA) Risk Management Standards, which is the highest level possible that can be achieved. We have also successfully achieved compliance with Level 2 Clinical Negligence Scheme for Trusts (CNST) Maternity Standards demonstrating that we have a high performing Maternity service.

The Trust has shown a sustained improvement in its Risk Adjusted Mortality Index (RAMI) over the last three years and the RAMI remains below the predicted figure of 100. However other measures of hospital mortality including the Hospital Standardised Mortality Index (Dr Foster) and the Summary Hospital Mortality Indicators (SHMI) have shown mortality rates higher than the expected. These indicators do not take into account issues such as deprivation and public health issues and Blackpool has amongst the highest levels of deprivation in the country with lower than average life expectancy. We are working with the Advancing Quality Alliance (AQuA) to undertake an independent external review of hospital mortality to identify any areas for improvement.

The Care Quality Commission (CQC) carried out an unannounced visit on 27th September 2011 on regulated activity for surgical procedures in the Surgical Directorate in order to review the Trust's compliance with the essential standards of quality and safety. The CQC report overall provided positive feedback, however the Trust has taken actions to address one area of non compliance in relation to consent and three areas to maintain compliance with the essential standards.

Our plans for continuing to improve and demonstrate quality in everything we do will evolve throughout the next financial year. We aim to work with our staff, patients, their families and carers, commissioners, stakeholders, Governors, members and the wider public in continually improving the quality of our services. Contributions to develop the Quality Report have been received from the Commissioners Governors, Local Involvement Networks, and the Overview and Scrutiny Committee together with our Corporate Governance Team.

An important development in 2012/13 will be the transfer of community health services from NHS Blackpool and NHS North Lancashire to Blackpool Teaching Hospitals NHS Foundation Trust. We believe the biggest benefit from this merger will be the improvements we can make to the patient experience. It gives us real opportunities for hospital and community health services staff to work together to redesign patient pathways so that all patients receive the right care in the right place at the right time.

Our plans for 2012/13 aim to build on the excellent progress we have made as well as new improvement targets in relation to patient care. This report details the approach this work will take, the measures the Board of Directors have identified as being key to its delivery and how success in these areas will be measured.

Looking forward to the year ahead, we intend to increase our efforts even further towards driving quality and safety improvements across the organisation.

The Quality Report 1st April 2011 – 31st March 2012 to the best of my knowledge the information in the document is accurate.

Aidan Kehoe

Aidan Kehoe
Chief Executive
Date: 24th May 2012

The Quality Report is aimed at assuring our patients, our commissioners, our stakeholders and our local population that we are focused on providing the highest level of clinical care, but also to show we are committed to continuously looking at ways of improving what we do.

Part 2: Priorities For Improvement And Statements Of Assurance From The Board

2.1 Priorities For Improvement

2.1.1 Performance In 2011/12 Against Each Quality Improvement Priority Identified In 2010/11 Quality Report

The Trust has a Quality Framework, approved by the Board of Directors which identifies three key elements in the quality of care it delivers to its patients. These three key elements define specific targets for action which were chosen through various consultation methods with commissioners, governors and LINks:

- Clinical Effectiveness
- Patient Experience
- Patient Safety

The following information provides an overview of the quality of care provided by the Trust based on the performance of each of the quality improvement priorities for 2011/12 as identified in the 2010/11 report against the indicators for clinical effectiveness, patient experience and patient safety. Wherever possible, the report will refer to performance in previous years, historical data and comparative performance benchmarked data, where available. This will enable the reader to understand progress over time and as a means of demonstrating performance compared to other Trusts. This will also enable the reader to understand whether a particular number represents good or poor performance. Wherever possible, references of the data sources for the quality improvement indicators will be stated, including whether the data is governed by national definitions.

Details of the priorities for quality improvement that were agreed by the Board of Directors as identified in the 2010/11 quality report are detailed in Table 1 below. Performance against these priorities will be reported on after Table 1.

Table 1: Priorities for Quality Improvement identified in 2010/11 Quality Report

Priorities for Improvement 2011/12			Indicators for Quality Improvement 2011/12
National Level NHS Outcomes Framework Domains of Quality	**Trust Level**	**Key Elements in the Quality of Care**	
Domain 1: Preventing people from dying prematurely (DH 2011/12 NHS Outcomes Framework)	To Provide Best In NHS Care For Our Patients	Clinical Effectiveness	North West Advancing Quality initiative that seeks compliance with best practice in six clinical areas: – Acute Myocardial Infarction (Heart Attack) – Hip and Knee Replacement Surgery – Coronary Artery Bypass Graft Surgery – Heart Failure – Community Acquired Pneumonia – Stroke – Patient Experience Measure Improve referral to treatment times for patients who suffer a Trans Ischemic Attack (TIA) Implementing 100,000 lives and Saving Lives Programme: – Reducing Cardiac Arrest calls – Reducing the incidence of Surgical Site Infections – Further embed and improve the implementation of Venous Thromboembolism (VTE) guideline within the Trust Nursing Care Indicators used to assess and measure standards of clinical care and patient experience. Implement Nursing and Midwifery high impact actions to improve the quality and cost effectiveness of care.
Domain 2: Enhancing quality of life for people with long-term conditions (DH 2011/12)			
Domain 3: Helping people to recover from episodes of ill health or following injury (DH 2011/12)			

Table 1: Priorities for Quality Improvement identified in 2010/11 Quality Report			
Priorities for Improvement 2011/12			**Indicators for Quality Improvement 2011/12**
National Level NHS Outcomes Framework Domains of Quality	**Trust Level**	**Key Elements in the Quality of Care**	
Domain 4: Ensuring that people have a positive experience of care (DH 2011/12)	To Provide Best In NHS Care For Our Patients To Deliver Best Environment For Patients, Staff And The Wider Community	Patient Experience	Improve National Inpatient Survey results in the following six areas; – In your opinion, how clean was the hospital room or ward that you were in? – Were you given enough privacy when being examined or treated? – Overall, did you feel you were treated with respect and dignity while you were in the hospital? – Were you bothered by noise at night from other patients – Were you bothered by noise at night from hospital staff – How would you rate the hospital food Improve National Outpatient Survey results in the following four key areas: – No copies of GP letters to patients – Poor information – Poor communication – staff not introducing themselves / Lack of information regarding waiting times and delays in clinic – Lack of time to discuss health issues Patient Environment Action Team (PEAT) Survey – To improve PEAT survey results/standards Liverpool Care Pathway for the Dying – Seeking patients and carers views to improve End of Life Care – Ensure that patients who are known to be at the end of their lives are able to spend their last days in their preferred place Ensure single sex accommodation is available for patients to ensure privacy and dignity whilst in hospital
Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm (DH 2011/12)	To reduce Avoidable Harms To Our Patients	Patient Safety	Reduce the Trust's hospital mortality rate Reduce MRSA and Clostridium Difficile infection rates as reflected by national targets Reduce patient harms through the following strands of work: – Global Trigger Tool to be used to measure adverse events – Reduction of Falls by 30% – Reducing Medication errors by 50% by 2011/12 – Reduce the incidence of newly acquired grade 2,3 and 4 pressure ulcers

In 2011, it was anticipated that the Trust would provide community health services from 1st April 2012. Therefore the community health services priorities for quality improvement for 2011/12 had also been included in the 2010/11 Quality Report which is also detailed in Table 1 below.

Table 1: Priorities for Quality Improvement identified in 2010/11 Quality Report		
NHS Blackpool: Community Healthcare Quality Improvement Priorities 2011/12		
Quality Improvement Area	**Quality Improvement Target Set by Provider**	**Quality Improvement Measure and Reporting Arrangements**
Patient Safety	Reduction in grade 3 & 4 pressure ulcers	Increase in the number of patients with a Waterlow score of 15 or with a Malnutrition Universal Screening Tool (MUST Tool) completed. Increase in the number of patients with a grade 2 pressure ulcer with a Malnutrition Universal Screening Tool (MUST Tool) completed 80% of community nursing staff to complete pressure ulcer training. Training to incorporate preventing, avoiding and treating pressure ulcers and include National Institute for Health and Clinical Excellence (NICE) guidance. Reduction in the number of hospital admissions and hospital attendances for patients requiring tissue viability care
	Methicillin-Resistant Staphylococcus Aureus (MRSA) & Clostridium Difficile	All confirmed cases Methicillin-Resistant Staphylococcus Aureus (MRSA) & Clostridium Difficile are reported and investigated. A very low number of cases each year are identified as having been acquired through contact with the Blackpool Community Health Services. This position must be monitored and maintained and will be reported to the Infection Prevention Committee. Trajectory for 2011 / 2012 is less than 5 MRSA reported incidents.
Clinical Effectiveness	48 hour target to access sexual health	All first attendances at the Genito-urinary medicine service to be seen within 48 hours of contacting the service
	Productive Community Services Implementation	Services to complete at least 1 Productive Community Services module and evidence that they are working towards another during 2011/12
Patient Experience	Choice of where to die Preferred place of Death	The service will record numbers of patients on their caseload who die and the proportion of these who have been facilitated to die in their preferred place of care.
Patient Safety, Clinical Effectiveness and Patient Experience	Reducing Urinary Tract Infections	Increasing the number of staff trained to carry out male and female catheterisation. Develop a catheter leaflet in line with National Institute for Health and Clinical Excellence (NICE) guidance (2006) for patients and carers

Table 1: Priorities for Quality Improvement identified in 2010/11 Quality Report		
NHS North Lancashire Teaching Primary Care Trust: Community Healthcare Quality Improvement Priorities 2011/12		
Quality Improvement Area	**Quality Improvement Target Set by Provider**	**Quality Improvement Measure and Reporting Arrangements**
Patient Safety	Reduction in grade 3 & 4* pressure ulcers	Patient incident reports submitted by staff will be analysed and reported quarterly to the Provider Services Risk Committee. A reduction trend over the year is anticipated, based on increased staff awareness and training
	MRSA and Clostridium Difficile (all services)	All confirmed cases of MRSA and Clostridium Difficile are reported and investigated. A very low number of cases each year are identified as having been acquired through contact with the Provider Services. This position must be monitored and maintained and will be reported to the Hygiene Code Implementation and Decontamination Group.
Clinical Effectiveness	Meet the national target - Access to genito-urinary medicine (GUM) clinics within 48 hours (sexual health service)	• Percentage: first attendances at a GUM service who were offered an appointment to be seen within 48 hours of contacting a service • Percentage: first attendances who were seen within 48 hours of contacting a GUM service Monitoring of data at Contract Performance and Review meeting.
Patient Experience	Choice of where to die (palliative care service)	The service will record numbers of patients on their caseload who die and the proportion of these whose treatment has been managed appropriately to allow them to die in their preferred place of care. Establish the baseline in 2011/12, with monthly reporting. Monitoring of data at the Contract Performance and Review meeting

The Trust has continued to work throughout the year to embed a culture of patient safety and deliver on the commitments made in our Quality Framework document. This has resulted in considerable progress and improvements in key quality measures, via a number of programmes undertaken in 2011/12.

A programme of work has been established that corresponds to each of the quality improvement areas we are targeting. Each individual scheme within the programme has contributed to one, or more, of the overall performance targets we have set i.e. improved hospital mortality rates, reducing avoidable harms, conformance to best practice and improving patient quality. Improvements have been delivered through staff engagement and the commitment of staff to make improvements.

Quality improvements will continue to be monitored and reported to the Board of Directors as part of the monthly Board Business Monitoring Report and the monthly Board Safety and Quality Report and to Sub Committees of the Board through the reporting of specific quality programmes of work.

The following information provides an overview of the quality of care provided by the Trust based on performance in 2011/12 against the 2010/11 indicators for clinical effectiveness, patient experience and patient safety. This also includes an overview of the quality of care provided by the Community Health Services based on performance in 2011/12 against the 2010/11 indicators for clinical effectiveness, patient experience and patient safety. Wherever possible, the report will refer to performance in previous years, historical data and comparative performance benchmarked data, where available. This will enable the reader to understand progress over time and as a means of demonstrating performance compared to other Trusts. This will also enable the reader to understand whether a particular number represents good or poor performance.

Wherever possible, references of the data sources for the quality improvement indicators will be stated within the body of the report or within the Glossary of Terms, including whether the data is governed by national definitions.

2.1.2 Clinical Effectiveness

There are many schemes, initiatives and processes that we can participate in that help us deliver high quality care. By meeting the exact and detailed standards of these schemes and initiatives we must achieve a particular level of excellence, this then directly impacts on the quality of care and provides evidence for the Trust that we are doing all we can to provide clinical effectiveness of care.

North West Advancing Quality Initiative

The Trust participates in the NHS North West (Strategic Health Authority) Advancing Quality Programme, which focuses on the delivery of a range of interventions for each of the following conditions. Examples of the interventions can be found in the following information and Tables below:

- Acute Myocardial Infarction (Heart Attack)
- Hip and Knee Replacement Surgery
- Coronary Artery By-pass Graft Surgery
- Heart Failure
- Community Acquired Pneumonia
- Stroke
- Patient Experience Measures (PEMs)

Research has shown that consistent application of these interventions has substantially improved patient outcomes resulting in fewer deaths, fewer hospital readmissions and shorter hospital lengths of stay.

Applying all the interventions will support our goals of reducing hospital mortality, reducing preventable harms and improving patient outcomes, thereby improving the quality of their experience. Approximately 3,000 patients a year will benefit from this programme.

Table 2

Commissioning for Quality and Innovation (CQUIN) and the respective Targets For The Trust

Scheme	Threshold	Collection Period
Acute Myocardial Infarction (Heart Attack)	95%	Discharges which occur between 1st April 2011 and 31st March 2012.
Coronary Artery By-pass Graft (CABG)	95%	
Community Acquired Pneumonia	84.81%	
Hip and Knee Replacement Surgery	95%	
Heart Failure	75.08%	
Stroke	90%	
Patient Experience Measures (PEMs)	25%	

Comparison of Data

For each of the key areas a series of appropriate patient care measures has been determined, known as the Composite Quality Score (CQS). Data are collected to demonstrate if these measures are being met and a Composite Quality Score for each key area is derived for every Trust in the programme. Performance thresholds have been agreed using this data which, whilst stretching, are aimed at each Trust having the opportunity to be awarded the full amount retained through the Commissioning for Quality and Innovation (CQUIN) framework. The percentage levels which would generate a CQUIN payment for each organisation and the data collection periods for each scheme are slightly different, and therefore each CQUIN and the respective targets for the Trust are detailed in Table 2 above.

In addition, to qualify for the Commissioning for Quality and Innovation awards, Trusts must achieve a minimum cumulative clinical coding and Quality Measures Reporter (QMR) data completeness score of 95%.

The Trust's performance against each of the seven key areas is detailed in the following information below. A Clinical Lead and Operational Manager have been identified for each key area and regular meetings are held to identify the actions required to improve scores achieved to date.

Acute Myocardial Infarction (Heart Attack)

Review

The Trust has always performed well against the advancing quality measure for Acute Myocardial Infarction (Heart Attack). A number of measures have been introduced to ensure compliance with all performance measures. The Trust achieved the CQUIN Threshold and scored 97.98% as shown in Table 3.

A number of measures have been introduced to ensure compliance with all performance measures which highlights that the Trust is working to a world class service. The Cardiac Specialist Nurses have ensured that all relevant data is collected and uploaded into the database and they check compliance with all measures.

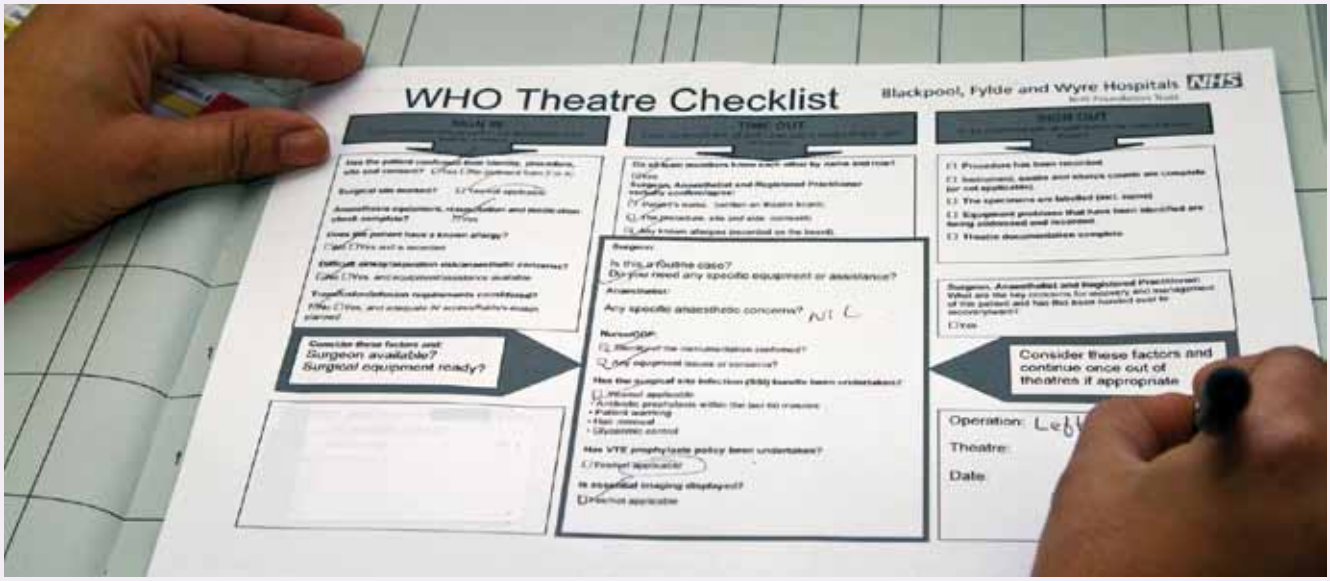
The Cardiac Specialist Nurses ensure that all information is captured in the Myocardial Ischaemia National Audit Project (MINAP). The Advancing Quality Adult Smoking Cessation advice/ counselling is further checked by the Cardiac Rehabilitation Team to ensure this is included within the patients individualised treatment plan.

All data is shared with the Consultant Team and Health Professionals at the monthly Directorate meeting and at the Divisional Governance meeting.

Performance against the achievement scores of the various measures is provided in Table 3.

Table 3

Acute Myocardial Infarction (Heart Attack)	Trust Performance		
Measure	**Year 1** Oct 08 – Sept 09	**Year 2** Oct 09 – Mar 10	**Year 3** Apr 10 – Mar 11
Aspirin at arrival	100.00%	100.00%	100.00%
Aspirin prescribed at discharge	99.40%	100.00%	100.00%
ACEI or ARB for LVSD	100.00%	100.00%	100.00%
Adult smoking cessation advice/counselling	92.86%	96.00%	96.61%
Beta Blocker prescribed at discharge	98.03%	100.00%	98.79%
Beta Blocker at arrival	99.07%		
Fibrinolytic therapy received within 30 minutes of hospital arrival	100.00%		
Primary Coronary Intervention (PCI) received within 90 minutes of hospital arrival	100.00%	100.00%	95.12%
Survival Index	96.76%	99.00%	90.80%
Acute Myocardial Infarction (AMI) Composite Quality Score (CQS)	**98.55%**	**99.62%**	**97.98%**
Top 25% CQS Threshold	97.02%	99.04%	
Top 50% CQS Threshold	94.40%	98.00%	
CQUIN Threshold		87.35%	95.00%
Year 1 – Trusts had to achieve over the Top 25% (green) or Top 50% (amber) to receive an incentive payment (red = no payment received).			
Year 2 – Trusts had to achieve the Attainment Threshold to receive the incentive. If they achieved the Attainment Threshold then they could also be eligible for the Top 25% (green) or Top 50% (amber) incentive.			
Year 3 –The Trust had to achieve the CQUIN Threshold of 95%. The Trust met the CQUIN Threshold – we scored 97.98%.			
The Trust treated 428 patients who suffered an Acute Myocardial Infarction (Heart Attack)			



Hip and Knee Replacement Surgery

Review

Both antibiotic and Venous Thromboembolism prophylaxis is the subject of a set of departmental protocols. Compliance with the Venous Thromboembolism prophylaxis protocol is 99% or better. With regard to antibiotic prophylaxis we have developed a protocol, involving both Flucloxacillin and Gentamicin antibiotics as a first line for patients without Penicillin/Cepahalosporin antibiotic allergy, and compliance in this area is 100%. The Trust achieved the CQUIN Threshold and scored 97.78%. Performance against the achievement scores of the various measures is provided in Table 4.

Table 4

Hip and Knee Replacement Surgery	Trust Performance		
Measure	**Year 1** Oct 08 – Sept 09	**Year 2** Oct 09 – Mar 10	**Year 3** Apr 10 – Mar 11
Prophylactic antibiotic received within 1 hour prior to surgical incision	99.53%	88.14%	97.96%
Prophylactic antibiotic selection for surgical patients	98.88%	97.36%	99.59%
Prophylactic antibiotic discontinued within 24 hours after surgery end time	95.33%	98.31%	96.64%
Recommended Venous Thromboembolism prophylaxis ordered	100.00%	99.66%	100.00%
Received appropriate Venous Thromboembolism (VTE) prophylaxis w/I 24 hrs prior to surgery to 24 hrs after surgery	99.84%	99.66%	100.00%
Readmission (28 Day) avoidance index	90.31%	94.02%	92.50%
Hip and Knee Composite Quality Score (CQS)	**94.52%**	**96.19%**	**97.78%**
Top 25% CQS Threshold	94.52%	96.89%	
Top 50% CQS Threshold	92.04%	94.27%	
CQUIN Threshold		75.67%	95.00%
Year 1 – Trusts had to achieve over the Top 25% (green) or Top 50% (amber) to receive an incentive payment (red = no payment received).			
Year 2 – Trusts had to achieve the Attainment Threshold to receive the incentive. If they achieved the Attainment Threshold then they could also be eligible for the Top 25% (green) or Top 50% (amber) incentive payment (red = no payment received).			
Year 3 – The Trust had to achieve the CQUIN Threshold of 95%. The Trust met the CQUIN Threshold – we scored 97.78% (green)			

Coronary Artery Bypass Graft (CABG) Surgery

Review

There are four Trusts undertaking Coronary Artery Bypass Graft Surgery within the North West, all of which have scored highly for Year 1, Year 2 and Year 3. It is very competitive due to the low number of Trusts involved in this initiative.

A number of actions have been introduced to further improve performance against the measures. Compliance with all measures has continued to improve. All data is collected and uploaded by a member of the administrative team working closely with the clinical lead.

The introduction of a new prescription sheet within the Cardiac Intensive Care Unit with the facility to prescribe antibiotics for a 48 hour period only has assisted with the compliance on antibiotic stop times. This ensures that clinicians review each patient and only continue with antibiotics based on individual clinical need if they are re-prescribed.

All data is shared with the Consultant Team and Health Professionals at the monthly Directorate meeting and in the Divisional Governance meeting.

The Trust achieved the CQUIN Threshold and achieved 96.54%. Performance against the achievement scores of the various measures is provided in Table 5.

Table 5

Coronary Artery Bypass Graft Surgery	Trust Performance		
Measure	**Year 1** Oct 08 – Sept 09	**Year 2** Oct 09 – Mar 10	**Year 3** Apr 10 – Mar 11
Aspirin prescribed at discharge	99.53%	98.54%	98.68%
Prophylactic antibiotic received within 1 hr prior to surgical incision	94.71%	87.89%	95.59%
Prophylactic antibiotic selection for surgical patients	98.14%	94.88%	98.30%
Prophylactic antibiotic discontinued within 24 hrs after surgery end time	82.15%	89.82%	93.62%
Coronary Artery Bypass Graft Composite Quality Score (CQS)	**93.77%**	**92.73%**	**96.54%**
Top 25% CQS Threshold	98.71%	97.75%	
Top 50% CQS Threshold	95.01%	97.73%	
CQUIN Threshold		95.00%	95.00%
Year 1 – Trusts had to achieve over the Top 25% (green) or Top 50% (amber) to receive an incentive payment (red = no payment received).			
Year 2 – Trusts had to achieve the Attainment Threshold to receive the incentive. If they achieved the Attainment Threshold then they could also be eligible for the Top 25% (green) or Top 50% (amber) incentive payment (red = no payment received).			
Year 3 - The Trust had to achieve the CQUIN Threshold of 95%. The Trust met the CQUIN Threshold – we scored 96.54% (green)			

Table 6			
Heart Failure	**Trust Performance**		
Measure	**Year 1** Oct 08 – Sept 09	**Year 2** Oct 09 – Mar 10	**Year 3** Apr 10 – Mar 11
Discharge instructions	7.33%	18.42%	34.43%
Evaluation of LVS function	70.20%	84.62%	87.70%
ACEI or ARB for LVSD	76.06%	81.37%	84.84%
Adult smoking cessation advice / counselling	27.78%	53.85%	28.13%
Heart Failure Composite Quality Score (CQS)	**42.40%**	**59.10%**	**65.94%**
Top 25% CQS Threshold	74.65%	77.60%	
Top 50% CQS Threshold	59.60%	72.19%	
CQUIN Threshold		65.34%	65.34%
Year 1 – Trusts had to achieve over the Top 25% (green) or Top 50% (amber) to receive an incentive payment (red = no payment received).			
Year 2 – Trusts had to achieve the Attainment Threshold to receive the incentive. If they achieved the Attainment Threshold then they could also be eligible for the Top 25% (green) or Top 50% (amber) incentive payment (red = no payment received).			
Year 3 - The Trust had to achieve the CQUIN Threshold of 65.34%. The Trust met the CQUIN Threshold – we scored 65.94% (green)			

Heart Failure

Review

The Trust has shown an improvement in performance in relation to the management of patients with Heart Failure. Heart Failure Specialist Nurses attend the Adult Medical Unit on a daily basis to identify any patients who have been admitted with Heart Failure. This ensures that these patients are treated by the most appropriate health professional as swiftly as possible and prevents extended length of stay. The Consultant Cardiologist who is responsible for the treatment of patients with Heart Failure is actively involved with patient management across the Trust. Regular ward rounds are undertaken within the Medical Directorate to review patients to assist with effective diagnosis and treatment. Near the end of the patients hospital stay, patients are seen by the Cardiac Rehabilitation Team who ensures appropriate discharge advice has been given.

All data is shared with the Consultant Team and Health Professionals at the monthly Directorate meeting and in the Divisional Governance meeting.

The Trust achieved the CQUIN Threshold and achieved 65.94%. Performance against the achievement scores of the various measures is provided in Table 6.

Community Acquired Pneumonia

Review

The figures in Year 3 clearly show that the Trust has continued to make significant progress compared to year one. A number of measures have been implemented during the year including the introduction of Advancing Quality Pneumonia Quality Cards, which is a credit card sized reminder for all medical staff of what is required in terms of ensuring high quality patient care for patients suspected of having Community Acquired Pneumonia. An e-learning tool is being launched for all medical staff to complete ensuring that they are fully aware of the need to deliver Advancing Quality measures for pneumonia.

Multidisciplinary meetings continue with nurses and managers from the Accident and Emergency Department, the Acute Medical wards and the Medical specialties. Performance is openly discussed at these meetings and recent clinical cases are reviewed in order that areas for improvement can be identified. The Trust is confident that the introduction of a pneumonia care pathway which will be recorded on the electronic patient record will further improve our performance parameters.

Performance of Blackpool Teaching Hospitals NHS Foundation Trust based on Premier data for Year 3 shows the Composite Quality Score (CQS) to be 86.29%. Performance against the achievement scores of the five key measures is provided in Table 7.

Table 7

Community Acquired Pneumonia	Trust Performance		
Measure	**Year 1** Oct 08 – Sept 09	**Year 2** Oct 09 – Mar 10	**Year 3** Apr 10 – Mar 11
Oxygenation assessment	96.89%	100.00%	99.81%
Blood Cultures performed in A&E prior to initial antibiotics received in hospital	17.09%	41.60%	80.35%
Adult smoking cessation advice / counselling	10.20%	39.62%	39.26%
Initial antibiotic received within 6 hrs of hospital arrival	54.21%	64.94%	79.24%
Initial antibiotic selection for Community Acquired Pneumonia in immune-competent patients	67.13%	97.32%	99.68%
Community Acquired Pneumonia Composite Quality Score (CQS)	**62.08%**	**76.28%**	**86.29%**
Top 25% CQS Threshold	82.11%	84.03%	
Top 50% CQS Threshold	74.77%	82.24%	
CQUIN Threshold		78.41%	78.41%

Year 1 – Trusts had to achieve over the Top 25% (green) or Top 50% (amber) to receive an incentive payment (red = no payment received).

Year 2 – Trusts had to achieve the Attainment Threshold to receive the incentive. If they achieved the Attainment Threshold then they could also be eligible for the Top 25% (green) or Top 50% (amber) incentive payment (red = no payment received).

Year 3 - The Trust had to achieve the CQUIN Threshold of 78.41%. The Trust met the CQUIN Threshold – we scored 86.29% (green)

Stroke

Review

During 2011/12 the Stroke Unit has seen significant improvements against key clinical indicators concerned with the timing assessment and treatment of stroke patients.

The Trust was ranked fourth in the North West region, with only Aintree University Hospital, Royal Liverpool and Broadgreen University Hospital and Salford Royal Hospital were performing better. It is pertinent to note the nature of these Trusts in comparison to Blackpool, being large multi-site Trusts. Nationally, out of 157 Trusts, the Trust was ranked 21st.

Performance against the Advancing Quality programme has also seen significant improvement. Having failed the CQUIN targets for stroke during the financial year 2010/11, the Trust has consistently achieved and over-performed against the two targets during 2011/12 and is again one of the highest performing Trusts in the North West of England.

Performance against the achievement scores of the various measures is provided in Table 8.

Patient Experience Measures

Review

The Advancing Quality Patient Experience Measure survey was introduced on 1st April 2011 and comprised of 8 questions for patients in the Advancing Quality clinical focus groups to complete prior to discharge and related to patient responses for those having treatment for Acute Myocardial Infarction, Coronary Artery By-pass Graft Surgery, Heart Failure, Hip and Knee Replacement Surgery and Community Acquired Pneumonia. The 8 questions were scored from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible. To facilitate collection of patient responses the Regional Advancing Quality team provided each Trust with electronic devices.

The 8 questions were as follows:

- Would you recommend this hospital to your friends and family?
- Did staff listen and act on your anxieties and fears?
- Did you get answers to your questions at the time you needed them, and in a way that you and your family or carers could understand and remember?
- On reflection, did you get the care that mattered to you?
- When you arrived in hospital, did you feel that the staff knew about you and any previous care you had received?
- Did staff respect you as an individual?
- Patients have said that 'sometimes in hospital members of staff will say one thing and then another' - did this happen to you?

The response rate represents the surveys returned that were eligible to be part of the Advancing Quality program.

On introducing the Patient Experience Measure there were a number of issues with patients participating in the clinical focus groups, firstly there were a limited number of electronic devices available and secondly there were a number of technical problems. These technical problems were raised with the Regional Advancing Quality team. This coupled with difficulty identifying Advancing Quality patients on medical wards meant that response rates were poor. Various changes have been made to the data collection process and response rates have started to improve since December 2011, however the Regional Advancing Quality team stopped the data collection from January to March 2011 due to regional problems with the machines.

Table 9 details the performance in this Advancing Quality performance measure.

Table 8	
Stroke (New Target Introduced October 2010)	**Trust Performance**
Measure	**Year 1** (1.10.2010 – 31.3.2011)
Stroke Unit Admission	41.92%
Swallowing Screening	97.77%
Brain Scan	68.15%
Received Aspirin	90.71%
Physiotherapy Assessment	98.48%
Occupational Assessment	97.01%
Weighed	98.15%
Stroke Composite Quality Score (CQS)	**83.65%**
Stroke Appropriate Care Score (ACS)	**34.27%**
CQS - CQUIN Threshold	90%
ACS - CQUIN Threshold	50%
Year 1 – The Trust had to achieve two CQUIN Thresholds – CQS target of 90% and ACS target of 50%. The Trust did not achieve the CQUIN Threshold – we scored 83.65% (CQS) and 34.27% (ACS) (red = no payment received)	

Table 9	
Patient Experience Measures (PEMs) (New Target Introduced April 2011)	**Trust Performance**
Measure	**Year 1** (April 10 – Dec 10)
Trust Response Rate	**6.69%**
Advancing Quality Threshold	**10%**
Trust Response Rate	**6.69%**
Year 1 – Advancing Quality Threshold missed – We scored 6.69% (red – no payment received)	

Improve referral to treatment times for patients who suffer a Trans Ischaemic Attack (TIA)

Clinics and robust referral protocols for both high and low risk patients who suffer a Trans Ischaemic Attack were introduced during 2011/12 to ensure GPs are able to access TIA clinics and the Stroke Unit with patients assessed as high risk easily and quickly.

Through the circulation of a revised TIA referral form and protocol, GPs now have a direct telephone number through to the Stroke Unit, which they are encouraged to phone whilst the patient is still within the GP practice. An appointment time can then be given to the patient before they leave the GP practice so that the patient is seen in the TIA clinic and receives treatment within 24 hours, in line with recommendations. Clinic slots for high risk patients are flexible and are available on an 'adhoc' basis, and appointments are also integrated into the working schedules of the Stroke Consultants, to enable patients to access the service in the timely manner required. Graph 1 demonstrates the improvement for patients receiving TIA treatment within 24 hours.

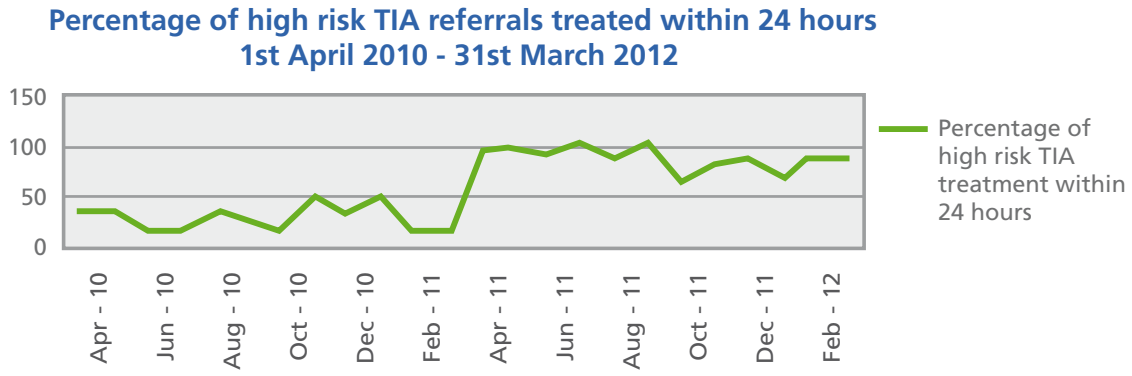
Implementing 100,000 Lives and Saving Lives Programme

These programmes have been adopted by the Trust, following their launch by the Institute for Healthcare Improvement and the Department of Health. As with the Advancing Quality Programme these schemes use evidence-based interventions with the aim of reducing patient harm across the Trust. The outcomes from implementing these measures will be:

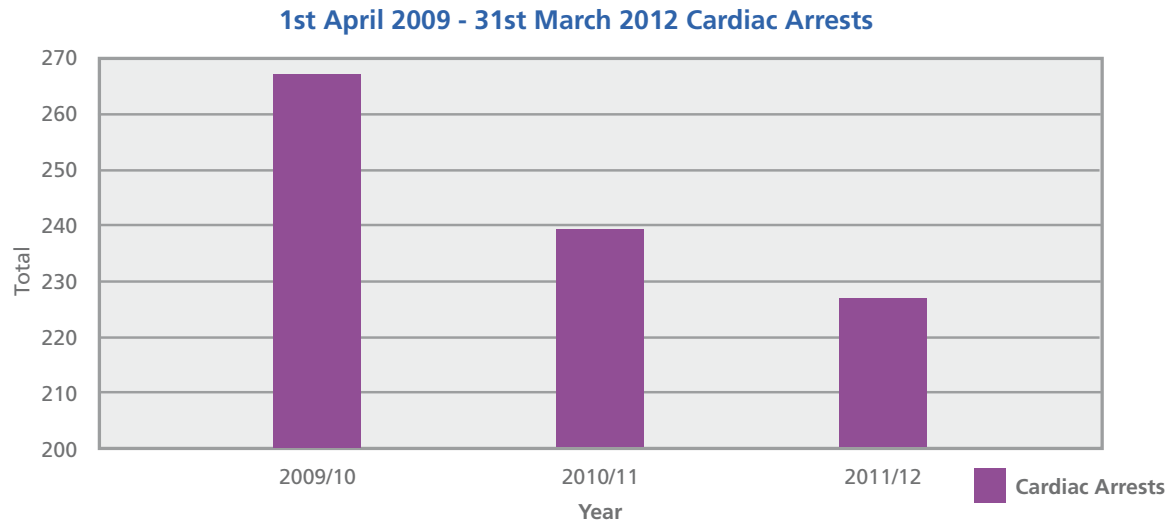
- Improved outcomes for patients who have suffered a heart attack.
- Reduction in the incidence of surgical site infection.
- Early identification and treatment of patients with worsening conditions.
- Reduction in infections due to central line insertion.
- Reduction in surgical infections.
- Elimination of ventilator associated pneumonias in critical care.
- Reduction in the risk of microbial contamination which means the growth of harmful microorganisms in an item used as food, making it unfit for consumption.
- Reduction in the incidence of catheter related bloodstream infections.

All patients who are treated at the Trust will benefit from these changes. We have established robust mechanisms to audit both compliance with the recommended provision of care and the impact on patient outcomes, in particular mortality rates and preventable harms. The Trust will also be continuing the implementation of best practice as described within the 'Map of Medicine' Care Pathways and National Institute for Health and Clinical Excellence (NICE) guidelines.

Graph 1



Graph 2



Rapid Response Team - Reducing Cardiac Arrest Calls - Improving Outcomes For Patients Who Have Suffered A Heart Attack

Data relating to in-hospital cardiac arrest and medical emergency calls are provided to the Care of the Acutely Ill Group/ Resuscitation Committee each month, together with a detailed presentation of improvement activities twice a year. A service redesign is currently underway to improve access for staff in resuscitation training and offer more time to staff for clinical care. Action plans for reducing in-hospital cardiac arrests and embedding "Do Not Attempt Resuscitation (DNAR)" principles are also discussed at each meeting and the findings within the DNAR Audit are delivered across the organisation to improve compliance in this area.

The number of in-hospital cardiac arrests for the period 1st April 2011 to 31st March 2012 was 227 in comparison to 239 for the previous reporting period 1st April 2010 to 31st March 2011. This data is represented in Graph 2.

The following information provides an overview of some of the initiatives that the Trust has undertaken to reduce the number of in-hospital cardiac arrests:

- Increase opportunities for staff to access Advanced Life Support education
- Ensured compulsory RC (UK) Advanced Life Support (ALS) status for all senior grade Doctors (Specialist Registrars/ Foundation Year 2) attending cardiac arrest calls via the 2222 cardiac arrest team.
- Ensured compulsory Royal College (UK) Intensive Life Support (ILS) status for all Junior Doctors (Foundation Year 1) attending cardiac arrest calls via the 2222 cardiac arrest team
- In the proposal stage of a medical emergency procedure so that front line nursing staff can access acute medical services in the deteriorating patient, aiming to reduce cardiac arrest
- Focus key staff for Immediate Life Support education
- Implement Basic Life Support and Automated External Defibrillation training to core staff incorporating blended learning to increase that amount of staff we can target and reduce time out of the clinical area improving on patient care and reducing costs
- Increase in Early Warning Score and Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) education in line with a generic adoption across community services to improve patient care and supporting the patient and family with preferred wishes in the last days of life
- Produce a Do Not Attempt Cardio-Pulmonary Resuscitation pledge to empower compliance with the Do Not Attempt Cardio-Pulmonary Resuscitation orders

The initiatives taken have impacted on the overall reduction of in-hospital cardiac arrests. It can be seen that the service redesign for resuscitation training which focuses on the deteriorating patient has reduced staff's time off the ward thereby improving staffing levels in the wards and departments. Early identification of the deteriorating patient can be identified and escalated through the graded response system we have in place and this impact and method of training has reduced the amount of cardiac arrest calls being placed.

It is clear that the number of in-hospital cardiac arrests is affected by admissions for that month and the co-morbidities of patients, but generally the Trust has seen improvements.

By introducing Do Not Attempt Resuscitation awareness and since the introduction of a DNACPR pledge, we have empowered senior doctors to approach the subject of resuscitation attempts with patients who would not benefit from CPR or CPR would not be in the best interest of the patient. In turn this has led to an increase in DNAR orders where we have had the opportunity to address other comfort measures benefiting the patient.

Reducing the Incidence of Surgical Site Infections

Monitoring of the incidence of surgical site infections is undertaken through a rolling schedule of audit and surveillance across all surgical specialties, with the review of all orthopaedic surgical wound infections being mandatory. All issues highlighted as a result of this surveillance will be used to improve practice across the Trust. Graph 3 below demonstrates the small number of wound infections that have been identified following surveillance of patients undergoing Hip Replacement Surgery.

The mandatory surveillance of patients undergoing Hip Replacement Surgery was reported for the period 1st April 2011 to June 2011. Non mandatory surveillance then continued to the end of November 2011; of which the results are shown in Graph 3. For the period 1st April 2011 and 30th June 2011, a total of 68 patients were included in the three month surveillance, one incidence of a deep seated wound infection was detected and reported to the Health Protection Agency (HPA).

Additionally Hip Replacement Surgery surveillance continued 'in-house' with a further 111 patients included in the surveillance period July to November 2011. Following the Health Protection Agency criteria it was identified that a further 5 patients having superficial post operative wound infections. In total there were 179 patients included in the surveillance with 6 patients identified with post operative wound infections. This represents an infection rate of 3.3%.

In comparison, for Hip Replacement Surgery surveillance completed for the period April 2010 to March 2011 a total of 214 patients were included with six patients identified with a post operative wound infection. This represents an infection rate of 2.8%.

In addition, 'in-house' surveillance of patients undergoing Caesarean Section Surgery (Graph 4) and Vascular Surgery (Graph 5) was completed in October and November 2011; the results from this surveillance are shown in Graph 4 and 5.

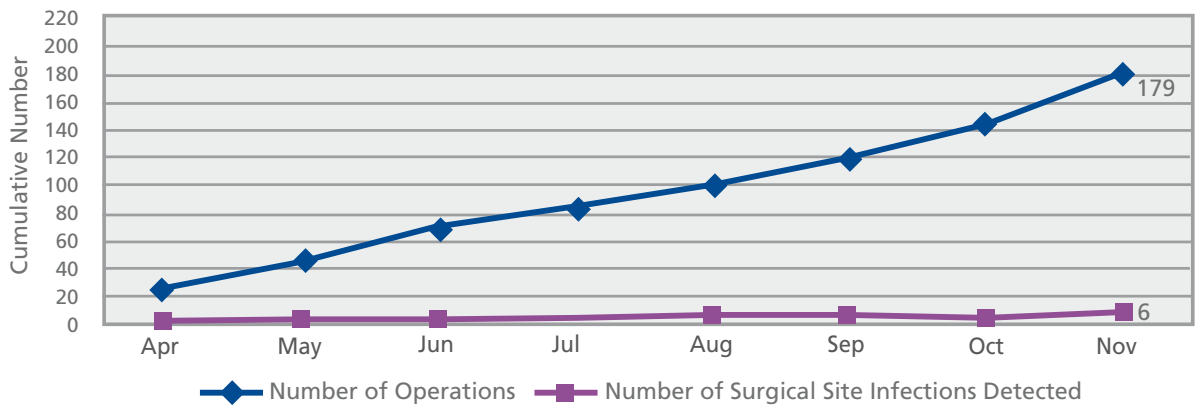
Graph 4 represents patients that underwent both elective and emergency Caesarean Section Surgery during October and November 2011. In total, 93 patients were included in the surveillance. Following the Health Protection Agency criteria a total of 21 patients were identified with a superficial post operative wound infection. None of the patients were deemed to have a deep seated wound infection. This represents an infection rate of 22.6%.

In comparison, for Caesarean Section surveillance completed for the period April 2010 – June 2010 a total of 118 patients were included with 14 patients identified with a post operative wound infection. This represents an infection rate of 11.9%.

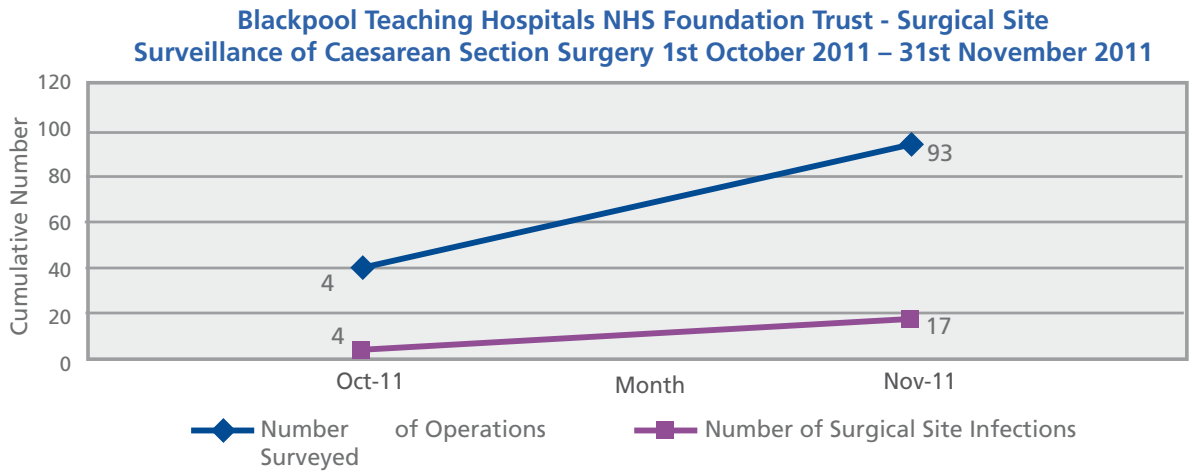
Graph 5 represents patients that underwent both elective and emergency vascular surgery during October and November 2011. In total, 51 patients were included in the surveillance. Following the Health Protection Agency criteria a total of 9 patients, were identified with a post operative wound infection; 1 of these was deemed as a deep seated wound infection and the other 8 were deemed superficial post operative wound infections. This represents an infection rate of 17.6%.

In comparison, for Vascular Surgery Surveillance completed for the period October 2010 – December 2010 a total of 51 patients were included with four patients identified with a post operative wound infection. This represents an infection rate of 7.8%.

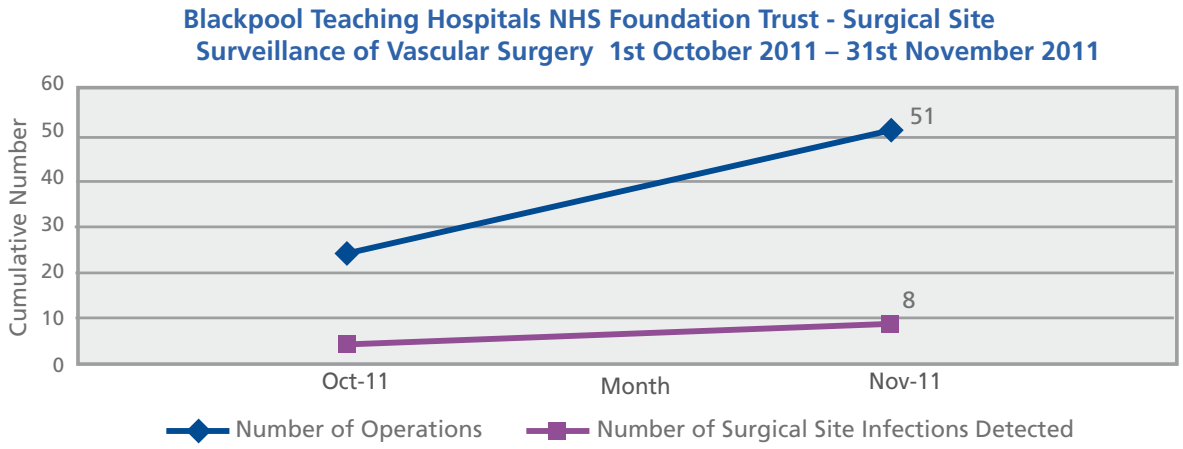
Graph 3



Graph 4



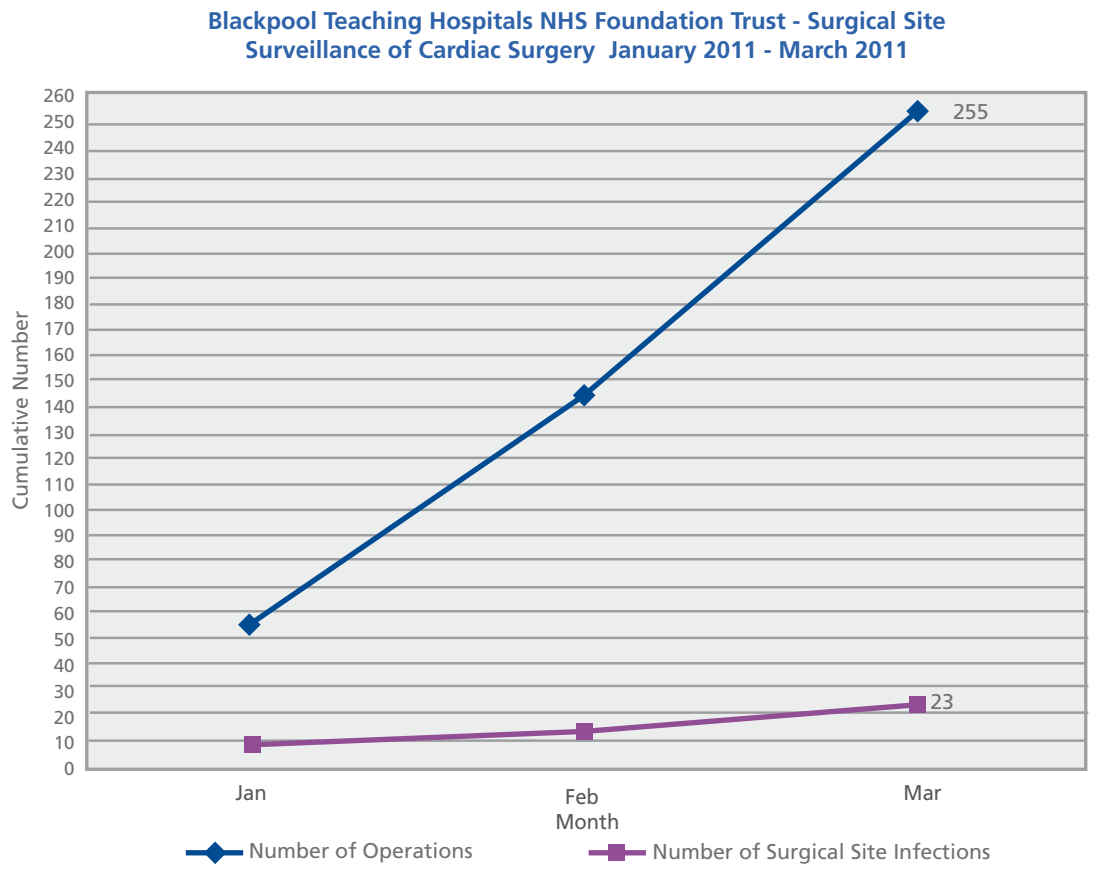
Graph 5



Graph 6 details the number of various different types of Cardiac Surgery operations performed together with the number of post operative wound infections during January 2011 – March 2011. The Trust has identified that there are improvements to be made for those patients who undergo surgery to have a Coronary Artery Bypass Graft (CABG). The Division has produced an action plan to reduce Surgical Site Infections and is working closely with the Infection Prevention Team. There has been a significant reduction in Surgical Site Infections during 2011. There is a full surveillance audit that has commenced in February 2012 for a three month period which audits the whole patient pathway to reduce Surgical Site Infections. This represents an infection rate of 9%.

In comparison, for Cardiac Surgery surveillance completed during April 2009 for one month only, 85 patients were included with 13 patients identified with a post operative infection. This represents an infection rate of 15.3%.

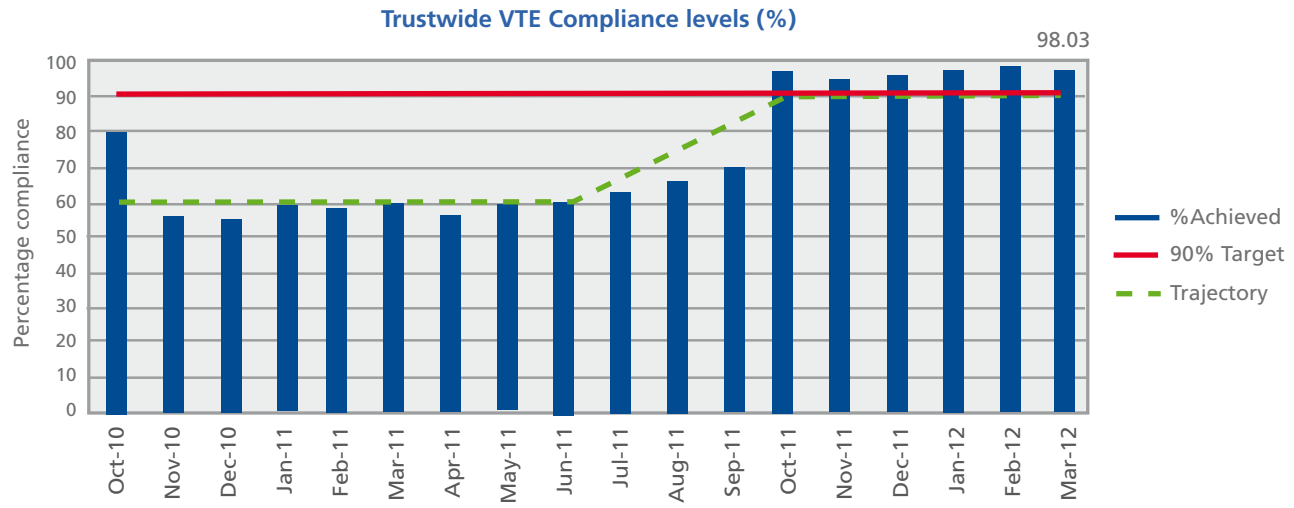
Graph 6



Further Embed And Improve The Implementation Of Venous Thromboembolism (VTE) Guideline Within The Trust

The Trust has aimed to implement current best practice guidelines in order to ensure that all adult inpatients receive a Venous Thromboembolism Risk Assessment on their admission to the hospital, and that the most suitable prophylaxis is instituted. The Trust has embedded and improved the implementation of VTE guidelines within the Trust and has demonstrated this by achieving above the 90% compliance indicator. From 1st April 2011 to 31st August 2011 the Trust did not achieve the VTE target, however from 1st September - 31st March 2012 the Trust achieved above 90% compliance due to the hard work, commitment and the actions taken by staff. Graph 7 shows the improvement in the number of risk assessments undertaken for adult patients on admission from 1st April 2011 to 31st March 2012. The Trust has established a Thrombosis Committee to implement and achieve compliance with the National Institute for Health and Clinical Excellence Venous Thromboembolism guideline (CG 92). These guidelines have been incorporated into easy to follow risk assessment forms across various specialties and are an integral part of clerking documents. This will not only ensure that VTE risk assessments are undertaken and embedded permanently in the admission pathway but also facilitates its documentation for subsequent analysis. The Thrombosis Committee monitors performance of individual clinical areas. An electronic assessment tool to give "live" information about compliance is in advanced stages of development and when rolled out will further improve performance. It will help us to give feedback to individual areas and address poor performance pro- actively.

Graph 7



Nursing Care Indicators Used To Assess And Measure Standards Of Clinical Care And Patient Experience

The Nursing Care Indicators are used as a measure of the quality of nursing care that is provided to patients during their stay in hospital. The framework for the nursing care indicators is designed to support nurses in understanding how they can deliver the most effective patient care, in identifying what elements of nursing practice work well, and in assessing where further improvements are needed. Our overall aim when introducing these measures is to reduce harm and to improve patient outcomes and experiences.

By benchmarking our nursing care across the Trust, we can increase the standard of nursing care that we provide, so that best practice is shared across all wards and departments. The measures are made visible in the ward environment and therefore by using this system we can ensure that accountability is firmly placed on the nurses providing bedside care. We have learned from this process and as a result have made significant reductions in patient harms. Compliance with nursing care indicators such as recording of observations and completion of risk assessments associated with the development of pressure ulcers have ensured that our frontline nurses can see the efforts of their work and make the link between the effective assessment and treatment of patients and improved outcomes. By improving the monitoring of vital signs we have reduced harms from deterioration and failure to rescue rates. By including the care of the dying indicators we have improved our referral times to palliative care services and the way that our staff interacts with relatives at this difficult time.

We have been observing nursing care using the Nursing Care Indicators for the past three years. The process involves a monthly review of documentation, ward environments and the nursing care delivered in each ward. The Associate Directors of Nursing closely analyse each area for trends and non-compliance and, where required, instigate improvement plans that reflect any changes in practise that may be required. The Trust recognises that it has set high standards to be achieved, with a target of 95% for all indicators.

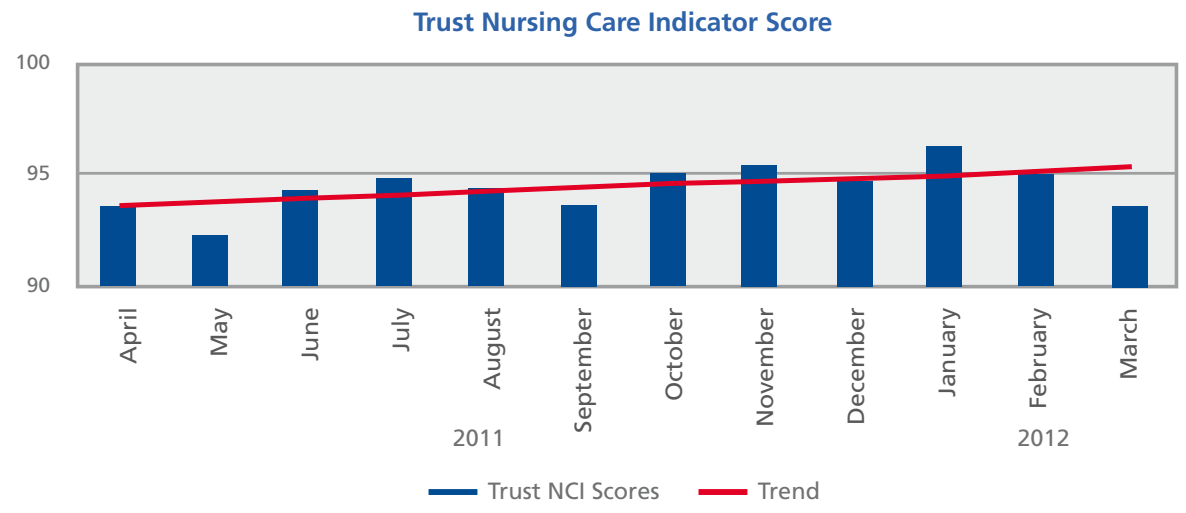
In the development of the Nursing Care Indicators, key themes for measurement were identified from complaints, the patients' survey, the Trust documentation audit, the benchmarks held within the essence of care benchmarking tool, and assessments against Trust nursing practice standards. Measurement of the Nursing Care Indicators is an evolving process and is subject to annual internal review to ensure the indicators reflect current best practice. During 2011, the Trust expanded them further into Neonatal and Endoscopy areas.

The following themes are measured monthly:

- Patient Observations
- Pain Management
- Falls Assessment
- Tissue Viability
- Nutritional Assessment
- Medication Assessment
- Infection Control
- Privacy & Dignity
- Care of the Dying
- Continence Care

Graph 8 shows the overall Trust performance, expressed as an average percentage of all 10 nursing care indicators, for 2011/12. The variation in scores seen is the type expected in a normal process. The trend clearly shows an overall improvement over the year.

Graph 8 1st April 2011 - 31st March 2012



Implement Nursing and Midwifery High Impact Actions To Improve The Quality And Cost Effectiveness Of Care.

The following information provides an overview of performance against the six High Impact Actions, which have been put in place to improve the quality and cost effectiveness of care. These High Impact Actions are in addition to the 10 Nursing Care Indicators.

High Impact Action 1 - Your Skin Matters

The aim of the High Impact Action (HIA) Your Skin Matters is 'no avoidable pressure ulcer in NHS provided care'. As a Trust we take the development of hospital acquired pressure ulcers seriously, and are working hard to reduce the incidence of these. Several initiatives have been undertaken over the last three years, from improved reporting, robust data analysis, staff education, set criteria within the nursing care indicators, introduction of intentional meetings with the Director of Nursing and Quality, Associate Directors of Nursing and Ward Managers to address areas that develop grade 4 hospital acquired pressure ulcers, which penetrates into the muscle. The purpose of these meetings has been to establish why these pressure ulcers occurred, and identify lessons learned in order to continuously improve patient safety. In addition the Trust participated in the safety node collaborative work which was led by Salford NHS Foundation Trust.

In addition to creating significant difficulties for patients, carers and families, pressure ulcers also increase the length of time spent in hospital and therefore cost to the Trust. The Trust is committed to reducing the prevalence of hospital acquired pressure ulcers and embedding cultural change through clinical ownership at ward level. To this end, pressure ulcer prevalence data is collected on a monthly basis and identified as a key performance indicator for each Division on a monthly basis. Incidence reports are generating a root cause analysis to be undertaken on all pressure ulcers. Support for staff at ward level is being provided in the assessment and prevention of hospital acquired pressure ulcers. The last 12 months have seen a 30% reduction in the number of hospital acquired pressure ulcers.

High Impact Action 2 - Keeping Nourished – Getting Better

The aim of the High Impact Action – Keeping Nourished – Getting Better is 'to ensure all patients receive a nutritionally adequate diet that is fundamental to their wellbeing and delivery of high quality care. The Trust recognises that malnutrition is a major cause and consequence of disease leading to worse health, delayed recovery, increased length of stay and increased financial cost to the NHS. In April 2011 the Trust demonstrated its commitment to improving the nutritional status of patients by launching its 'Nutrition Mission' – a 'rapid spread' campaign which is based on a Department of Health methodology, to provide the best possible nutrition for its patients. This is a multi-disciplinary approach that has resulted in many improvement initiatives being undertaken throughout the Trust through energising and engaging the ward staff and ensuring ownership of the care of their patients through sustained improvements, with the aim of ensuring that all patients are adequately nourished and hydrated. The Trust recognises that well-hydrated and nourished patients get better quicker, have a shorter length of stay and feeling nourished is a key to a positive patient and carer experience.

The Nutrition Mission has introduced evidence based care bundles at scale and pace across the whole organisation. Some of the improvements made include every inpatient having access to the correct food at the correct time, help with feeding where necessary and it is intended that no patient is malnourished whilst staying with us. This project has already seen food wastage reduced by more than 50%. Protected mealtimes have been reinstated with support departments e.g. X-ray adjusting their working patterns to work around patient mealtimes.

High Impact Action 3 - Staying Safe – Preventing Falls

The aim of the High Impact Action Staying Safe – Preventing Falls is to demonstrate a year on year reduction in the number of falls sustained by elderly patients whilst in NHS care. The Trust recognises that even a fall that causes no injury can cause a level of psychological damage to the patient and can result in a loss of confidence and independence which in turn can lead to the need for increased support from the NHS.

The last 2 years have seen an overall 20% decrease in the number of patient falls occurring as shown in Graph 9. The work of the Falls Prevention Group continues with multi-disciplinary representation across all divisions. The focus remains clearly on preventing harms occurring to patients in order to improve patient safety and the patient experience. A range of initiatives to prevent patient falls continue to be reviewed and implemented and include:

- Falls sensors have been introduced.
- Footwear and low bed trials are underway.
- Documentation has been revamped
- Intentional rounding, in the form of a safety bundle has been introduced into all clinical areas.

Intentional rounding is a checklist approach to check on all patients hourly to ensure they are receiving safe, harm free care. The intentional rounding tool covers all aspects of nursing care and enhances the care given, contributing to the reduction of harm. As a result Falls are reducing; in particular serious falls have significantly reduced. (Validate March data)

Complimenting the work we have already been undertaking to reduce patient harm and as part of our High Impact Action work, the Trust is a member of a North West "Transparency Project" set up in response to the Government's vision for greater transparency. We have been working to further reduce the harm that patients sometimes experience when they are in our care, and have made a commitment to publish a set of patient outcomes, patient experience and staff experience measures.

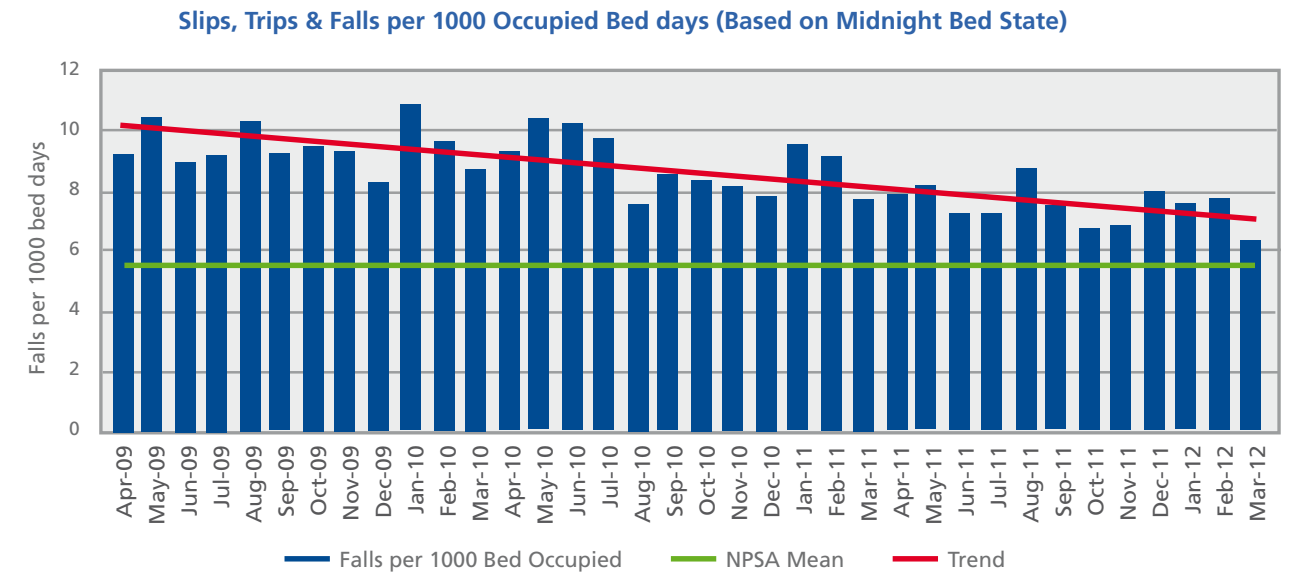
We have looked at the incidence of harm caused by grade 2, 3 and 4 pressure ulcers and falls that have resulted in a moderate or serious harm occurring, and then talked to patients and staff about the care that was provided on those wards. As a result of talking to patients and nurses and reviewing the care, the nursing teams are able to make changes so that all patients receive the care they need and have the best possible experience.

High Impact Action 4 - Promoting Normal Birth

The promotion of normal birth is a priority for the Maternity Department. The Caesarean section rate has continued to decrease, with a rate of 22.5% against a national average of 33% for 2011. The department has also seen optimum outcomes for both maternal and neonatal health. The introduction of the Vaginal Birth After Caesarean clinic has resulted in a 38% increase in successful vaginal births after a previous Caesarean section. As well as antenatal care and planning the ethos during labour has promoted mobility therefore improving the outcome and the experience. The Maternity Department are engaged in ongoing work to further the promotion of normal birth and these include:

- Use of aromatherapy
- Case review/incidents and good practice
- Staff training
- Family engagement in service changes.

Graph 9 1st April 2009 - 31st March 2012



High Impact Action 5 - Important Choices – Where to Die when the time comes

Please see section 2.1.3 for further information regarding this improvement initiative.

Advance care planning is the identification of a person's preferences regarding end of life care which are included in an advance care plan such as the Preferred Priorities for Care document. The individual's plan needs to be communicated to all those potentially involved in future care (e.g. Primary Care, Out of Hours providers). However there is as yet no agreed format as to how this information should be shared. The Information Standards Board has issued a notification to have in place electronic palliative care coordinating systems (locality registers) in place by December 2013. This would support the coordination of care between Primary, Secondary and Hospice and Social Care providers. However this is proving difficult to achieve. The Fylde Coast End of Life Care Steering Group have agreed to discuss the development of an electronic locality register with commissioners but in the meantime a national electronic register is in the process of being piloted.

High Impact Action 6 - Protection from infection

The Trust is committed to reducing the risk of infections for all patients. Policies and procedures are in place to ensure the risk of infection is minimised. Infection Prevention training and education is provided for all staff through Induction and Mandatory training. All patients admitted to the Trust are screened for Methicillin Resistant Staphyloccocus Aureus (MRSA) as per Department of Health guidelines.

High Impact Action 7 - Fit and Well to care

The Trusts actively focuses on the health and well being of our staff through the support by our occupational health department. We have extended the boundaries of our health and well being support from just support to return and remain at work to include projects on healthy lifestyle and overall well being with projects linking into weight watchers, fitness programmes, yoga and a holistic approach for all employees. We manage sickness and absence through a process of wellbeing meetings ensuring that we maintain regular contact with employees in order to facilitate their return to work and support them during extended period of sickness and absence. In addition we have also provided managers with an in-house sickness and absence management programme which provides them with the tools to manage sickness and absence proactively with empathy and support. The Nursing and Midwifery sickness and absence data for the period 1st April 2011 – 31st March 2012 is 3.84% which is just above the local target of 3.2%. This has demonstrated a reduction in sickness and absence in comparison to 4.2% in 2010/11.

High Impact Action 8 - Ready to go – No delays

A multidisciplinary team approach is facilitated throughout the discharge process to ensure safe timely and appropriate discharges from the hospital setting. We have established an estimated date of discharge process, agreed within 48 hours of admission, to ensure multiagency working and timely referral to agencies such as social services. We work in close collaboration with statutory and voluntary organisations (Age Concern, British Red Cross, Chloe Care) that support timely discharges whilst providing extra support for patients, particularly older patients and the vulnerable. We have a well established integrated discharge team with an implemented referral system of same day assessment provision. The rapid discharge processes are now established for End of Life patients and Early Supported Discharge programmes are also available for patients suffering from a Stroke and Coronary Obstructive Pulmonary Disease patients. Patients have access to rapid response and intermediate care services via the High Dependency Team and Social Service enablement also supports the discharge processes. We have established temporary nursing home placements to transfer patients to whilst completion of continuing health care processes are facilitated, which allows the patient to be in a nursing home setting rather than acute hospital environment. To co-ordinate information that may impact on effective discharge processes, we have implemented 'at a glance' boards on each ward so that any risk of harm that may need to be taken into consideration when planning care, planning the patient journey or planning discharge is easily identifiable.

2.1.3 Patient Experience

We will only be able to improve and maintain high quality services if we listen to the people who use our services and their carers. They are the experts in the care we provide and the Trust continually tries to learn from the experience of individuals to ensure we get it right first time, every time.

Improve the National Inpatient Experience Survey Results In The Following Six Areas

The National Inpatient Survey is undertaken on an annual basis by the Picker Institute, an independent organisation. Between the period October 2011 and January 2012 a questionnaire was sent to 850 recent inpatients. 410 patients responded. Table 10 shows a comparison of data for six indicators from 2008 to 2011 and progress remains consistent.

These indicators were chosen to be monitored since they relate to key issues that are of great importance to the Board and/or have been identified by our patients as of most importance to them.

Improvements to the indicators will be monitored on a monthly basis through the Nursing Care Indicators and this information will be presented to the Board of Directors on a monthly basis to monitor improvements made.

Table 10				
National Inpatient Survey				
Indicator	**2008 Result**	**2009 Result**	**2010 Result**	**2011 Result**
In your opinion, how clean was the hospital room or ward that you were in?	Very clean - 70% of patients stated that the hospital or room was very clean (national average was 60%) ↑	Very clean - 72% of patients stated that the hospital or room was very clean (national average was 65%) ↑	Very clean – 69% patients stated that the hospital or room was very clean (national average was 67%) ↑	Very clean – 70% patients stated that the hospital or room was very clean (national average was 66.4%) ↑
Were you given enough privacy when being examined or treated?	Yes always - 89% of patients stated that they were always given enough privacy when being examined (National average was 89%) →	Yes always - 91% of patients stated that they were always given enough privacy when being examined (National average was 89%) ↑	Yes always – 89% of patients stated that they were always given enough privacy when being examined (national average was 89%) →	Yes always – 88.8% of patients stated that they were always given enough privacy when being examined (national average was 88%) ↑
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	Yes always - 81% of our patients felt they were treated with respect and dignity whilst they were in hospital. (National average 80%) ↑	Yes always - 81% of our patients felt they were treated with respect and dignity whilst they were in hospital. (National average 80%) ↑	Yes always – 81% our patients felt they were treated with respect and dignity whilst they were in hospital (national average 81%) →	Yes always – 80% our patients felt they were treated with respect and dignity whilst they were in hospital (national average 78.1%) ↑
Were you bothered by noise at night from other patients?	Not Applicable	Yes – 37% of our patients were bothered by noise at night from other patients (National average 39%) ↑	Yes – 34% of our patients were bothered by noise at night from other patients (National average 40%) ↓	Yes – 35.6% of our patients were bothered by noise at night from other patients (national average 37.9%) ↓
Were you bothered by noise at night from hospital staff?	Not Applicable	Yes – 24% of our patients were bothered at night by noise from staff. Noise is a result of both general ward noise and staff dealing with patients. (National average 22%) ↑	Yes – 19% of our patients were bothered at night by noise from staff . Noise is a result of both general ward noise and staff dealing with patients. (National average 21%) ↓	Yes – 19.5% of our patients were bothered at night by noise from staff. Noise is a result of both general ward noise and staff dealing with patients. (National average 20.2%) ↓
How would you rate the hospital food?	Not Applicable	The majority of our patients rated the food highly with 34% rating it as very good and 40% as good (National average 21% very good and 36% good) ↑	The majority of our patients rated the food highly with 32% rating it as very good and 40% as good (National average 21% very good and 36% good) ↑	The majority of our patients rated the food highly with 26.6% rating it as very good and 41.7% as good (National average 21.1% very good and 34.8% good) ↑

Improve The National Outpatient Survey Results In The Following Four Key Areas

The Trust was not required to complete the National Outpatient Survey for 2010/2011 and the next National Outpatient Survey will be undertaken in 2013. However, in relation to the four key areas for improvement that were identified in the 2010/2011 National Outpatient Survey Results, improvements have been undertaken as described in the progress section identified in Table 11.

Table 11

National Outpatient Survey

Indicator	2009 Results	2010 Results	2011/12 Progress/Actions Being Taken
No copies of GP letters provided to patients	21% National Average 27%	45% National Average 33%	Several areas of the Trust routinely give patients copies of all letters once they have requested them. Some areas have found when this is routinely done, patients do not understand the language used and this caused more distress and upset to the patients and their families.
Poor information provided to patients in relation to their clinical condition	38% National Average 45%	79% National Average 81%	Over 300 information leaflets for diagnosed conditions and operations, including the relevant risks and benefits, have been created. A Nurse Practitioner triage service is in place in the outpatients department to offer specialist advice, information and care to all surgical patients. Supernumerary team leaders are in post to ensure that patients who require further advice are seen before leaving the clinic
Poor information provided to patients in relation to their clinical condition	38% National Average 45%	79% National Average 81%	A "discharge from clinic" booklet is being developed to provide patients with appropriate information and points of contact for the future if required. A pre-written consent form is being development for all surgical specialties including urology and orthopaedic surgery, providing details of risks and benefits of surgery.
Poor communication – staff not introducing themselves / Lack of information regarding waiting times and delays in clinic	66% National Average 71%	61% National Average 66%	The Trust has employed a dedicated Professional Development Nurse to enhance training, including customer care training and this is being rolled out to all staff. Regular audits will be developed to monitor this. All staff will be expected to introduce themselves to patients. This is being audited on a daily basis by the team leaders. A Nurse Practitioner service is now in place to offer advice and care to all surgical patients.
Lack of time to discuss health issues	71% National Average 76%	69% National Average 75%	The outpatients' team have started to undertake some focused face to face questioning of patients within the outpatients department to understand the issues that affect them and the care that mattered to them. Once this is complete a more details action list will be developed in order to enhance the care delivered to patients within the outpatients department.

Patient Environment Action Team (PEAT) Survey

To Improve PEAT Survey Results/ Standards

Our aim is to deliver the best environment for our patients to ensure that the patient experience exceeds the standards set by the National Patient Safety Agency. Providing a clean and safe environment for our patients is extremely important to the Trust. We monitor this through the Patient Environment Action Team (PEAT) annual audits across all hospital sites.

The teams comprise a multidisciplinary team, including a patient's representative and an external PEAT assessor who conduct annual audits regarding the quality of standards we provide to our patients. The key areas which are audited are:

- Cleanliness
- Specific bathrooms/toilet cleanliness
- Catering Services
- Environment
- Infection Prevention
- Privacy and Dignity
- Access all external areas

The audit follows guidelines set by the National Patient Safety Agency and the results are publicised nationally on an annual basis. In 2011/12, PEAT audits were extremely encouraging across all hospital sites resulting in excellent standards achieved. The results in Table 12 demonstrate the commitment and dedication of all staff within the Trust who strive to ensure that the patient experience is met or exceeded during their stay in our hospitals.

Table 12

Patient Environment Action Team (PEAT) Survey Results

Site	Overall Rating 2009/2010	Overall Rating 2010/2011	Overall Rating 2011/2012
Victoria Hospital	Good	Good	Excellent
Clifton Hospital	Excellent	Excellent	Excellent
Bispham Nurse Led Unit	Excellent	Excellent	Excellent
Wesham Rehabilitation Unit	Excellent	N/A	N/A
Rossall Rehabilitation Unit	Excellent	Excellent	Excellent

Liverpool Care Pathway for the Dying Patient

Seeking Patients and Carers Views to Improve End of Life Care

The Trust continues to recognise the importance of providing high quality care to all patients at the end of their lives. We have been working hard to improve the care we provide during this often very difficult period for patients and their carers, families and friends. Key to improving quality in the End of Life care is our strong working relationship with our local Primary Care Trusts and Trinity Palliative Care Services to ensure continuity and coordination of care for patients and their families.

The Bereavement and Carer Group within the Trust has designed and implemented a questionnaire that is offered to all bereaved families after death to allow us to obtain feedback about the quality of our services and areas for further improvement. To date feedback on the care provided to patients and their families has been generally positive. Where this is not the case, the Bereavement Coordinator has contacted the family (where identified) to discuss their comments so that we can make improvements in our care.

Further quality improvements include:

- Development of a Rapid Discharge Pathway at the End of Life. Many patients spend the last days of their life in hospital even when hospital based care is no longer appropriate nor wished for by the patient and their family. In quarter 3 (October 2011 - December 2011) patients who were felt to be within their last few days of life were safely discharged home at their request within 4 hours of their admission, with their care taken over by community teams. A further 57 patients were discharged either home or to a nursing home, depending on their preference, within 24 hours. The numbers of patients being cared for using the rapid discharge process has increased each quarter since the service was launched.

- The Liverpool Care Pathway (LCP) for the Dying Patient continues to be used across our hospitals. It is nationally recognised as the most appropriate pathway available to support clinical staff when caring for patients who have reached the final stage of their lives, to follow evidence based good practice in the care of patients and to ensure the same high quality care is provided to all. With ongoing training and support provided by our Trust End of Life Project Coordinator and Trinity Palliative Care Specialist Nurses, we have seen the proportion of pathways used increase to almost 35% of all deaths within the Trust. We have also participated in the 2nd round of the National Care of the Dying Acute Hospitals (NCDAH) Audit and are currently utilising the information obtained to drive forward both the use of the LCP and also the quality of the documentation within it.

- Training is crucial to ensure ongoing improvement and increase staff confidence and competence in the End of Life Care. In September 2010, a 6 month training pilot started on 2 medical wards within the Trust and includes the following 4 key areas to support End of Life Care: symptom control, communication skills, advanced care planning and holistic assessment. This pilot has led to the completion of a Trust wide training needs analysis and the development of a modular training programme is now in progress.

- The Trust's Bereavement and Carers Group continues to monitor and develop bereavement care. As part of this group the Bereavement Care Development Officer has been working on four main work-streams:
  1. The development of a 'care after death pathway' to document all care of the deceased person
  2. The dignified introduction of body bags with training for staff in their use
  3. The introduction of a bereavement care questionnaire given to the bereaved via the general office. This questionnaire is providing valuable and up to date information on the experiences of the bereaved.
  4. The development of bereavement standards for wards to commit to, ensuring effective and dignified care for the deceased, their families and next of kin.

- Additionally the Trust continues to provide memorial services for the bereaved and has also built modern viewing facilities in the new mortuary.

- The Trust has two identified members on the Fylde Coast End of Life Care Steering Group. This group was given the mandate to develop End of Life Care services across the Fylde Coast health community by the Fylde Coast Unscheduled Care Board.

Ensure that patients who are known to be at the end of their lives are able to spend their last days in their preferred place

The Trust has agreed to pilot the Amber Care Bundle. This is a tool that has been developed nationally as part of the 'Routes to Success' work being coordinated by the National End of Life Care team and aims to identify patients in the 'amber' stage of the North West End of Life Care model. The pilot commenced in March 2012 and piloted on two respiratory wards and two care of the elderly wards. The pilot will necessitate increased use of the Preferred Priorities for Care document.

Ensure Single Sex Accommodation Is Available for Patients To Ensure Privacy And Dignity Whilst In Hospital

Blackpool Teaching Hospitals NHS Foundation Trust is pleased to confirm that we continue to be compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice. We have the necessary facilities, resources and excellent staff culture who champion this requirement to ensure that patients who are admitted to our hospitals will not share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in emergency or critical care areas), or when patients actively choose to share.

The Trust has had five breaches in 2011/12 compared to two breaches in 2010/11 - breach of timescales in transferring patients out of critical care areas to ward areas. Monthly spot audits continue with Commissioners and members of Blackpool LINks who regularly monitor the Trust for single sex accommodation as they believe this is a good marker for privacy and dignity and will remain a contractual requirement in 2012-13. Posters and patient leaflets are in all ward areas to inform patients and relatives defining what the elimination of mixed sex accommodation means to them, patients are also asked about their experiences within the monthly patient experience surveys.

If our care should fall short of the required standards, we will report it. We will also establish an audit mechanism to make sure that we do not misclassify any of our reports. We also publish the results of these audits on our website www.bfwhospitals.nhs.uk.

2.1.4 Patient Safety

We know that our service must not only be of high quality and effective, but that they must always be safe. We have a range of processes and procedures to ensure that safety always remains a top priority.

Reduce the Trust's Hospital Mortality Rate

The Trust has worked with an independent benchmarking company over the last five years to track hospital mortality rates and take action where rates have been seen as high. Over the period, we have implemented a range of actions to reduce our mortality rates and over the last 12 months have introduced a further set of actions. These include:

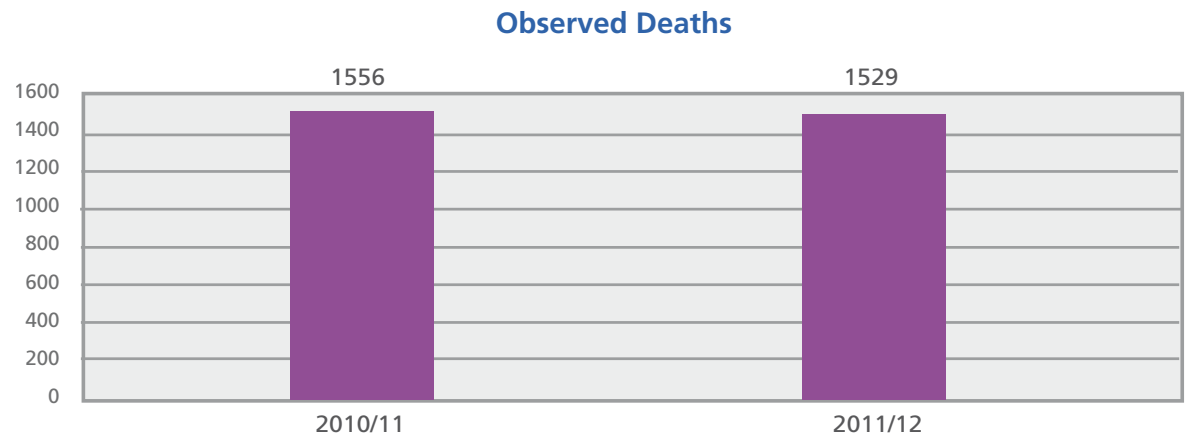
- A process of consultant sign-off for coding of deaths. The purpose of this is to ensure that the final diagnosis attributed to a patient accurately reflects the prevalent condition. This allows us to identify areas of high mortality and plan appropriate action.
- The roll-out of a mini 'Alert' course for all clinical staff as part of mandatory training. The aim of this is to improve the response to early warning scores and evidence of physiological deterioration.
- Consolidation and expansion of the Trust Mortality Board which meets bi-monthly and is chaired by the Medical Director.
- Establishment of monthly Divisional mortality meetings.

At the same time we have maintained our focus on harm reduction strategies such as reducing medical outliers (medical patients receiving treatment on non-medical wards), hospital acquired infections and medication errors. Progress on all these objectives has been reported to the Board on a regular basis. The emphasis has been on improving processes so that the improvements are local, measurable and immediate and are owned by the team providing the care.

The Trust has shown a sustained improvement in its Risk Adjusted Mortality Index (RAMI) over the last three years and the RAMI remains below the predicted figure of 100. However other measures of hospital mortality including the Hospital Standardised Mortality Index (Dr Foster) and the Summary Hospital Mortality Indicators (SHMI) have shown mortality rates higher than the expected and in response to them the Trust has commissioned AQuA to undertake an independent external review of hospital mortality. Following the review, an action plan has been developed and progress monitored by the Board on a regular basis to ensure improvements are made. Graph 10 below shows our progress on our risk adjusted mortality Trust trend.

The improvement in our RAMI rates reflects a lot of hard work in many areas. The Trust has been part of a North West Collaborative Programme for mortality reduction and has implemented programmes specifically around the care of patients with pneumonia and patients with severe sepsis. In addition to this work hospital mortality has been improved by the implementation of harm reduction strategies including reduction in hospital acquired infections, progress on reducing Venous Thromboembolism (VTE), strict adherence to quality measures as part of the North West Advancing Quality initiative and improving the management of deteriorating patients.

Graph 10 1st April 2010 - 31st March 2012

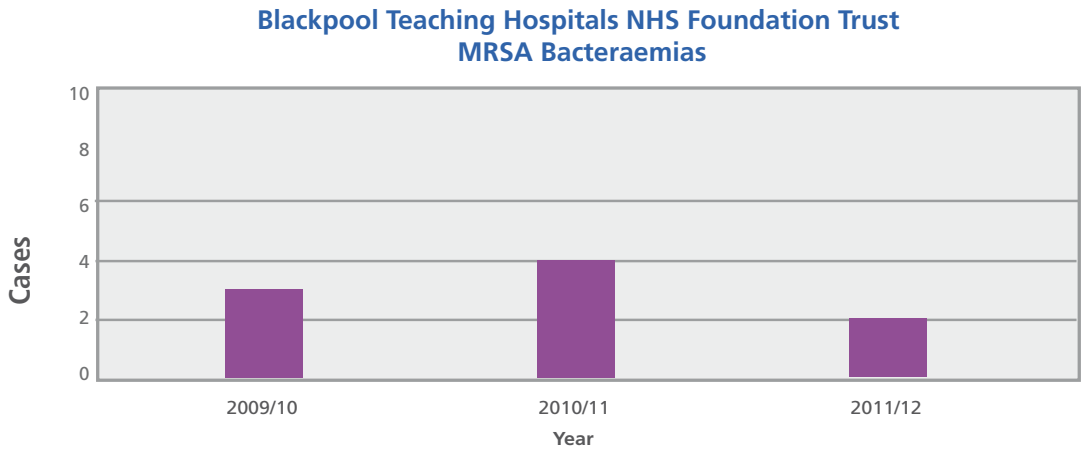


Reduce Methicillin Resistant Staphylococcus Aureus (MRSA) Infection Rates As Reflected By National Targets

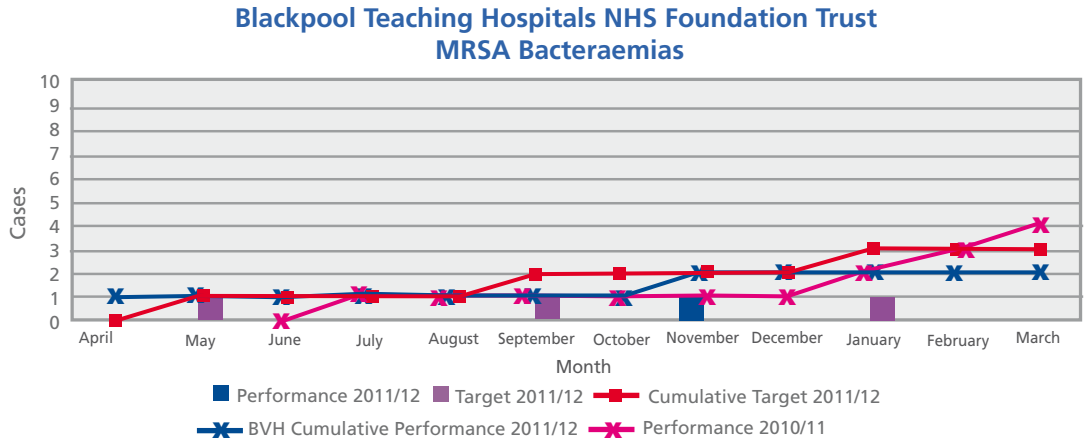
Following the significant reductions in Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia by 92% for the Acute Trust when compared to 2007/08, the Trust has continued to make tremendous progress in the last few years and embed Infection Prevention principles across the organisation, ensuring that the risk of acquiring an infection for patients is further reduced as shown in Graph 11 and 12.

The delivery of the MRSA Bacteraemia target remains a clinical risk, in relation to Monitor's Compliance Framework which identifies an MRSA trajectory of 3 cases for the reporting period. The Trust has reported 2 cases for this year, which is under the trajectory remaining within Monitor's Compliance Framework target, as detailed in Graph 11 and 12. Information on how the criteria for this indicator has been calculated is detailed in the Glossary of Terms.

Graph 11 1st April 2009 - 31st March 2012



Graph 12 1st April 2010 - 31st March 2012



Reduce Clostridium Difficile Infection Rates As Reflected By National Targets

Clostridium Difficile is an organism which may be present in approximately 2% of normal adults. This percentage rises with age and the elderly have colonisation rates of 10-20%, depending on recent antibiotic exposure and time spent in an institution. Symptomatic patients are those whose stools contain both the organism and the toxins which it produces, and have diarrhoea. Those patients who are most at risk of acquiring Clostridium Difficile diarrhoea are the elderly, those on antibiotic therapy and surgical patients. Antibiotic administration is the most important risk factor for Clostridium Difficile diarrhoea, which is also known as Antibiotic Associated Diarrhoea. The clinical features of Clostridium Difficile infection can range from diarrhoea alone, to diarrhoea accompanied by abdominal pain and pyrexia to pseudo membranous colitis (PMC) with toxic megacolon, electrolyte imbalance and perforation. Following the significant reductions in Clostridium Difficile Infection (83.59% for the last five years for the Acute Trust from 2007/2008) the Trust has continued to embed measures to reduce levels further within the organisation.

There have been 53 cases of Clostridium Difficile Infection (CDI) attributed to the Acute Trust between April 2011 and March 2012, in comparison to 101 for the period April 2010 to March 2011, demonstrating a reduction of 47.52% The Trust was required to achieve a trajectory of 86, a reduction of 14.85% on Clostridium Difficile rates from the 2010 -11 level, by March 2012 as shown in Graph 13 below. Information on how the criteria for this indicator has been calculated is detailed in the Glossary of Terms.

Reduce Patient Harms

Global Trigger Tool to Be Used To Measure Adverse Events

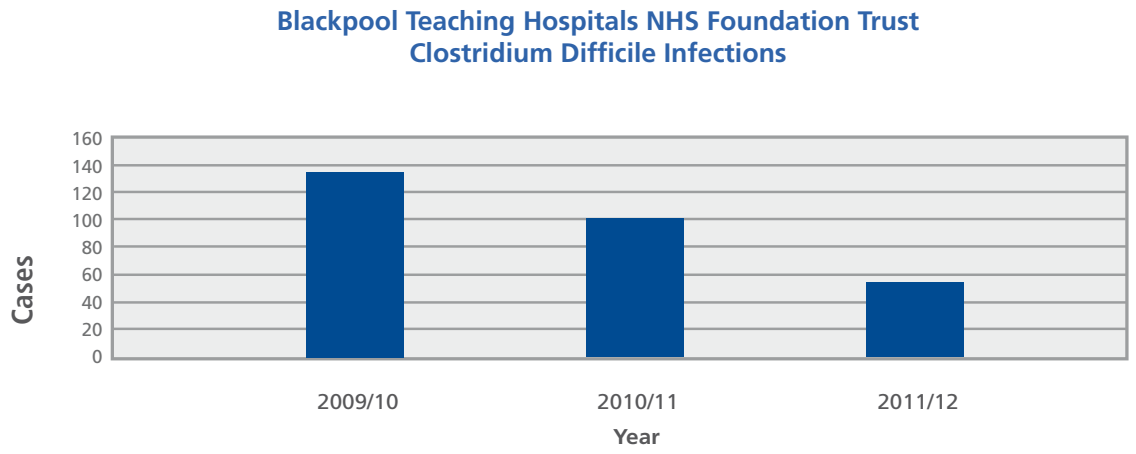
Traditionally the Trust's efforts to detect and deal with adverse events have focused on reporting and tracking of errors. However, research published by the Institute for Healthcare Improvement has shown that only 10 to 20% of errors are reported and of those, 90 to 95% cause no harm to patients. The Trust has therefore decided to adopt the Institute for Healthcare Improvement Global Trigger Tool to measure adverse events. The Global Trigger Tool (GTT) is a method of measuring events of harm that may happen to a patient during their admission and stay in an acute hospital. It is an easy-to use method for accurately identifying events that cause harm to patients and measuring the rate at which they occur. It also provides information on whether changes being made in response to adverse incidents are improving safety.

The Global Trigger Tool team is a multidisciplinary team of 5 Senior Nurses and 2 Consultants from across the Divisions who have reviewed over 400 patient case notes in order to establish the level of harm occurring to patients, identify the themes of harm, and recommend and institute improvement programmes.

Our teamwork over the past 18 months has provided the Trust with its first opportunity to accurately identify and quantify the triggers to and causes of harm occurring to our patients. Therefore we can direct real improvements to be made in patient safety.

The methods employed are a retrospective review and scoring system of a randomly selected sample of patient case notes to identify triggers to or actual harm occurring in either the active delivery of healthcare (commission) or in substandard care (omission). A quarterly report is produced and submitted to the Board for monitoring results.

Graph 13 1st April 2009 - 31st March 2012



Our results in Graph 14 to date shows a reduction in the number of harms occurring to patients who have been contributed to by the programmes we have proposed, together with greater awareness for patient safety that our teamwork has delivered. The following issues and interventions have been identified and addressed to improve the quality of care to our patients as a result of the findings of the team:

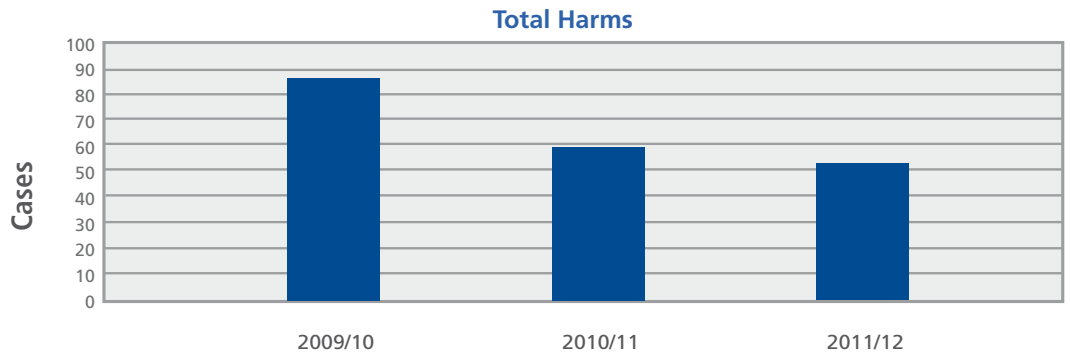
- Regular presentation of results, key findings and recommendations to the Board, as well as senior medical and nursing staff
- Regular presentation of key cases and learning points at mortality grand rounds for education of all Trust staff
- Identified a lack of senior medical review as a key factor with omissions in patient care
- Identified potential millions of pounds in savings by the reduction in levels of patient harm leading to reduced length of stay
- Recurring themes such as inadequate venous access, falls, pressure ulcers and medication errors are areas for attention
- Safety issues regarding infections incorporated into the Trust wide "Surviving Sepsis" campaign
- Focus on Trust wide documentation on Early Warning Score - a recurrent theme in omission of care
- Requested a change in x-ray documentation - approved by the Ionising Radiation Medical Exposure Regulations (IRMER) Radiology group and is now in use
- Development of administration of medicines / medicines management programme which incorporated leadership and change processes - delivered to ward managers, foundation year doctors, student doctors and nurses
- Blood transfusion policy revisited
- Bedside light maintenance commenced to facilitate bedside blood and drug checks
- Initiation of 'Recognise and Act - managing the deteriorating patient course" - successfully added to mandatory training for every Trust Registered Nurse and Midwife to attend
- Initiated Trust-wide pressure ulcer prevention project
- Trust-wide Implementation of Situation Background Assessment Recommendations (SBAR) safety communication tool

Graph 14 shows the total number of harms discovered per twenty sets of patient case notes reviewed each month.

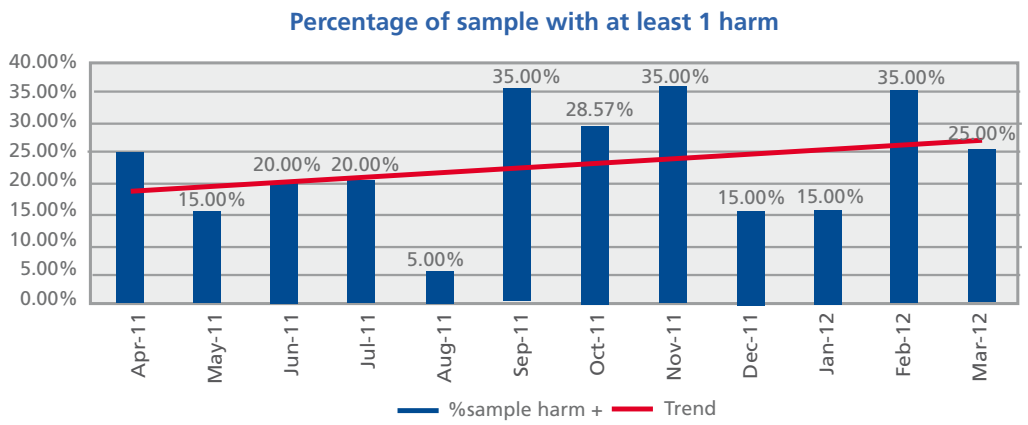
Graph 15 compares the total number of harms discovered per twenty sets of patient case notes each month over the last year.

Graph 16 shows the number of harms discovered at the review scaled up to reflect the number of harms that could be expected per 1000 bed days. For example, in March 2012 the number of harms discovered in the patient case note review divided by the number of bed days that the reviewed cases stayed in hospital was around 0.02. This equates to around 20 harms per 1000 bed days.

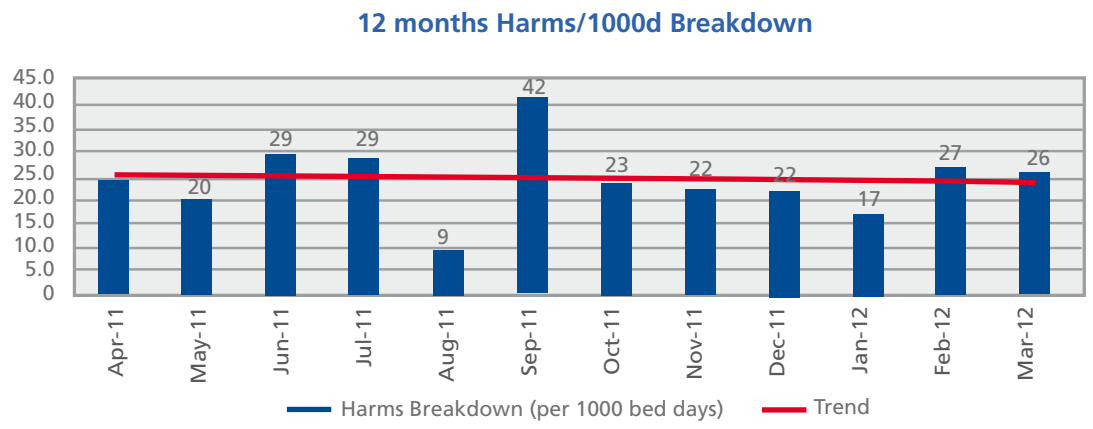
Graph 14 1st April 2009 - 31st March 2012



Graph 15 1st April 2011 - 31st March 2012



Graph 16 1st April 2011 - 31st March 2012



Reduction Of Falls By 30%

Patient falls are one of the most common patient safety incidents reported. The majority of slips, trips and falls result in low or no harm to patients physically. However, any slip, trip or fall can result in the patient losing their confidence. There have been significant improvements within all areas of the Trust in reducing the numbers of falls as shown in Graph 17 and 18 below. There have been a number of initiatives introduced during 2011/12 which have contributed to the downward trend of a 20% reduction in the number of patient falls that has been demonstrated over the last 2 years in the number of falls each month.

- There has been intensive support and training given to wards within both the Scheduled and Unscheduled Divisions to improve the quality of falls risk assessment and the formulation of a care plan for patients at risk of falling. This has resulted in a significant improvement in the standard of care plans and an overall reduction in the number of falls.
- The Trust has introduced movement sensors in all the clinical divisions, both on the acute wards and in the community hospitals, for patients who are identified to be at high risk of falling. The sensors are discreet and can be placed either under the mattress of the bed, or on the chair if the patient is sitting out of their bed. The sensors alert the ward nurses via a pager system if a patient attempts to get out of bed or move from the chair unaided. The sensors have already helped prevent potential injury to patients as the nursing staff have been alerted swiftly and assistance given.
- Intentional rounding in the form of a safety bundle has been introduced across all clinical areas to ensure that any patient who is at high risk of falling is visited at least once every hour. This has been proven to help reduce the risk of patients attempting to mobilise unaided as they know a member of staff will regularly attend to their needs.
- Low beds are being trialled with a view to introducing them to prevent falls for at risk patients.
- A footwear trial is currently in progress
- Documentation has also been reviewed

There has been an overall reduction in the number of slips, trips and falls over the last 12 months as demonstrated in Graph 17. Graph 18 also demonstrates an overall reduction in the number of serious falls from 1st April 2009 – 31st March 2012. Measures have been put into place as outlined above and it is anticipated that the Trust will continue to see a downward trend for serious patient falls.

Reducing Medication Errors By 50% By 2011/12

The Pharmacy Department continues to actively engage all professionals in the safe management of medicines within the Trust. Safe medicines management ensures that the patients within our care receive their prescribed medication without exposure to risk or injury. Medicines are an integral part of modern disease management, whether they are used for prevention, treatment or alleviation of symptoms. The volume of medicines prescribed and their cost is increasing each year. It is estimated that over 700 million prescription items are dispensed in England each year at a total cost approaching £8 billion.

Nationally incidents involving medicines between July 2010/11 and March June 2011/12 are the second largest group (11%) of all incidents reported to the National Reporting and Learning Service (NRLS) after patient accidents (28%) and treatment and procedures (10%) from a total of 1,256,955 incidents of all types reported. For the same time period, analysis of the data relating nationally but specifically to Large Acute General Hospitals highlights that medication error is the third largest group (12%) of all incidents reported to the National Reporting and Learning Service (NRLS) after patient accidents (28%) and treatment and procedures (13%) from a total of 898,934 incidents of all types reported.

Medication incident reports are those which actually caused harm or had the potential to cause harm involving an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicines advice. The most frequently reported types of medication incidents involve:

- wrong dose
- omitted or delayed medicines
- wrong medicine

The number of medication errors continue to be reported as detailed in Graph 19 below. Graph 20 identifies a comparison of medication errors from 2009/10 to 2011/12. The Trust is continually raising awareness to staff of safe medicines management and the commitment of staff to ensure that patients receive prescribed medicines safely is a priority in all wards and departments.

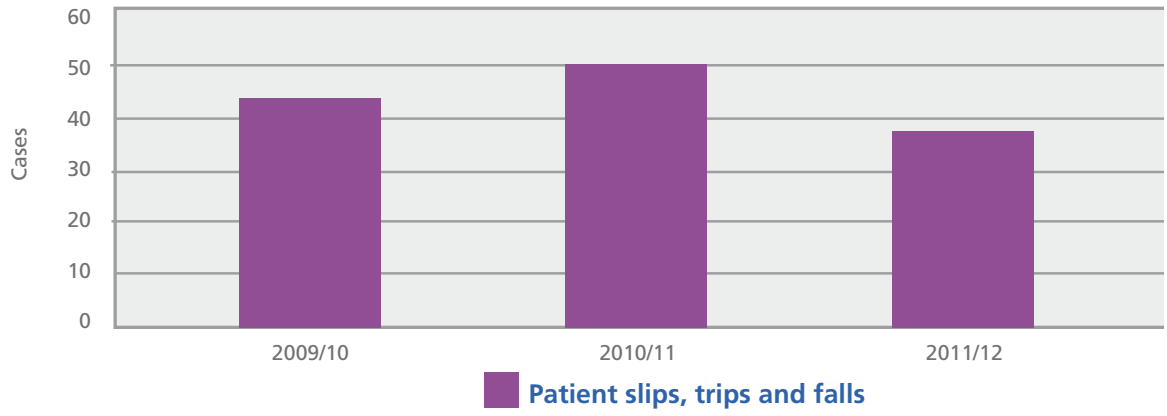
Further improvements need to continue to be made and this will include the development of administration of medicines / medicines management programme which incorporates leadership and change processes and is delivered to ward managers, foundation year doctors, student doctors and nurses.

The Medicines Management Team continue to work collaboratively, combining the knowledge and experiences of the Lead Pharmacist for Risk Management and the Medicines Management Specialist Nurse for Pharmacy to ensure that National Patient Safety Agency (NPSA) recommendations in relation to medicines are implemented and sustained within practice in all areas.

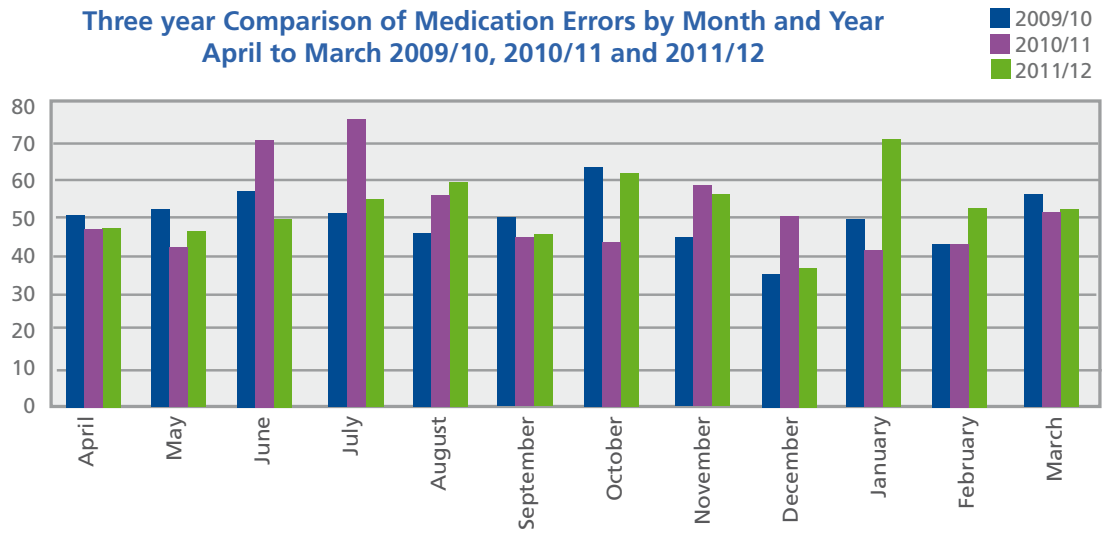
The number of NPSA alerts continues to increase and the Medicines Management Team has ensured that all alerts and associated deadlines for changes in practice have been met. This ensures that the Trust can declare compliance with the NPSA alerts, and demonstrate robust and comprehensive audit procedures undertaken by the Medicines Management Team that monitor sustained compliance and safety within all aspects of Medicines Management.

Graph 17 - Patient Slips, Trips and Falls 1st April 2009 - 31st March 2012

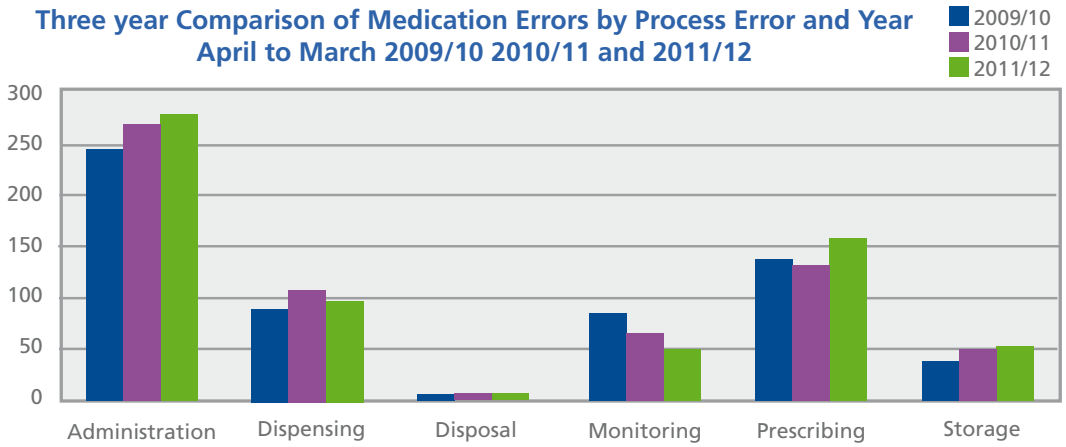
Graph 18 - Patient Slips, Trips and Falls 1st April 2009 - 31st March 2012



Graph 19 - Medication Errors



Graph 20 - Medication Errors



Medicines Management educational support and training is now available in multiple formats, this ensures that staff are knowledgeable and competent to manage medicines safely. Along with the introduction of a workbook to the lectures, it is anticipated that the E-Learning module will be available shortly. The training programme is now mandatory within the Trust and includes all staff groups that are authorised to handle medicines as part of their role.

Work continues within the Trust to ensure that patients receive the appropriate information and advice regarding their medications whilst in hospital.

Community Health Services Priorities for Improvement

It has been confirmed that the Trust will provide Community Health Services on 1st April 2012. In preparation for this, an overview of performance of the Community Health Services priorities for quality improvement that were included in the 2010/11 quality report can be accessed from the link below. A copy of NHS Blackpool and NHS North Lancashire Teaching Primary Care Trust Quality Accounts reports 2011/12 can be accessed from the NHS Choices website via the following link: www.nhs.uk

2.1.5 Priorities for Quality Improvement in 2012/13

The Trust has identified 3 key elements in the quality of care it delivers to its patients. These are:

- Clinical Effectiveness of Care
- Quality of the Patient experience
- Patient safety

Rationale for the Selection of Priorities in 2012/13

Additional quality improvement priorities for 2012/13 have been identified as detailed below in Table 13 in bold italics.

The following information provides an overview of the quality of care and the rationale for the selection of priorities for improvement in 2012/13. It is important to note that as a result of our continuous review of services throughout the year in conjunction with our key stakeholders, governors and staff and after consultation at Board level, the following quality improvement priorities for 2012/13 were proposed and agreed by the Board of Directors which it believes will have maximum benefits for our patients. These are reflected in the Trust's Corporate Objectives 2012/13 which are available on the Trust's website www.bfwhospitals.nhs.uk

These quality improvement priorities are also reinforced by the standards outlined in the NHS Outcomes Framework 2012/13 five domains of quality which set out the high-level national outcomes that the NHS should be aiming to improve. Domains one to three include outcomes that relate to the effectiveness of care, domain four includes outcomes that relate to the quality of the patient experience and domain five includes outcomes that relate to patient safety. The following two additional quality improvement priorities have been selected due to these being reinforced by the standards outlined in the NHS Outcomes Framework 2012/13:.

Enhancing quality of life for people with Dementia

- Improve the outcome for older people with dementia by ensuring 90% of patients aged 75 and over are screened on admission.

The Trust is working to ensure that 90% of patients aged 75 and over are screened on admission to ensure that patients with a diagnosis of Dementia are prescribed appropriate medication and treatment

Improving outcomes from planned procedures

- Patient Reported Outcome Measures (PROMS)

Improve the scores for the following elective procedure

i) Groin hernia surgery
ii) Varicose veins surgery
iii) Hip replacement surgery
iv) Knee replacement surgery

The reason why PROMs have been selected is that they are measures of a patient's health status or health-related quality of life. They are typically short, self-completed questionnaires, which measure the patients' health status or health related quality of life at a single point in time. The health status information collected from patients by way of PROMs questionnaires before and after an intervention provides an indication of the outcomes or quality of care delivered to NHS Patients.

Other indicators have been selected in view of Monitor's proposal to include national quality indicators relevant to the services we provide to be included in the Quality Accounts for the 2012/13 reporting year and for organisations to provide a commentary covering performance activity within the report. In view of the proposed core set of quality indicators, the Board has agreed to include the majority of these indicators in the 2012/13 quality report which are highlighted in bold italics in Table 13. The Board will also review those proposed indicators that have not been included in the 2011/12 report to identify the most suitable process for the indicators to be monitored via other reporting systems within the Trust. This is in the event that they may become mandatory indicators for the 2012/13 Quality Report.

It has been confirmed that the Trust will provide Community Health Services on 1st April 2012. Therefore both Hospital and community health services priorities for quality improvement for 2012/13 have been selected and agreed by the Board and integrated into the priorities for improvement for the enlarged organisation detailed in Table 13 and highlighted in bold italics. This is with the expectation of reporting on these in the Annual Quality Report 2012/13.

Table 13: Priorities for Quality Improvement			
Priorities for Improvement 2012/13			**Indicators for Quality Improvement 2012/13**
National Level NHS Outcomes Framework Domains of Quality	**Trust Level**	**Key Elements in the Quality of Care**	
Domain 1: Preventing people from dying prematurely (NHS Outcomes Framework, DH 2012/13)	To Provide Best In NHS Care For Our Patients	Clinical Effectiveness of Care	Reduce premature mortality from the major causes of death - Reduce 'preventable' mortality by reducing the Trust's hospital mortality rates / ***Summary Hospital Mortality Indicators*** North West Advancing Quality initiative that seeks compliance with best practice to improve patient outcomes in seven clinical areas: – Acute Myocardial Infarction – Hip and Knee Surgery – Coronary Artery bypass graft surgery – Heart Failure – Pneumonia – Stroke – ***Patient Experience Measures*** Implementing 100,000 Lives and Saving Lives Programme: – Reducing the incidence of surgical site infections.
Domain 2: Enhancing quality of life for people with long-term conditions (NHS Outcomes Framework, DH 2012/13)	To Provide Best In NHS Care For Our Patients	Clinical Effectiveness of Care	***Enhancing quality of life for people with dementia*** - ***Improve the outcome for older people with dementia by ensuring 90% of patients aged 75 and over are screened on admission***
Domain 3 Helping people to recover from episodes of ill health or following injury (NHS Outcomes Framework, DH 2012/13)	To Provide Best In NHS Care For Our Patients	Clinical Effectiveness of Care	Improve referral to treatment times for patients who suffer a Trans Ischemic Attack (TIA) Nursing Care Indicators used to assess and measure standards of clinical care and patient experience. Implement Nursing and Midwifery high impact actions to improve the quality and cost effectiveness of care ***Improving outcomes from planned procedures*** - ***Improve Patient Reported Outcomes Measure (PROMs) scores for the following elective procedures:*** ***I Groin hernia surgery*** ***Ii Varicose veins surgery*** ***Iii Hip replacement surgery*** ***Iv Knee replacement surgery*** ***Reduce emergency readmissions to hospital (for the same condition) within 28 days of discharge***

Table 13: Priorities for Quality Improvement			
Priorities for Improvement 2012/13			**Indicators for Quality Improvement 2012/13**
National Level NHS Outcomes Framework Domains of Quality	**Trust Level**	**Key Elements in the Quality of Care**	
Domain 4 Ensuring that people have a positive experience of care (NHS Outcomes Framework, DH 2012/13)	To Provide Best In NHS Care For Our Patients	Quality of The Patient Experience	***Improve hospitals' responsiveness to inpatients' personal needs by improving the CQC National Inpatient Survey results in the following five areas:*** – ***Were you involved as much as you wanted to be in decisions about your care and treatment?*** – ***Did you find someone on the hospital staff to talk to about your worries and fears?*** – ***Were you given enough privacy when discussing your condition or treatment?*** – ***Did a member of staff tell you about medication side effects to watch for when you went home?*** – ***Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?*** ***Improve staff survey results in the following area:*** – ***Percentage of staff who would recommend their friends or family needing care***
Domain 4 Ensuring that people have a positive experience of care (NHS Outcomes Framework, DH 2012/13)	To Provide Best In NHS Care For Our Patients To Deliver Best Environment For Patients, Staff And The Wider Community	Quality of The Patient Experience	Improving the experience of care for people at the end of their lives – Seeking patients and carers views to improve End of Life Care – Ensure that patients who are known to be at the end of their lives are able to spend their last days in their preferred place across all services. Patient Environment Action Team (PEAT) Survey – To improve PEAT survey results/standards
Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm (NHS Outcomes Framework, DH 2012/13)	To reduce Avoidable Harms To Our Patients	Patient Safety	Reduce The Incidence of Avoidable Harm to our patients through the following strands of work: – ***'Safety Thermometer' to be used as a measure to prevent harm*** – Reduce the incidence of MRSA and Clostridium Difficile infection rates in the Trust as reflected by national targets – Improve the percentage of admitted patients risk assessed for Venous Thromboembolism (VTE) – Reduce the incidence of inpatient Falls by 30% resulting in moderate or major harm – Reduce the medication errors by 50% – ***Reduce the incidence of newly-acquired category 2, 3 and 4 pressure ulcers by 30% in the Trust*** – ***To monitor the rate of patient safety incidents and reduce the percentage resulting in severe harm or death***

It has been agreed to remove five of the indicators for quality improvement used in 2011/12 but the rest of the indicators identified in 2011/12 will remain unchanged because these continue to be considered as priorities by the Board of Directors.

The first indicator agreed to be removed is in relation to reducing Cardiac Arrest Calls as this is now monitored via the mortality reduction action plan and progress is reported to the Board on a monthly basis.

The second indicator removed is in relation to the six indicators from the National Inpatient Survey that the Trust has monitored and reported on over the last three years and improved upon. Therefore as an alternative the Board have selected a set of six other questions. The first five questions are in relation to the CQC National Inpatient Survey. Moving forward, having reviewed the results of the 2011 survey, several areas for improvement relate to how patients feel at the time of their discharge, the amount of information they are given, the delays that they experience and also what to do if they need to contact someone following their discharge for advice and guidance. A Sixth question is in relation to improving the staff survey result for those who would recommend their friends needing care. A set of six questions shown in Table 13 and highlighted in bold italics will form part of the improvement work undertaken over 2012/13.

The third indicator agreed to be removed is in relation to the National Outpatient Survey where improvements remain constant. The reason why this has been removed is that the Trust is not required to undertake the Survey until 2013.

The fourth indicator agreed to be removed is in relation to ensuring single sex accommodation is available for patients to ensure privacy and dignity whilst in hospital. This has been removed due to sustained changes made and the Trust can confirm that we continue to be compliant with the Government's requirement to eliminate mixed-sex accommodation. This will continue to be covered in the CQC National Inpatient Survey results and will also be monitored via the monthly local patient experience survey which is reported to the Board on a monthly basis.

The fifth indicator agreed to be removed is in relation to the Global Trigger Tool which is used to measure adverse events but this has been replaced by a similar tool called the 'Safety Thermometer' which is to be used as a measure to prevent harm.

Monitoring, Measuring And Reporting Progress To Achieve The Priorities for Quality Improvement 2012/13

The priorities for quality improvement for 2012/13 will continue to be monitored and measured and progress reported to the Board of Directors as part of the monthly Board Business Monitoring Report and the monthly Quality and Safety Report. For indicators that are calculated less frequently, these will be monitored by the Board by the submission of an individual report. The Trust has well-embedded delivery strategies already in place for all the quality priorities, and will track performance against improvement targets at all levels from ward level to Board level on a monthly basis using the ward quality boards and the integrated quality monitoring reports. The priorities for quality improvement will also be monitored through the high level Risk Register and Divisional Risk Register process and by the Sub-Committees of the Board.

Reporting Ongoing Progress

The Trust will report ongoing progress regarding implementation of the quality improvements for 2012/13 to our staff, patients and the public via our new performance section of our website. You can visit our new website and find up-to-date information about how your local hospital is performing in key areas:

- Safety
- Quality
- Delivery
- Environment
- Cost
- People

Improving patient safety and delivering the highest quality care to our patients is our top priority. We believe that the public have a right to know about how their local hospitals are performing in these areas that are important to them.

As well as information on key patient outcomes such as infections, death rates, patient falls and medication errors, the website also includes data on our waiting times, length of stay, complaints, privacy and dignity, cleanliness, hospital food, and the opinions of our patients, carers and staff about our hospitals.

We are keen to build on the amount of data we publish but we need to ensure that the information is what you want to see and that it is easy to understand. Please have a look at these web pages and let us know if there are any areas that could be improved by completing the feedback form which is available on the website: http://www.bfwh.nhs.uk/about/performance/

Engagement With Patients, Public, Staff and Governors

The Trust has taken the views of patients, public, relatives, carers and the wider public into account for the selection of priorities for quality improvement through the completion of feedback forms which are available from the Trust's website.

Other methods of obtaining the views of patients, public, staff and governors has been through feedback from local and national patient surveys, information gathered from formal complaints, comments received through the Patient Advice and Liaison Service (PALS) and various local stakeholder meetings and forums.

Listening to what our staff, governors, patients, their families and carers tell us, and using this information to improve their experiences, is a key part of the Trust's work to increase the quality of our services.

The Trust wants to make sure that staff, governors, patients, their families and carers have the best possible experience when using our services.

2.2 Statements Of Assurance From The Board

2.2.1 Information On The Review of Services

During 2011/12 the Blackpool Teaching Hospitals NHS Foundation Trust provided and/or subcontracted 49 NHS Services.

The Blackpool Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 49 of these NHS services.

The income generated by the NHS services reviewed in 2011/12 represents approximately 89% per cent of the total income generated from the provision of NHS services by the Blackpool Teaching Hospitals NHS Foundation Trust for 2011/12.

The quality aspirations and objectives outlined for 2011/12 reached into all care services provided by the Trust and therefore will have had impact on the quality of all services. The data reviewed on various activities enable assurance that the three dimensions of quality improvement for clinical effectiveness, patient experience and patient safety is being achieved including:

- Divisional monthly performance reports
- Quality Boards based in our wards and departments
- Clinical audit activities and reports
- External independent audits, such as the JACIE Accreditation
- Investors In People Gold Standard Assessment
- Endoscopy Accreditation

The patient safety walkabout visits undertaken by the Executive Directors on a weekly basis and the Non-Executive Directors on a monthly basis have been a powerful tool in making the Trust's quality and safety agenda tangible to ward staff, prompting us to take ownership of our services in a new way. This initiative has been of great value in assisting clinical staff in achieving the highest quality environment in a very visible way.

2.2.2 Information On The Participation in Clinical Audits And National Confidential Enquiries

During 2011/12, 50 national clinical audits and 4 national confidential enquiries covered NHS services that Blackpool Teaching Hospitals NHS Foundation Trust provides.

During 2011/12 Blackpool, Teaching Hospitals NHS Foundation Trust participated in 82% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2011/12 are detailed in Column A of Tables 14 and 15 below:

The national clinical audits and national confidential enquiries that Blackpool Teaching Hospitals NHS Foundation Trust participate in during 2011/12 are detailed in Column B of Tables 14 and 15 below:

The national clinical audits and national confidential enquiries that Blackpool Teaching Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2011/12, are listed below in Column B of Tables 14 and 15 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry identified in Column C and D of Tables 14 and 15.

Table 14

List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2011/12

Number	National Clinical Audit Title	Column A Eligible to participate in	Column B Participated In	Column C Number of cases submitted	Column D Number of cases submitted as a percentage of the number of registered cases required
1	NNAP: neonatal care	Yes	Yes	214	93%
2	ICNARC CMPD: adult critical care units	Yes	Yes	935	100%
3	Centre for Maternal and Child Enquiries (CMACE): Perinatal mortality	Yes	Yes	25	100%
4	NJR: hip and knee replacements	Yes	Yes	534	100%
5	DAHNO: head and neck cancer	Yes	Yes	25	100%
6	MINAP (inc ambulance care): AMI & other Acute Coronary Syndrome	Yes	Yes	911	100%
7	Heart Failure Audit	Yes	Yes	321	100%
8	NHFD: hip fracture	Yes	Yes	427	100%
9	TARN: severe trauma	Yes	Yes	268	100%
10	National Sentinel Stroke Audit (n=40-60)	Yes	Yes	318	100%
11	National Audit of Dementia: dementia care (n=40)	Yes	Yes	40	100%
12	National Falls and Bone Health Audit (n=60)	Yes	Yes	60	100%
13	British Thoracic Society: National Bronchiectasis Audit	Yes	Yes	6	100%
14	National Audit of Familial Hypercholesterolemia	Yes	Yes	No cases	No cases
15	RCP: National Care of the Dying Audit	Yes	Yes	Audit commenced January 2011 and not due for completion until July 2012, therefore data not available at present	
16	National comparative audit of blood transfusion in adult cardiac surgery	Yes	Yes	310	16
17	National Carotid Interventions Audit	Yes	No	N/A	
18	NBS: National Comparative re-audit of Platelet Transfusion	Yes	Yes	40	18
19	NBS: National Comparative Audit of Bedside Transfusion Practice	Yes	Yes	70	19

Number	National Clinical Audit Title	Column A Eligible to participate in	Column B Participated In	Column C Number of cases submitted	Column D Number of cases submitted as a percentage of the number of registered cases required
20	Oesophago-gastric cancer (National O-G Cancer Audit)	Yes	Yes	Audit still ongoing at time of publishing	
21	CCAD: Adult cardiac interventions	Yes	Yes	1860	100
22	CCAD :Heart rhythm management (pacing and implantable cardiac defibrillators (ICDS)	Yes	Yes	664	100
23	CCAD: Congenital Heart Disease	Yes	Yes	8	100
24	Adult cardiac surgery: CABG and valvular surgery	Yes	Yes	11,299	24
25	NDA: National Diabetes Audit	Yes	Yes	89	25
26	NBOCAP: bowel cancer	Yes	Yes	247	26
27	NLCA: lung cancer	Yes	Yes	150	27
28	RCP: Audit to assess and improve service for people with inflammatory bowel disease	Yes	Yes	18	28
29	National audit of patients undergoing emergency laparotomy	Yes	Yes	53	100
30	Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	No	N/A	
31	National Elective Surgery PROMs: four operations*	Yes	Yes	956	73%
32	National Insulin Pump Audit	Yes	No	N/A The reason for not participating in this audit was because the previous national audit results had just been published and an action plan had been developed. To re-audit before any improvements were made would not demonstrate a difference in results, so a decision was taken not to participate this year but we would participate in 2012/13	
33	National Mastectomy and Breast Reconstruction Audit	Yes	No	N/A	
34	Chronic pain (National pain audit)	Yes	Yes	Data not available at time of publishing	
35	Heavy Menstrual bleeding (National audit of HMB)	Yes	Yes	300	100

Table 14

List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2011/12

Number	National Clinical Audit Title	Column A Eligible to participate in	Column B Participated In	Column C Number of cases submitted	Column D Number of cases submitted as a percentage of the number of registered cases required
36	Diabetes (National diabetes audit)	Yes	No	N/A The reason for not participating in this audit was because the previous national audit results had just been published and an action plan had been developed. To re-audit before any improvements were made would not demonstrate a difference in results, so a decision was taken not to participate this year but we would participate in 2012/13	
37	Emergency use of oxygen (ward based audit)	Yes	Yes	All patients on oxygen on 24 wards	100
38	BTS audit on Adult community acquired pneumonia	Yes	Yes	Data collection still ongoing at time of publishing	
39	Non invasive ventilation - adults	Yes	Yes	Data collection still ongoing at time of publishing	
40	Pleural procedures	Yes	No	N/A	
41	Cardiac arrest (National Cardiac arrest audit)	Yes	Yes	247	100
42	Severe sepsis & septic shock	Yes	Yes	30	100
43	Potential donor audit	Yes	Yes	507	100
44	Seizure management (National audit of seizure management)	Yes	No	N/A	
45	Paediatric Pneumonia	Yes	No	N/A	
46	Paediatric asthma	Yes	No	N/A	
47	Pain Management in children	Yes	Yes	50	100
48	National Paediatric Epilepsy 12 Audit	Yes	Yes	39	100
49	National Health Promotion in Hospitals	Yes	Yes	100	100
50	National Paediatric Diabetes Audit	Yes	Yes	121	100

Table 15

List of National Confidential Enquires that Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2011/12.

Number	National Confidential Enquiries	Column A Eligible to Participate In	Column B Participated In	Column C Number of cases submitted	Column D Number of cases submitted as a percentage of the number of registered cases required
1	Resuscitation (NCEPOD)	Yes	Yes	2	100%
2	National Enquiry into Maternal and Child Health (CEMACH);	Yes	Yes	25	100%
3	Knowing the Risk – A Review of the peri-operative Care of Surgical Patients	Yes	Yes	6	100%
4	Surgery in Children – Are We There Yet?	No	No	N/A	N/A

The reports of 3 national clinical audits (confidential enquiries) were reviewed by the provider in 2011/12 and along with ongoing work from previous reports Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of health care provided as shown in Table 16.

Local clinical audit is important in measuring and benchmarking clinical practice against agreed markers of good professional practice, stimulating changes to improve practice and re-measuring to determine any service improvements.

During 2011/12, 49% of clinical audits approved and registered with the Clinical Audit Department were fully completed, with action plans to address areas for improvements developed and fully implemented or currently being monitored by the relevant division and reporting committee. Of the remaining, 35% are still in the data collection phase, 5 are awaiting the publication of a national report and 0.12% have completed the data collection and are currently undergoing review within the relevant division. The audits in the latter 3 categories will roll over to 2012/13 to ensure continuous monitoring and completion.

Table 16

National Clinical Audits (Confidential Enquiries) presented for assurance to the Board of Directors	Details of actions taken or being taken to improve the quality of local services and the outcomes of care.
Elective and Emergency Surgery in the Elderly – An Age Old Problem (NCEPOD)	• Presentation of report findings made to the following: • Grand Round • Clinical Policy Forum • Clinical Improvement Committee • Anaesthetic Meeting • Leads from each Division are currently carrying out a baseline assessment and formulating an action plan to improve healthcare provision. • Fractured Neck of Femur pathway being developed
A Mixed Bag	• Cross divisional work ongoing with GAP analysis completed and action plan developed to improve services • Total Parenteral Nutrition proforma developed in draft • Business case for Nutrition team developed
Adding Insult to Injury – A review of the care of patients who died in hospital with a primary diagnosis of acute kidney injury (acute renal failure)	• A review of all fluid balance charts used throughout the Trust
	• Introduction of a new fluid balance charts throughout the Trust
	• Review of intravenous fluid administration equipment available throughout the Trust to ensure accurate timing and administration of fluid infusions
	• Education programme to recognise the acutely ill patient and recognising renal impairment • Development of a fluid balance monitoring procedure • Regular audits around compliance of Early Warning Score / Recognise and Act / Fluid balance • Biochemistry trialling flagging patients with a raised creatinine • Risk assessment for kidney injury being developed
Confidential Enquiry into Maternal and Child Health (CMACE)	• Improved and revised obesity guideline • Development of business case to extend medical clinics to include maternity patients with asthma and epilepsy • Development of services to facilitate 'spoke' centre for regional maternal cardiac care
Knowing the Risk – A Review of the peri-operative Care of Surgical Patients	• Report presented and disseminated throughout organisation by National Confidential Enquiry Peri- Operative Death Ambassador and Reporter • Report reviewed and GAP analysis undertaken • Trust data benchmarked and compared to National position
Surgery in Children – Are We There Yet?	• Report presented and disseminated throughout organisation by NCEPOD Ambassador and Reporter • Report currently being reviewed and GAP analysis undertaken to identify if any improvements can be made as a result of national recommendations overall

The reports of 131 local clinical audits were reviewed by the provider in 2011/12 and Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve the quality of healthcare provided as detailed in Table 17 below. A further 51 audits were completed with action plans developed and their implementation is currently being monitored by the divisions.

Table 17

Local Clinical Audits presented for assurance to the Board of Directors	Details of actions taken to improve the quality of local services and the outcomes of care.
Re-audit of NPSA Vaccine cold storage alert	PH1127 Fridges to be hard wired to the mains. All fridges that hold medicines to be locked Estates to hold extra keys. Records maintained of deliveries and maintenance. Increased education and training in the correct storage of medicines and the management of vaccine fridges
Macular hole surgery: results and outcomes	OP1101 Improved coding and liaison between VR consultant and coding department
Re-audit of The use of anti TNF therapy in ankylosing spondylitis	GM1106 Standards met in general but improvements to documentation re physio assessment, inclusion criteria and discontinuation of therapy would improve even further
Handover of care between the Maternity team on delivery suite and within the hospital	OB1104. New handover sheet developed including requirements for CNST standards. Consultant obstetricians & anaesthetists present for at morning handovers. Maternity theatre staff included for handover.
Re-audit of ensuring the accuracy of all prescription charts	PH1119R Pharmacists reminded on the subsequent visit to remove the yellow pharmacy advice/intervention sheet from the prescription when the amendments have been
Re-audit of the safe management of controlled and restricted drugs within clinical areas	PH1120R Senior nurses reminded of the requirement of daily checks of controlled drugs. Authorised signatory list updated. Controlled drug keys separated.
Reducing harm from omitted and delayed medicines in hospital/ The correct use of omission codes	PH1121 Critical medicines lists as per NPSA alert have been introduced and included in all medicine policies
Reducing dosing errors with opioid medicines	PH1122 Ward stock now routinely checked by pharmacist.
Reducing the risk of overdose with Midazolam injection in adults	PH1123 Wards stock Flumazenil if stocking Midazolam
BTS Emergency Oxygen Audit 2011	GM1109 Ongoing process to improve oxygen prescription and improve nurse signatures on drug rounds.
Local audit of incontinence in the elderly 2001	GM1101 Audit results to be forwarded to Division head nurse, CoE matron and CoE PD sister for further dissemination. Trust guidelines in the process of being produced by gynaecology.
Trust wide Medicines Adherence - Implementing NICE Guidelines 2011	PH1101 Dispensing staff ensure all patients are asked if they have any questions about their medicines before handing them over. Prescribers and health care professionals (HCP) ensure they have read and understood the guidelines on medicines adherence. Prescribers and HCP ensure patients feel that the decision to give a prescription is made by them and the prescriber or HCP together
Management of Influenza Pandemic	AE1010 No action plan required standards met
Injectable Medicines promoting safer use	PH1103 Training for staff recorded in clinical areas All areas completed risk assessments
VTE risk assessment in obstetric patients	OB1017. VTE documentation reviewed Trust-wide and standardised to a single form.

Table 17 cont	
Local Clinical Audits presented for assurance to the Board of Directors	**Details of actions taken to improve the quality of local services and the outcomes of care.**
Densiron its success and complications at BVH	OP1102 The use of Densiron restricted to complicated cases
Ultrasound guided liver biopsies are we delivering	RA1002 Introduction of pro forma for improved documentation. Supervision of trainees
An audit of the number of patients being correctly assessed and prescribed Tinzaparin for Venous thromboembolism (VTE)	PH1125 The Trust Procedure has changed and now nursing staff are monitoring VTE assessment being conducted rather than pharmacy staff.
Assisted vaginal delivery	OB0818 Formal communication of shift leaders re requirements for 1st void and volume of urine to be documented on Euroking along with documenting of emptying bladder, colour of urine and measurement
Safe and secure handling of medicines	PH1118 Review Trust policies relating to safe and secure handling of medications on wards to ensure they incorporate all relevant aspects of standard Purchase of additional green tamper proof delivery bags Development of the current receipted delivery system for all medicines Development and delivery of a basic training package for hospital transport staff Development of a risk assessment for all medicinal products All medicines storage areas on wards assessed and labelled accordingly by Pharmacy staff Ward top-up procedures reviewed and amended
Performing Aseptic Technique Compliance with CORP/PROC/473	CG1106 Education of staff re hand washing techniques Technique Guidelines developed and displayed in clinical areas Education of cleaning product availability Attendance at training sessions re NTT Encouragement of staff to challenge poor practise
Drug preparation using non-touch technique Compliance with CORP/PROC/505	CG1108 Education of staff re hand washing techniques Technique Guidelines developed and displayed in clinical areas Education of cleaning product availability Attendance at training sessions re NTT Encouragement of staff to challenge poor practise
Induction of labour	OB1102 Separate audits for low risk and high risk Induction of Labour. Provide patient leaflets. Improve documentation.
Injectable Medicines self declaration of compliance audit	PH1109 Standards met
Reducing treatment dose errors with low molecular weight heparin (LWMH)	PH1110 Review of local policy and procedure to ensure the method of weighing and recording of weight in appropriate documentation (CORP/PROC/088) Review and amendment of local policy for treatment doses of LMWH to ensure renal function monitoring included Dose calculation tools are available in all clinical areas Education of staff re need to ensure all relevant information relating to patient dose, weight, renal function, creatinine clearance, indication and duration of treatment are documented Education of staff re the need to ensure doses of LMWH are checked based on weight and renal function
Reducing risk of harm from oral bowel cleansing solutions	PH1111 All areas that stock and issue bowel cleansing solutions have a supply of patient information leaflets to issue to the patient for each bowel cleansing product issued
Promoting safer measurement and administration of liquid medicines via oral and other enteral routes	PH1112 All devices used with oral/enteral syringes are compliant with the syringe Educate staff re the policies relating to oral/enteral syringe use

Table 17 cont	
Local Clinical Audits presented for assurance to the Board of Directors	**Details of actions taken to improve the quality of local services and the outcomes of care.**
NPSA Safe Use of Epidurals (Self Declaration)	PH1115 All clinical areas that use epidurals have a supply of labels available for use Education of staff to ensure they are aware of the need to store epidurals in the fridge
Re-audit reducing the risk of hyponatraemia when administering intravenous infusion to children	PH1106 Dissemination of information to clinical divisions - Local actions monitored via Medicines Management Committee
Re-audit of NPSA cold storage alert self declaration of compliance audit	PH1107 All clinical areas keep a daily record of fridge temperatures All fridges have a thermometer that records the current temperature, minimum and maximum ranges and a daily reset facility
Re-audit of NPSA Rapid Response 4 fire hazard with paraffin based skin products on dressings and clothing	PH1108 All areas that store white soft paraffin display a hazard alert poster
Actions that make anticoagulant therapy safer	PH1113 All clinical areas stock patient anticoagulant record/information books All clinical areas have VS458 counselling records available Development and delivery of staff training re delivering counselling on anticoagulant therapy
Potassium chloride concentrate solutions self declaration of compliance	PH1114 Dissemination of information to clinical divisions -Local actions monitored via Medicines Management Committee
Medicines Administration and Patient Identification Procedure Compliance	PH1104 Implementation of locally held signature list for staff when they have read the requirements of the associated policy Improved education and training of staff re requirements for safe administration of medicines and identification of patients Actions monitored via Medicines Management Committee
Self Administration of medicines	PH1117 Standard met, but good practice would be to develop a policy covering self administration of medicines – under review via medicines management committee
30 day post endoscopy mortality Audit (annual audit)	GM1102 Education of staff re improving data quality entry onto mortality database
National Lung Cancer Audit (NLCA)	GM1036 Awaiting national report and confirmation of Re-audit date
Fluid balance chart audit	GM1031 Education programme re need to complete fluid balance charts in accordance with HAEM/PROC/003
The use of Rituximab for the treatment of rheumatoid arthritis against NICE guidelines	GM1033 Standards met
Investigation into Warfarin loading doses	PH1021 Guideline introduced regarding loading dose protocol for Warfarin. Education of staff re need for baseline INR recording
Metformin use in pregnancy	OB1021 Continue to offer Metformin to women with gestational diabetes. Local guidelines updated to include use of Metformin in pregnancy.
Management of shoulder dystocia	OB1020 Skills training - multidisciplinary drills days. Critical analysis - incident forms completed for ALL cases. Euroking proforma to be used in all cases. Incident review meetings - ensure documentation.
Management of ectopic pregnancy	OB1018 Development of early pregnancy pathway Education programme on diagnosis and management of ectopic pregnancy for junior doctors. Laparascopic training for middle grades
Audit and re-audit of The Management of Pre-existing Diabetes in Pregnancy	OB1016 Education of reducing risks for pregnant women with diabetes and raising hypoglycaemia awareness Offer pregnant women with diabetes antenatal USS of the 4 chambers of the heart at 20 weeks

Table 17 cont	
Local Clinical Audits presented for assurance to the Board of Directors	**Details of actions taken to improve the quality of local services and the outcomes of care.**
The management of post partum haemorrhage (PPH)	OB1015 Introduce skills and drills training in management of PPH Education of staff re identification of risk factors for PPH and use of active 3rd stage. Review of Trust guideline to incorporate RCOG/WHO definition. Development and implementation of PPH proforma for documentation
Fluid balance chart completion compliance pre-audit	AN1020 Development and introduction of new fluid balance chart
Heavy Menstrual Bleeding (Out-patient hysteroscopy)	OB1014 Communication memo to all doctors in gynae clinic that all women need to be counselled about hysteroscopy prior to booking Design and publication of information leaflet re hysteroscopy
Intrapartum management of multiple pregnancies	OB1013 Improved documentation
Trust wide Prospective Audit on Severe sepsis	AN1019 Education programme for nursing and medical staff Review and update of current Trust Sepsis guidelines
An audit of inpatient insulin storage and administration	PH 1116 Development of new dispensing protocol to minimise waste of insulin Training of nursing staff re storage of insulin
Documentation of controlled drugs administration in theatres	AN1001 Education programme for staff re need to ensure signatures are legible Development of specimen signature or index system
National BTS asthma audit	GM1024 Education of staff re: Administering oral steroids within 1st hour of arrival at hospital Checking and documenting peak flow before and after bronchodilators Performing ABG if initial saturations on air less than 92% If the patient was on inhaled steroids - increase dosage on discharge if appropriate
National Bronchiectasis Audit 2010	GM1025 Documentation of 24hr sputum volume and level of breathlessness when the patient is stable Recording of a baseline spirometry before starting IV and nebulised antibiotics and during the course of antibiotics Patients with MRC 3 level of breathlessness should be referred for pulmonary rehabilitation
Prescribing Antibiotics in respiratory tract infections.	GM1026 Education of staff re need to follow prescribing guidelines for antibiotics Education of staff re importance of documenting CURB score for patients with pneumonia
Re-audit of Fetal Blood Sampling	OB1012 Communication memo to doctors re need for cord gases whilst awaiting placental separation and whilst taking Rh Neg bloods Synchronisation of all clocks on unit with delivery suite clock. Include recommendations in doctor's induction. Include criteria for sampling in Euroking
Sterility of light handles in orthopaedic theatres	OR1005 Standards met - no cause for concern, identified that light handles are not a source for infection
Recording of times intravenous chemotherapy infusions commenced and stopped for patients undergoing PBSC autografts	PH1017 All staff to have access to Varian. Senior nursing staff to do spot checks on Varian. Records kept of problems encountered with Varian so they can be followed up sooner. Further training given to nursing staff
Audit to assess compliance of local protocols in VTE Prophylaxis	AN1015 Nil required - standards met
Assessment of compliance with NICE CG50 in Acutely ill patients in hospital	AN1017 Education programme re use of POTTS chart and managing acutely ill patients Review and revision of Trust Observation procedure CORP/PROC/080 Identification of additional equipment requirements and purchase
Audit of Percutaneous Tracheostomy complications performed on ITU	AN1016 Education of staff re need to improve completion of consent form 4 in ITU

Table 17 cont	
Local Clinical Audits presented for assurance to the Board of Directors	**Details of actions taken to improve the quality of local services and the outcomes of care.**
Requirements to undertake risk assessment for the management of slips, trips and falls involving patients	GM1022 All divisions reminded of importance of updating falls risk assessment on a weekly basis or when clinically indicated All divisions have been reminded to include the revised falls risk assessment score and actions taken to reduce the risk on the Untoward incident Form submitted following a fall for every patient (Falls risk assessment document will be reviewed as part of falls steering group)
Local arrangements for managing the risk associated with safeguarding vulnerable adults	GM1023 Education programme for 002 bleep holders re safeguarding practice
Arrangement for control and supply of medicinal blood products	PH1013 Review and update of standard operating procedure (SOP) 0034 to state 'secure box' Development of SOP for out of hours supply to another Trust
Neonatal transfer/discharge audit	OB1010 Education of all staff re policy for transfer / discharge of neonates. Policy amended to include transfer from post natal ward to NNU of babies that have no RDS
Maternal transfer/discharge audit	OB1011 Improved staff education re documentation requirements on transfer. Re-education of staff re transfer checklist completion. Improved checking process of medical equipment
Paediatric Transfer/Discharge Audit	CH1010 Improved staff education re documentation requirements on transfer. Re-education of staff re transfer checklist completion. Improved checking process of medical equipment
Compliance with TA199 in the use of Etanercept, Infliximab and adalimumab	GM1021 12 week PSARC scores to be recorded PASI scores to be recorded for patients Patients are tried on 2 DMARDS before referring for Anti TNF therapy Treatment stopped if no adequate response Referral to dermatology if no adequate response
Discharge of adult patients	CG1020 Education of staff re completion of e-discharging forms Review and revision of transfer documentation Review and revision of Transfer of Adults procedure CORP/PROC/074
Management of obstetric cholestasis	OB1009. Tests carried out as AMA/ASA. Viral screening and liver USS in all patients optimise treatment. Post delivery counselling provided. All patients followed up at 4-6 weeks on MDU
60 Death Audit	CG1018 Improved process in place with general office
Audit of WHO surgical safety checklist	GS1008 Standards changed as audit completed – will be re-audited in future
NICE Guidance CG56 Head Injury	AE1007 Introduction of formal training for new starters Development of a head injury proforma incorporating NICE guidance Incorporation of proforma into VISION pathway Development of a head injury advise leaflet
Feverish illness in children	AE1008 Improved documentation and utilisation of EPR
Vital Signs	AE1009 Education programme for staff re need for accurate documentation Introduction of a scoring system to flag up 60 minute recording of observations for high risk patients Link to VISION project to introduce an alert system for abnormal observations
Management of NCEPOD - Compliance with CORP/PROC/065	CG1016 Education programme re requirements of documentation NCEPOD integrated into Governance Agenda in Division Divisional Reps at CIC to include progress report on NCEPOD in divisional exception reports
Management of NICE- Compliance with CORP/PROC/023	CG1017 Education programme re requirements of documentation NICE integrated into Governance Agenda in Division Divisional Reps at CIC to include progress report on NICE in divisional exception reports

Table 17 cont	
Local Clinical Audits presented for assurance to the Board of Directors	**Details of actions taken to improve the quality of local services and the outcomes of care.**
Implementation of NICE guidance in urinary tract infection in children	CH1008 Develop a care pathway for all children diagnosed with a UTI Education of team about management of UTI by CBD and include in regular teaching sessions For better continuation of care consider if all UTI patients should be admitted for further imaging investigations as in patient
Doctor led hand hygiene audit	PA1009 Recruited staff groups that do not have a conflict of interest to audit compliance. 'Secret shopper' audit conducted routinely. Staff members to continue to challenge non compliance.
Renal Colic National Audit 2010/2011	AE1006 Development of renal colic protocol and incorporation into VISION
Compliance with procedure 561 Undertaking a Clinical Audit	CG1023Education programme re requirements of documentation Audit integrated into Governance Agenda in Division Divisional Reps at CIC to include progress report on Clinical Audit in divisional exception reports
Good antimicrobial prescribing on the general surgical & orthopaedic wards at BVH	GS1006 Education programme for junior doctors on induction re antibiotic prescribing Microbial formulary requirements to be incorporated into VISION - Is being addressed as part of VISION project
Fluid balance chart	GM1018 Fluid balance competency assessments carried out for staff
2010 National comparative re-audit of platelet transfusion	PA1008 Update of local guidelines
Effectiveness in improving swallowing following insertion of stent	GM1017 Reduce number of stents used
Accuracy of renal tumour staging	RA1004 Discussed and agreed at urology multi-disciplinary team. Pre and post operative staging entered into cancer database Awareness raised of limitations of CT staging
Safe and secure handling of medicines	PH1014 Development and implementation of a procedure re record keeping requirements Development and implementation of a policy re medication errors, injectable preparations, ready to use products, missing medicines, and risk assessments for new products Development of SOP's for all relevant aspects of procurement, receipt and storage and distribution of medicines Review storage areas and labelling on shelves to allow easy selection of products Staff training requirements incorporated into appraisal Separate secure area for the storage of recalled products and stock for destruction Discuss Temperature monitors to be fitted to all supplier deliveries Review of procedure for temperature monitoring Ensure QCNW informed when risk medicines purchased
Obesity in Pregnancy	OB1005 Education of staff re need for VTE assessment on all obese patients and refer for GTT
Post operative oxygen prescriptions administration	AN1009 Reviewed and revised oxygen prescription chart - now on hold due to the advent of e prescribing, propose to make changes on the new system; Education of anaesthetists to use oxygen prescription chart
Audit of all Obstetric Admissions to Critical Care Services July 2009-July 2010	OB1007 Development of new guidance for care of critically ill obstetric patient OBS/GYNAE/GUID/002. Review of consultant job plans to ensure access to senior advise Education programme for staff re recognition of unwell woman
Management of Neutropenic Sepsis	GM1011 Daily spot check of compliance to ensure care provided as per standards Development of document proforma to go in patients notes

Table 17 cont	
Local Clinical Audits presented for assurance to the Board of Directors	**Details of actions taken to improve the quality of local services and the outcomes of care.**
Re-audit of Compliance with Trust Policy for Managing Sepsis and Severe Sepsis	AE1005 Education programme for staff re early identification and management of severe sepsis. Improved access to lactate testing in the Trust
Cardioselective Beta Blockers for COPD	GM1010 Re-education of staff re cardioselective beta blockers for COPD patients and the need to ensure documentation is accurate
Management of febrile children against NICE guidance	CH1006 - See AE1008
Venous thromboprophylaxis audit	GM1008 New VTE guidelines and pathway developed
Safety Indicators in Anticoagulant Services	PA1002 Recruitment of a number of new staff who will undergo intensive training. Re-audit to be undertaken by secondary care joint ADAS
Resuscitation- Monitoring and Compliance of DNAR	CG 1003 Improved communication, documentation and handover
Audit on Benign Hysterectomy Post Op Recovery	OB1003 Communication to all anaesthetists and operating staff re the need for a MDT approach to peri-operative care and the need to implement fast track interventions where appropriate.
Monitoring VTE propohylaxis in urology patients	GS1005 All surgical patients to have VTE assessment on admission Anaesthetists to consider regional anaesthesia to reduce risk of VTE Patients to be offered thromboprophylaxis to reduce VTE risk Minimise hospitalisation by considering minimal invasive procedures
Audit of patient case notes who have undergone Peripheral Stem Cell Transplantation	GM1028 Improved presence of key workers in OPD Improved documentation of virology results Improved documentation and storage of transplant flowchart and documents All patients to be reviewed by CNS prior to discharge and review documented in notes Use of one Transplant Wallet with checklist of key documentation in section 4 of patient notes
Trust Wide Audit of Record Keeping	CG1002 Dissemination of findings in governance newsletter and need for attaining standards in Team Brief Education programme re clinical record keeping Development and introduction of a clinical record keeping procedure
Audit and re-audit of venous thromboembolism prophylaxis in patients admitted to BVH (initial audit April and re-audit June)	GM1027 Continuation of training of staff in completion of VTE involving consultants - this will always be ongoing Access to electronic copy of patients in MAU
Diagnosis and management of early inflammatory arthritis	GM1003 Development of an early arthritis clinic as part of service re-design.
Where do Platelets go in the North West of England?	PA1001 Development of Trust guidelines for the use of platelets in adults and children, and actions required for high risk/use areas Review and amendment to existing policies to reflect BCSH guidelines Improved education programmes for staff to be rolled out Review and implementation of methods of waste reduction All requests for platelets to comply with local and national guidance Development and implementation a national request form
Assessment and treatment of children with Gastroenteritis under 5yrs of age	CH1003 Education of staff re need for awareness of risk factors for dehydration and need to start ORS challenge. Education of staff that clinically dehydrated need to tolerate 50mls/kg + maintenance in 4 hours. Education of staff that if patient clinically shocked to give 20mls/kg along with UE's/glucose/VBG/Chloride. Education of staff that those patients requiring boluses need 100mls/kg as deficit to maintenance. Education of staff to provide written information to parents on discharge re advise about re-establishing diet and other general advice.

Table 17 cont	
Local Clinical Audits presented for assurance to the Board of Directors	**Details of actions taken to improve the quality of local services and the outcomes of care.**
ICD implantation in tertiary care - An audit patient selection	CAR1001 standards met
Management of women with substance abuse in pregnancy	OB1002 Introduction of specialist midwife clinic at BTH All staff informed of the need to inform paediatricians antenatally Patient education re use of contraception post delivery prior to discharge. Continue MDT working across whole health economy
Cardiac chest pain in A&E	AE1001 Development of ACS protocol and incorporation into VISION
Sentinel audit in prescribing for the elderly	GM1001 Education programme for junior doctors re prescribing
Audit of peripheral IV cannulation to assess compliance with date labelling and duration of insertion	CG1028 Education of staff re improved documentation needs Education programme re recording of VIP score, use of fluid administration sets and cannula lifespan/re-siting requirements
Caesarean Sections under general anaesthetic	AN0916 Education of staff re assessment of need of patient to receive regional blocks
Fracture NOF - National Audit 2009	AE099 Negotiations with Medical Dept re job planning more ortho-geriatric support, i.e. more ortho-geriatric consultant sessions dedicated to the orthopaedic wards Improving medical skills & knowledge of orthopaedic doctors.
Audit of Written Consent including form 4	AN0913 Education of staff re need to implement requirements of the policy in completing consent form 4 in critical care
Audit on Tarceva Monotherapy in patients with NSCL at BVH	GM0922 Standards met - re-audit in 2012
To assess iron deficiency anaemia compliance against BSG Guidelines	GM0920 Agree preliminary pathway development for patients with IDA with BTH and BNHS- This will be an ongoing project and dependant on PCT Education of staff re need for complete GI investigations being carried out
Re-audit of Management of TVT/ TOT	OB0910 Improvement of documentation re stress leakage of urine Urodynamics not recommended for women with pure stress incontinence Offer trial of physiotherapy as first ;line treatment for all women with mixed/stress incontinence Communication with staff to ensure it is documented when leaflet issued to women prior to consenting and operative procedures
Review of drug elating stents usage against NICE criteria	CAR 096 standards continue to be met
IV fluid prescribing	GM0911 No actions as NICE guideline being developed which will require implementing when published
Commode Audit	CG1013These audit findings are presented to the HICC and circulated to Head Nurses who address issues identified monthly with individual wards to ensure commodes are cleaned after each patient use, vernacare tape insitu, inspected and stored appropriately
Time to access level 2 and 3 critical care	AN097 Implementation of sick or scoring baton bleep (600) 24 hr service provision of rapid access to senior nurses (CCOC and ART). Development of graded response strategy with clear recommendations to direct care towards critical care if indicated Ongoing education and training of Trust staff via ALERT and Recognise and Act (local mandatory in house course) All critical care discharges followed up within 48 hours All non admitted patients re-assessed by CCOC if clinically indicated
Induction of labour with PGE2 gel following previous caesarean section	OB093 Ensure consultant involvement in decision making re IOL Ensure patients receive counselling prior to IOL Develop a guideline for IOL.

Table 17 cont	
Local Clinical Audits presented for assurance to the Board of Directors	**Details of actions taken to improve the quality of local services and the outcomes of care.**
Compliance with CORP/PROC/505 Post aseptic non touch technique project audit	CG097 Introduction of trust ANTT project Staff challenge poor practise
Safer Lithium therapy	PH1126 Lithium training now included in Mandatory Medicines Management Training. Lithium training to be included in FY1 and FY2 induction training packages
Reducing Risks with Intravenous Heparin Flush Solutions	PH1128 All divisions to nominate responsible person to ensure latest local policies/practice re Heparin Flush are being used
Audit of blood collection process using blood track courier	PA1109 Dissemination of results to PD sisters and portering services manager to ensure all wards and clinical areas are informed of the findings and assist in the action plan for improvements
Re-audit of Maternal transfer/ discharge audit	OB1117 Increased awareness of discharge planning and need for improved documentation Improved forward planning for discharge so medications are ready in advance.
Non medical prescribing in the NW	CG1113 Audit completed -Results did not drill down to local level, therefore no actions can be identified to improve practise
Does third trimester CTG influence patient management in pregnant women with diabetes mellitus	OB1113 Routine weekly CTG monitoring withdrawn from 34 weeks in diabetic patients. Not for re-audit as results showed comprehensively that weekly CTG is deemed unnecessary.
Amniocentesis - Compliance with Standards	OB1110 Fully compliant. No change to practice as all standards are met - no pregnancy lost at any stage after amniocentesis. Annual audit.
NHSLA audit of blood and blood component transfusions including patient identification	PA1110 NPSA blood administration competency document amended on the CSC webpage. Increase sample size for re-audit
RCOA National Audit Project 4 - Major complications of airway management in the UK	AN1104 Pre- audit of airway complications in Critical Care to be undertaken in 2011/2012.

2.2.3 Information On Participation in Clinical Research in 2011/12

The number of patients receiving NHS services provided or sub-contracted by Blackpool Teaching Hospitals NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee was 2,673, identified in Graph 21 below, of which the number of patients recruited to National Institute of Health Research (NIHR) Portfolio Studies is 2,257*.

* It should be noted that 2011/12 NIHR Portfolio Study data is not signed off nationally until 30th June 2012. We therefore estimate the total patient recruitment total to be higher than currently reported (as at 6th June 2012).

The National Institute of Health Research Portfolio studies are high quality research that has had rigorous peer review conducted in the NHS. These studies form part of the NIHR Portfolio Database which is a national data resource of studies that meet specific eligibility criteria. In England, studies included in the NIHR Portfolio have access to infrastructure support via the NIHR Comprehensive Clinical Research Network. This support covers study promotion, set up, recruitment and follow up by network staff.
Participation in clinical research demonstrates Blackpool Teaching Hospitals NHS Foundation Trust's provider's commitment to improving the quality of care offered and to making our contribution to wider health improvement. Our clinical staff maintain abreast of the latest possible treatment possibilities, and active participation in research leads to successful patient outcomes.
Blackpool Teaching Hospitals NHS Foundation Trust was involved in conducting 151 clinical research studies during 2011/12. There were 45 clinical staff participating in research approved by a research ethics committee at Blackpool Teaching Hospitals NHS Foundation Trust during 2011/12. These staff participated in research covering 15 medical specialties as outlined in Table 18 opposite.

In addition, over the last three years, 69 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. The improvement in patient health outcomes in Blackpool Teaching Hospitals NHS Foundation Trust demonstrates that a commitment to clinical research leads to better treatment for patients.

Graph 21- Participation in Clinical Research

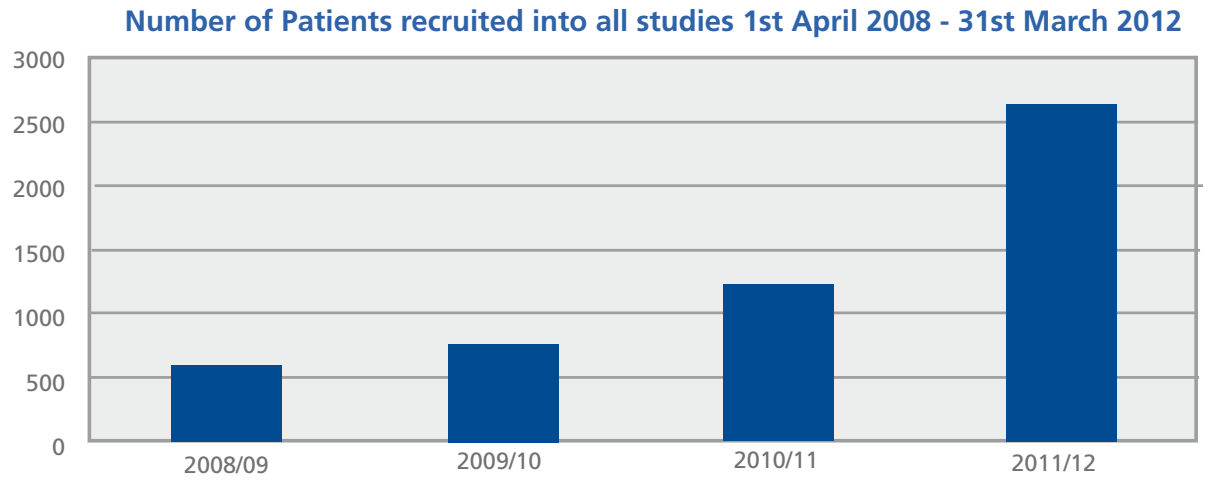


Table 18- Number of patients recruited to National Institute of Health Research Portfolio studies			
Specialty	**No. of Patients Recruited 2009/10**	**No. of Patients Recruited 2010/11**	**No. of Patients Recruited 2011/12**
Anaesthetics & Pain	3	24	6
Cancer	111	121	234
Cardio-Vascular	209	268	447
Critical Care	25	977	359
DeNDRoN	0	11	6
Dermatology	0	21	9
Diabetes	0	6	150
Gastro Intestinal	67	106	238
Medicines For Children	30	43	48
Musculo-Skeletal	57	26	1
Other	0	1	4
Paediatrics	10	30	225
Palliative Care	0	0	0
Primary Care	0	0	132
Public Health	2	7	1
Renal	114	90	0
Reproductive Health & Childbirth	88	54	41
Respiratory	13	19	28
Stroke	71	94	116
Total	**800**	**1898**	**2,045**

2.2.4 Information on the Use Of The Commissioning For Quality And Innovation Framework

The Commissioning for Quality and Innovation (CQUIN) payment framework aims to support the cultural shift towards making quality the organising principle of NHS services. In particular, it aims to ensure that local quality improvement priorities are discussed and agreed at board level within and between organisations. The CQUIN payment framework is intended to embed quality at the heart of commissioner-provider discussions by making a small proportion of provider payment conditional on locally agreed goals around quality improvement and innovation.

A proportion of Blackpool Teaching Hospitals NHS Foundation Trust's income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between Blackpool Teaching Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at: http:// www.monitornhsft.gov.uk/sites/all/modules/fckeditorplugins/ktbrowser/_openTKFilephp?id=3275

The payment mechanism in 2011/12 was that Contracted Commissioners paid 50% of the CQUIN value through block contracts followed by the remaining 50% upon the Trust successfully achieving the agreed goals. The total planned monetary value of CQUIN in 2011/12 conditional upon achieving quality improvement and innovation goals is £3,268,826; however, it is estimated that the Trust will achieve a total monetary value of £2,900,864 in 2011/12 for the associated payment in 2010/11.

The variance in CQUIN monetary value expected compared to planned is due to lower than expected performance in 2 CQUIN themes; VTE assessment (target failed during first 5 months of the year) and Patient Experience (aggregate score for the 5 questions lower than target). In addition, information to date suggests that the trust will fail to achieve the Advancing Quality targets for Pneumonia and Patient Experience and TARN; however performance against these measures will not be confirmed until August 2012.

2.2.5 Information Relating To Registration With The Care Quality Commission And Periodic/Special Reviews

Statements From The Care Quality Commission

Blackpool Teaching Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is compliant with no conditions.

The (CQC) has not taken enforcement action against Blackpool Teaching Hospitals NHS Foundation Trust during 2011/12.

Special Reviews/Investigations

Blackpool Teaching Hospitals NHS Foundation Trust has participated in special reviews or investigations by Care Quality Commission relating to the following areas during 2011/12. The Care Quality Commission has undertaken two unannounced visits during 2011/12 in which the details are provided below. Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to address the recommendations or requirements reported by the Care Quality Commission as detailed below. Blackpool Teaching Hospitals NHS Foundation Trust has made the following progress by 31st March 2012 in taking such action in which the details are provided below.

Participation in regulated activity for surgical procedures in the Surgical Directorate

The Care Quality Commission (CQC) carried out an unannounced visit on 27th September 2011 on regulated activity for surgical procedures in the Surgical Directorate in order to review the Trust's compliance with the essential standards of quality and safety. The Trust recieved the final CQC report on the 17th January 2012. The CQC report overall provided positive feedback. Blackpool Teaching Hospital NHS Foundation Trust took the following actions to address the conclusions or requirements reported by the Care Quality Commission.
The Trust received improvement actions in order to maintain compliance for three essential standards of quality and safety in relation to:

- Outcome 07: Safeguarding people who use services from abuse
- Outcome 14: Supporting staff
- Outcome 16: Assessing and monitoring the quality of service provision.

The Trust developed an action plan and implemented the recommendations to address the actions to maintain compliance in relation to Outcome 07; 14; and 16. This has been achieved by providing increased Deprivation of Liberty Safeguard (DoLs) training; Root Cause Analysis Training; and the increased uptake of appraisals and coaching skills/ conversations training for clinical leaders in the surgical Divisions. The Trust have now addressed the minor concerns and are declaring compliant with Outcome 07, 14 and 16 with no further improvements.

The Trust also received one compliance action as one standard had been identified as not being met. This was in relation to:

- Outcomes 2: Consent to care and treatment

The Trust developed an action plan and commenced implementation of the recommendations to address the compliance action in relation to Outcome 2. Due to a number of improvement initiatives including Mental Capacity Act (MCA) training policy review; and ward/ departmental support from the MCA Implementation Lead, the Trust are now declaring compliant with this criteria.

A progress report regarding implementation of the action plan has been provided to the Board in order to demonstrate the actions taken to achieve compliance with the identified standards. The completed action plan and progress report has been submitted to the Care Quality Commission in February 2012 following approval by the Board.

Participation in regulated activity for surgical procedures in the Women's Unit

The Care Quality Commission (CQC) carried out an unannounced visit on 21st March 2012 on regulated activity for Termination of Pregnancy surgical procedures in the Women's Unit in order to review the Trust's compliance with Outcome 21: Records with the essential standards of quality and safety and contributed to part of a National CQC inspection. They reviewed the last 6 months records concerning women who have undergone a medical Termination of Pregnancy and reviewed 18 Case Records, in particular Form A and were satisfied with the standards. The CQC identified compliance with Outcome 21: Records and provided positive feedback with no recommendations identified.

2.2.6 Information on the Quality of Data

Good quality information and data is essential for:

- The delivery of safe, effective, relevant and timely patient care, thereby minimising clinical risk
- Providing patients with the highest level of clinical and administrative information
- Providing efficient administrative and clinical processes such as communication with patients, families and other carers involved in patient treatment
- Adhering to clinical governance standards which rely on accurate patient data to identify areas for improving clinical care
- Providing a measure of our own activity and performance to allow for appropriate allocation of resources and manpower
- External recipients to have confidence in our quality data, for example, services agreements for healthcare provisions
- Improving data quality, such as ethnicity data, which will thus improve patient care and improve value for money.

NHS Number And General Medical Practice Code Validity

Blackpool Teaching Hospitals NHS Foundation Trust submitted records during 2011/12 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:

- which included the patient's valid NHS Number was:
- 99.2% for Admitted Patient Care;
- 99.5% for Outpatient care; and
- 97.9% for Accident and Emergency Care.

- which included the Patient's valid General Practitioners Registration Code was:
- 100% for Admitted Patient Care;
- 100% for Outpatient Care; and
- 99.9% for Accident and Emergency Care.

Information Governance Assessment Report 2011/12

Blackpool Teaching Hospitals NHS Foundation Trust's Information Governance Assessment Report overall score for 2011/12 was 83% and was graded (colour green) from the Information Governance Toolkit Grading Scheme.

For 2011/12 the grading system is based on:

- **Satisfactory** (coloured green): level 2 achieved in all requirements

- **Not Satisfactory** (coloured red): level 2 not achieved in all requirements

The Trust has achieved a Level 2 Satisfactory rating (colour green) against the grading criteria. This change links directly to the NHS Operating Framework (Informatics Planning 2011/12) which requires all organisations to achieve Level 2 in all requirements.

Blackpool Teaching Hospitals NHS Foundation Trust will be taking the following actions to improve data quality. There is an overarching Information Governance work plan which has been agreed by the Trust Board. This is alongside a formulated action plan for 2011/12.

The Information Governance Toolkit is available on the Connecting for Health website (www.igt.connectingforhealth.nhs.uk).

The Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

Statements Or Relevance Of Data Quality And Actions To Improve Data Quality

Blackpool Teaching Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- Data quality indicators on NHS number coverage, GP of patient, Ethnicity, Gender, national secondary users service (SUS) quality markers will continue to be monitored on a daily, weekly and monthly basis from the Trust's dedicated data quality team all the way through to the Board.
- Areas of improvement have been identified and actioned to maintain the Trust's high quality standards.

Over the last two years the following progress to improve data quality has been made:

- Ethnicity coding quality raised from 87.66% in January 2007 to 91.68% in January 2011
- Inpatient NHS number coverage has been raised from 96.72% in Jan 2007 to 99.08% in January 2012
- GP Code coverage maintained at over 99%
- Gender assignment at 100% in January 2012

Payment By Results (PBR) Clinical Coding Audit

Blackpool Teaching Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period (January 2012) by the Audit Commission and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were 5.9%.

The results are detailed in Table 19 below and demonstrate better than national average performance:

Table 19	
Data Published by the Audit Commission	
Clinical Coding	**Percentages**
Primary Diagnoses Incorrect	9.0%
Secondary Diagnoses Incorrect	6.0%
Primary Procedures Incorrect	7.5%
Secondary Procedures Incorrect	2.6%

These percentages show the percentages of errors made in each of the categories detailed and have improved from previous years and show the Trust achieving above the national average. Three actions were identified to improve the quality of coding in the latest audit and are detailed below:

- Provide feedback and training to the coders on the issues highlighted in this report including
- Establish a method of capturing pressure ulcers information
- Remove the facility from the system to add and remove codes from any staff other than coding staff and other essential users

The results should not be extrapolated further than the actual sample audited.

The following services were reviewed within the sample as shown in Table 20 below

Table 20		
Data Sampled		
Area Audited	**Specialty/ Sub-chapter/ Healthcare Resource Group**	**Sample size**
Theme	Trauma and Orthopaedic	100
Speciality	Random Sampling	100

Part 3 Other Information

3.1 Overview Of 2011/12 Performance

3.1.1 An Overview Of The Quality Of Care Based On Performance In 2011/12 With An Explanation Of The Underlying Reason(s) For Selection

Table 1 in part 2 sets out the priorities for improvement which were identified in the 2010/11 report and none of these priorities have changed in 2011/12 but the rest will remain unchanged because these continue to be considered as priorities by the Board.

The first indicator removed is in relation to the six indicators from the National Inpatient Survey that the Trust has monitored and reported on over the last three years and improved upon. Therefore the Board have selected a set of six other questions in relation to the CQC National Inpatient Survey. Moving forward, having reviewed the results of the 2011 survey, several areas for improvement relate to how patients feel at the time of their discharge, the amount of information they are given, the delays that they experience and also what to do if they need to contact someone following their discharge for advice and guidance. A set of six questions shown in Table 13 and highlighted in bold italics will form part of the improvement work undertaken over 2012.

The second indicator agreed to be removed is in relation to the National Outpatient Survey where improvements remain constant. The reason why this has been removed is that the Trust is not required to undertake the Survey until 2013.

The two additional indicators for Quality Improvement have been identified and included and monitored during the reporting period 2011/12 for the following reasons detailed below:

Advancing Quality Initiative Patient Experience Measures

The Patient Experience aspect of the Advancing Quality Programme was introduced in 2011 by the Regional Advancing Quality Team. The Trust participated in the Patient Experience Programme in order to identify and implement any actions required to improve the patient experience and achieve over the top 25% or Top 50% performance in comparison to other Trusts'. Further information on performance of this priority indictor is detailed in Section 2.1.2 of this report.

Reduce the incidence of newly acquired grade 2, 3 and 4 pressure ulcers

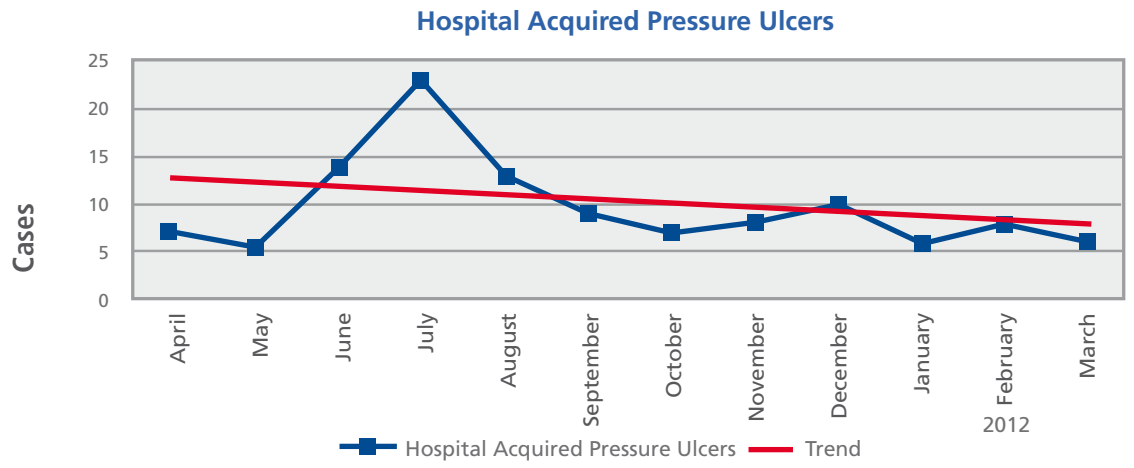
The reduction of pressure ulcers has also been identified as a priority indicator to enable the Trust to meet national healthcare directives and current local quality improvement priorities for 2011/12. To improve the quality of care provided, the Trust made a commitment to ensure that all patients who suffered a hospital acquired pressure ulcer would have a root cause analysis undertaken.

Through the implementation of a quality improvement initiative programme the Trust has demonstrated how pressure ulcers have been reduced and targets met due to the initiative being implemented over the last twelve months as shown in Graph 22.

The above strand of work is being monitored to enable the Trust to measure progress in reducing avoidable patient harms and to improve patient outcomes and experiences.

Work will continue to ensure that changes are embedded into practice and the improvements in performance are sustained.

Graph 22 1st April 2011 - 31st March 2012



Reason for Selection of Additional Indicators 2012/13

We have also identified additional indicators for quality improvement in 2012/13 which are detailed in Table 13 and highlighted in bold italics and added for the following reasons:

The following two additional quality improvement priorities have been selected due to these being reinforced by the standards outlined in the NHS Outcomes Framework 2012/13 five domains of quality which set out the high-level national outcomes that the NHS should be aiming to improve.

Enhancing quality of life for people with Dementia

- **Improve the outcome for older people with dementia by ensuring 90% of patients aged 75 and over are screened on admission.**

The Trust is working to ensure that 90% of patients aged 75 and over are screened on admission to ensure that patients with a diagnosis of Dementia are prescribed appropriate medication and treatment

Improving outcomes from planned procedures

- **Patient Reported Outcome Measures (PROMS)**

Improve the scores for the following elective procedure

i) Groin hernia surgery
ii) Varicose veins surgery
iii) Hip replacement surgery
iv) Knee replacement surgery

The reason why PROMs have been selected is that they are measures of a patient's health status or health-related quality of life. They are typically short, self-completed questionnaires, which measure the patients' health status or health related quality of life at a single point in time. The health status information collected from patients by way of PROMs questionnaires before and after an intervention provides an indication of the outcomes or quality of care delivered to NHS Patients.

- **Monitor's proposed mandatory core set of indicators**

Other indicators have been selected in view of Monitor's proposal to include national indicators relevant to the services they provide to be included in the Quality Accounts for the 2012/13 reporting year and for organisations to provide a commentary covering performance activity within the report. In view of the proposed core set of quality indicators, the Board has agreed to include these indicators in the 2012/13 quality report which are detailed in Table 13 and highlighted in bold italics.

- **Community Health Services Priorities for Improvement 2012/13**

The Trust has integrated with Community Health Services on 1st April 2012. Therefore Community Health Services priority indicators for monitoring for 2012/13 have also been selected and integrated into the performance indicators for the 'enlarged' organisation detailed in Table 13 and highlighted in bold italics.

3.1.2 Performance Against Key National Priorities

The Board of Directors monitors performance compliance against the relevant key national priorities and performance thresholds as set out in the Department of Health's Operating Framework 2011/12. This includes performance against the relevant indicators and performance thresholds set out in Annex B of the Compliance Framework 2011/12. Performance against the key national priorities is detailed on the Business Monitoring Report to the Board each month and is based on national definitions and reflects data submitted to the Department of Health via Unify and other national databases. For 2011/12 the key national priorities for the Department of Health's Operating Framework were:

- Improving cleanliness and improving healthcare associated infections
- Improving access
- Keeping adults and children well, improving health and reducing health inequalities
- Improving patient experience, staff satisfaction and engagement
- Preparing to respond in a state of emergency, such as an outbreak of a new pandemic

Table 21 shows the results from Trust's self assessment of performance against national priorities, indicators and thresholds over the past 3 years.

Table 21: Performance against Key National Priorities, Indicators and Thresholds			
Quality Standard	**Trust Self Assessment 2009/10**	**Trust Self Assessment 2010/11**	**Trust Self Assessment 2011/12**
All Cancers: one month diagnosis to treatment:			
First Treatment (target >= 96%)	Achieved	Achieved	Achieved Q1 99.5% Q2 99.6% Q3 99% Q4 99.8%
Subsequent treatment – Drugs (Target >=98%)	Achieved	Achieved	Achieved Q1 100% Q2 100% Q3 99.3% Q4 99.3%
Subsequent treatment – Surgery (Target >=94%)	Achieved	Achieved 100% for all 4 quarters	Achieved Q1 100% Q2 100% Q3 100% Q4 100%
All Cancers: two month GP urgent referral to treatment:			
62 day general (target >=85%)	Achieved	Achieved	Achieved Q190.8% Q2 87.2% Q3 92.3% Q4 87%
62 day screening (target >=90%)	Under-achieved	Achieved	Achieved Q1 90.5% Q2 93.7% Q3 86.8% Q4 96.7%
62 day upgrade (Target - None set)		Achieved greater than 95% in all 4 quarters	Achieved greater than 94% in all 4 quarters
All Cancers: two week wait	Achieved	Achieved Q1, 95.4%; Q2, 95.1%; Q3, 95.4%; Q4, 95.8%	Achieved Q1 94.4% Q2 95% Q3 94.4% Q4 94.2%
Breast Symptoms – 2wk wait	Achieved	Achieved Q1, 93.7%; Q2, 95.7%; Q3, 94.9%; Q4, 96.2%	Achieved Q1 94.1% Q2 94.7% Q3 93.2% Q4 96.4%
Reperfusion (Thrombolysis waiting times).	Not applicable	Achieved	Achieved
Delayed Transfers of Care (target <3.5%)	1.42%	Achieved	Achieved
Percentage of Operations Cancelled (target 0.8%)	0.53%	Achieved 0.6%	Achieved 0.56%
Percentage of Operations not treated within 28 days (target 0%)	0%	Achieved 0%	Achieved 0%
Patient Experience	Achieved	Achieved	
Quality of Stroke Care		Achieved	No longer measured
Ethnic Coding Data quality	Achieved	Achieved	Achieved
Maternity Data Quality	Achieved	Achieved	Achieved
Staff Satisfaction	Achieved	Achieved	Achieved
18 week Referral to Treatment (Admitted Pathway) (target >=90%)	95.48%	Achieved 94.08%	Achieved 91.89%
18 week Referral to Treatment (Non-Admitted Pathways [including Audiology]) (Target >=95%)	97.43%	Achieved 96.46%	Achieved 95.76%
Incidence of MRSA	8 (target <=12)	4 (target <=3)	2 (target <=3)
Incidence of Clostridium Difficile	134 (target <=185)	101 (target <=152)	53 (target <=86)
Total time in A&E (target 95% of patients to be admitted, transferred or discharged within 4hrs)	98.93%	Achieved 97.69%	Achieved 95.93%

Table 21: Performance against Key National Priorities			
Quality Standard	**Trust Self Assessment 2009/10**	**Trust Self Assessment 2010/11**	**Trust Self Assessment 2011/12**
Patient waiting longer than three months (13 weeks) for revascularisation (target 0)	0	0	0
Waiting times for Rapid Access Chest Pain Clinic	100%	100%	100%
Access to healthcare for people with a learning disability	Achieved	Achieved	Achieved
Participation in heart disease audits	Achieved	Achi eved	Achieved
Engagement in Clinical Audits	Achieved	Achieved	
Smoking during pregnancy	26.05%	Under-achieved 26.99%	24.59%
Breast-feeding initiation rates	66.94%	Under-achieved 63.14%	60.47%
Emergency Preparedness	**	**	
Where needed the criteria for the above indicators has been included in the Glossary of Terms			

** The Pandemic Influenza Plan (Version 4) was reviewed in February 2012 and ratified by the Board of Directors. This document defines the key pandemic influenza management systems and responsibilities of staff.

To support these arrangements the Trust has a Trust Wide Business Continuity Plan (Version 3) which was reviewed and ratified by the Board of Directors in February 2012. Beneath the Trust Business Continuity Plan are thirty three Directorate Business Continuity Plans with operational information on alternative options to deliver their services. The Emergency Planning Officer continues to undertake one-group training with the seventy seven on call or duty staff, this includes Duty Directors, Duty Managers, members of the Acute Response Team, Associate Directors of Nursing, Senior Nurses covering bleep 002, On Call Consultant Haematologists and Loggists.

Readmissions within 30 days

The Trust has been working with its health economy partners to implement strategies to reduce readmissions. Overall the percentage of all readmissions in 2011/12 was below peer average; however for readmissions following non-elective admissions the Trusts was above peer average. Further work is being undertaken to improve performance.

Indicator	Trust	Peer
All Admissions	6.6%	6.9%
Non-elective	11.5%	10.8%
Elective	2.9%	3.2%

3.2 Additional Other Information In Relation To The Quality Of NHS Services

Improve Local Patient Experience Survey Results

The local patient experience survey is monitored monthly and all patients and/or their relatives have the opportunity to participate in this survey. We have worked hard over 2011/12 to ensure the returns for this survey continue to increase. Results are fed into the Trust board on a monthly basis with updates on specific actions that the Clinical Divisions are doing in relation to their results.

We have reviewed this survey in order to ensure the questions relate to an individual's experiences and the care that mattered to them.

Over the last few years the Trust has been committed to improving the experience of our patients. The Trust invested heavily in a "Being With Patients" programme to improve customer service to patients, with a message about caring for patients how they wish to be cared for, not how we want to provide care. This included training in effective communication methods and the physical approach to patient care. We have since incorporated these messages in other similar training.

In 2010 we commissioned a company called Purple Monster to take the messages further across wider staff groups and to develop customer care champions across the organ isation.

In 2011/12, we are continuing with further training by developing some in-house interactive sessions which combine messages from all previous programmes.

The success of these programmes is evidenced by our recent staff survey results and the retention for the second year running of Investors in People Gold status. Customer care qualities in our staff are also assessed during appraisals as part of 'Being the Blackpool Person'.

Customer care programme launched to improve performance and customer satisfaction

Over the last few years the Trust has continued its commitment to improving the patient experience, of our patients. We have trained staff in effective communication methods, and physical approach through a variety of programmes. We commissioned a company called Purple Monster to take the messages further between staff and to develop some customer care champions across the organisations in 2010.

This training was effective and valued but at a cost. It has given us a good baseline on which to continue training in-house.

Table 22: Formal Complaints Across All Sites Within The Trust

Date - Financial Year	Complaints
2011/2012	353
2010/2011	309
2009/2010	387
2008/2009	399

We have also incorporated customer care training into the new Trust Induction programme for 2011 and beyond.

In 2012 we are developing this further with more training and action learning sets and this is driven by our recent staff survey results and the retention of Investors in People Gold status. Customer care qualities in our staff are also assessed during appraisals as part of 'Being the Blackpool Person'. The Blackpool Person is in relation to our Organisational Development Programme focusing on engaging staff and harnessing their potential.

Learning from Patients

We encourage patients to give us feedback, both positive and negative, on their experiences of our hospital services so that we can learn from them and develop our services in response to patients' needs.

During the financial year 1st April 2011 to 31st March 2012 we received 2,491 thank you letters and tokens of appreciation from patients and their families.

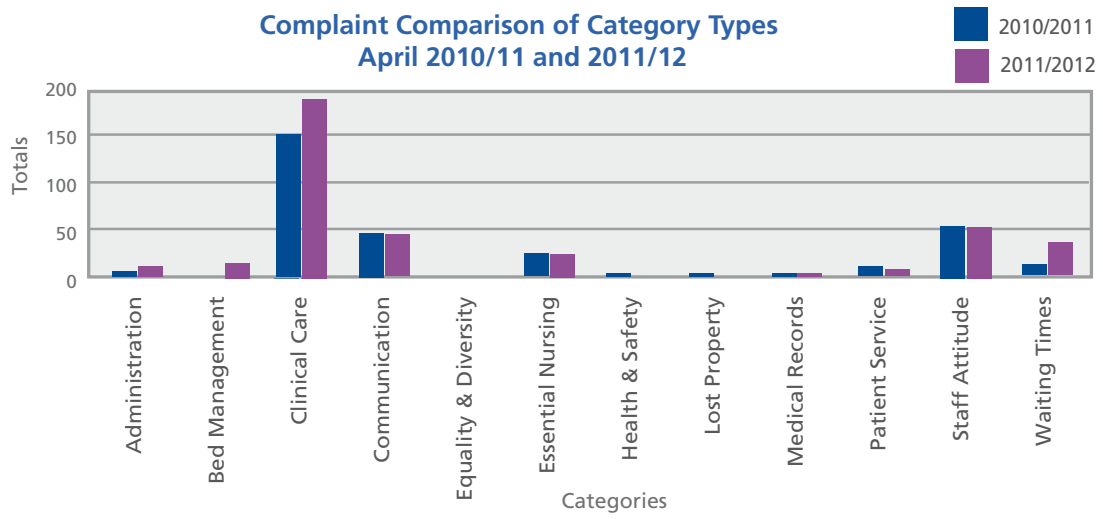
The number of formal complaints received by the Trust during the same period was 353. There were also 39 verbal complaints made. The overall numbers of formal complaints show an increase of 44 compared to the previous year as shown in Table 22.

Whilst there has been an increase in complaints, the perception of the Trust is that this is thought to be due to an increase in awareness amongst the general public of the complaints procedure and the openness of staff to complaints.

The main categories of complaints are detailed in Table 23 and include:

- Clinical Care
- Communication
- Staff Attitude
- Waiting Times
- Essential Nursing

Graph 23 1st April 2010 - 31st March 2012



Once the complaint has been acknowledged by the Trust, it is sent to the appropriate Division for local investigation. Once this investigation has been completed, their response is compiled and, following quality assurance checks, the response is signed by an Executive Director and posted to the complainant. Divisions are actively encouraged to arrange face to face meetings with complainants and during 2012/12, 74 meetings were held in order to resolve a complaint in a more timely manner (9 after a final response and 65 before a final response), an increase of 7 from the previous year.

Lessons learned from complaints are discussed within the Divisional Governance meetings, whilst lessons that can be learned across the organisation and trends in the number of category of complaints are discussed at the Learning from Incidents and Risks Committee and the weekly complaints meeting to ensure learning is across the organisation.

Once local resolution has been exhausted the complainant has the right to contact the Health Service Ombudsman for a review of the complaint. During 2010/11, 21 complaints were considered by the Ombudsman. Of these, there are 14 cases where the Ombudsman has assessed the issues and decided not to investigate any further, one was not upheld, two were resolved by local resolution, and one has been closed pending local resolution. There are three cases still ongoing.

Table 23: Number of Cases And Issues Dealt With By PALS Across All Sites Within The Trust

Date - Financial Year	BVH Cases	BVH Issues
2011/2012	3124	3508
2010/2011	2609	2887
2009/2010	1990	2266
2008/2009	1453	1655

Patient Advice and Liaison Service (PALS)

The aim of the Patient Advice and Liaison Service (PALS) is to be available for on-the-spot enquiries or concerns from NHS service users and to respond to those enquiries in an efficient and timely manner.

Table 23 below shows the number of issues dealt with by the by PALS team over the last three years.

The number of cases handled by the PALS team this year has increased by 515 cases on the previous year.

The main themes that have emerged from the PALS cases recorded are detailed in Table 24 and include:

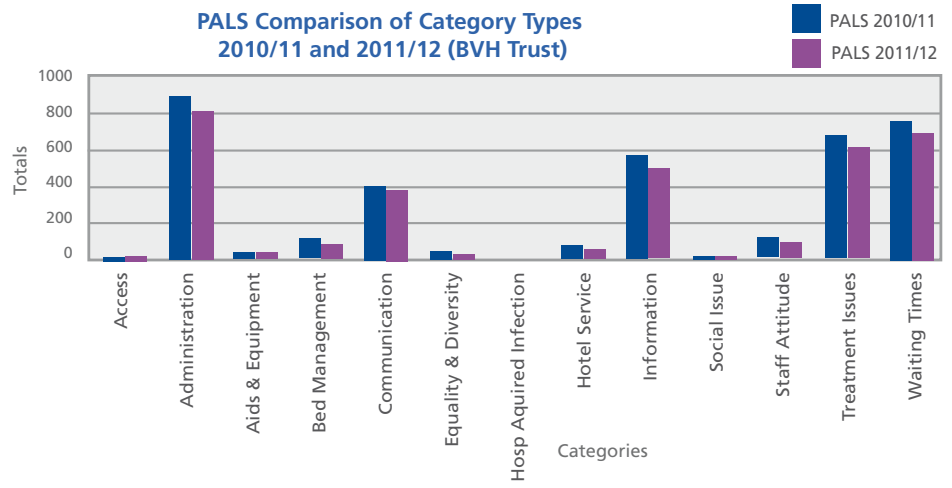
- Administration (830 issues)
- Information (487 issues)
- Treatment Issues (638 issues)
- Waiting Times (695 issues)
- Communication (436 issues)

The Trust are encouraging patient feedback and developing lessons learned in the Divisions and ensuring that lessons learned are embedded and sustained. Lessons learned and service activities are reported to the Patient Experience Committee. Regular reports are produced throughout the year for the Learning from Incidents and Risks Committee (L.I.R.C), the Patient Environment Action Team (P.E.A.T), the Equality and Diversity (E&D) Committee. The Complaints, Litigation Incidents and PALS (C.L.I.P) Report contains the indicators that the service is required to achieve to meet the NHS Litigation Authority Risk Management Standards. In addition PALS activity and lessons learned also feature in the quarterly and annual Patient Experience Board reports.

Examples of lessons learned following the investigation of a complaint or PAL's incident are outlined below. It can be seen that the dissemination of lessons learned enables Trust wide learning which can benefit both patients and staff. Often lessons learned result in a change in practice, the procurement of new equipment etc.

An example of a lesson learned following an investigation into a complaint resulted in a number of policies and procedures

Graph 24



being reviewed in order that they could be utilised across different divisions to enable the patients care to follow the same pathway regardless of which area they are receiving treatment. It was recognised that where the patient's condition involves several different specialities all Trust polices must be followed by all staff from all specialities with no deviation as this can lead to harm to patients.

Following a PAL's incident where a patient was moved without being given sufficient time to say goodbye to the ward staff and patients it was recognised that the patient had spent some time mentally preparing herself to say goodbye to the staff and other patients whom she had befriended. Lessons learned following this incident included the requirement to ensure that in the future if patients are moved they are briefed beforehand and given time to say goodbye to staff and fellow patients.

Supporting Carers

The Trust has developed a partnership with Blackpool Carers Centre and has supported staff from the carers centre visiting hospital areas in order to ensure carers of all ages and their families are receiving the support that is needed.

Never Events

"Never Events" are defined as serious largely preventable patient safety incidents that should not occur if the prevailable preventable measures have been implemented by healthcare providers.

In 2011/12 the Trust has had no "Never Events" in comparison to three 'Never Events' reported in 2010/11.

Data Quality Reporting Information

- **Accident and Emergency**

The Trust has achieved the national 4 hour standard in every quarter of the financial year, whereby 95% of patients are to be treated, admitted discharged within 4 hours of arrival to the Accident & Emergency Department

The Trust is monitoring performance against the new clinical quality standards with two of the national standards consistently being delivered. The Trust is implementing several changes to improve compliance with all of the clinical quality indicators and expects to report significant performance improvements in 2012/13.

- **18 Weeks Referral to Treatment Targets**

The Trust has delivered the 18 week referral to treatment performance target consistently since December 2007. The revision to the Operating Framework 2010/11 in June 2010, whilst removing the 18 week standard from performance monitoring, confirmed the patients' rights to treatment within 18 weeks under the NHS Constitution. The Trust therefore continued to monitor and redesign pathways to ensure the delivery of timely and efficient patient care. During 2011/12, Trust performance remained well above the standard, with 91.89% of patients for admitted care and 95.76% of patients for non admitted care being treated within 18 weeks of referral. The Trust also met the 95th percentile targets of 23 weeks for admitted and 18.3 weeks for non-admitted pathways throughout the year.

- **62 day Cancer Waiting Time Standard**

During 2011/12 the Trust delivered the 62 day Waiting Time standards for both GP urgent and screening programme referrals. The Trust achieved in excess of the target each quarter achieving above 85% for urgent GP referrals and 90% for screening programme referrals. However, delivery of the standards continued to require significant work and pathway development across the Trust, the local health economy and wider Cancer Network. A significant amount of work was undertaken to understand and address the issues within pathways and across organisations for the benefit of patients. Information on how the criteria for this indicator has been calculated is detailed in the Glossary of Terms.

- **Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)**

The Trust has recruited a Mental Capacity Implementation Lead who commenced in post from the 14th November 2011. Since the Mental Capacity Implementation Lead has been in post the MCA/DOLS policies and procedures have been reviewed and updated where appropriate. The Trust has now established a MCA/DOLS Intranet page for staff to reference further information about MCA/DOLS. The Mental Capacity Implementation Lead regularly visits the hospitals Ward and Departments supporting clinical staff with advice and guidance on the MCA/DOLS with reference to patient queries and concerns. This helps to support patients receiving high quality of care for their safety and protection. The Mental Capacity Implementation Lead has actively engaged with staff regarding patient contacts and enquiries. From 14th November 2011 - 31st March 2012 the lead has managed 59 contact and enquiries. Since the Mental Capacity Implementation Lead has been in post there has been one DoLS Application but this was not authorised.

The Mental Capacity Implementation Lead has established an extensive training programme across the Trust which has included the Mental Capacity Implementation Lead going out into clinical areas and providing training in the work place. This is in addition to the mandatory MCA/DOLS training days. The number of clinical staff who have received training from the 1st January 2012 – 31st March 2012 is 445 which has included Medical staff. This training remains on-going.

The Trust's corporate induction programme has also increased its Safeguarding training time which includes 20 minutes allocation on MCA/DOLS. The Trust has achieved 87% compliance with staff accessing this training. The Mental Capacity Implementation Lead in partnership with the Local Authority is working on establishing a MCA/DOLS e-learning package to implement across the Trust.

The Trust also has a number of policies and procedures in place to ensure that staff joining the Trust and those moving post internally fully comply with the NHS Pre-Employment Check Standards. These national mandatory standards are designed to offer the best possible level of protection to patients and staff. The Standards cover Identification verification, employment history, references, the right to work in the UK, professional qualifications, registration, Enhanced Criminal Records (CRB) check (where the post is eligible) and occupational health clearance. All staff must meet the requirements of the checks before they are permitted to commence in post.

3.3 Statements from Commissioning Primary Care Trusts (PCT's), Local Involvement Networks (LINks) and Overview and Scrutiny Committees (OSCs)

The statements supplied by the above stakeholders in relation to their comments on the information contained within the Quality Report can be found on page 173. Additional stakeholder feedback from Public Governors has also been incorporated into the Quality Report. The lead Commissioning Primary Care Trusts have a legal obligation to review and comment on the Quality Report, while LINks and OSC's have been offered the opportunity to comment on a voluntary basis. Following feedback, wherever possible, the Trust has attempted to address comments to improve the Quality Report whilst at the same time adhering to Monitor's Foundation Trusts Annual Reporting Manual for the production of the Quality Report and additional reporting requirements set by Monitor.

3.4 Quality Report Production

We are very grateful to all contributors who have had a major involvement in the production of this Quality Report.

The Quality Report was discussed with the Council of Governors which acts as a link between the Trust, its staff and the local community who have contributed to the development of the Quality Report.

3.5 How to Provide Feedback On The Quality Report

The Trust welcomes any comments you may have and asks you to help shape next year's Quality Report by sharing your views and contacting the Chief Executive Department via:

Telephone 01253 655520

Email mary.aubrey@bfwhospitals.nhs.uk

Deputy Director of Corporate Affairs and Governance
Blackpool Teaching Hospitals NHS Foundation Trust
Trust Headquarters,
Whinney Heys Road,
Blackpool
FY3 8NR

3.6 Quality Report Availability

If you require this Quality Report in Braille, large print, audiotape, CD or translation into a foreign language, please request one of these versions by telephoning 01253 655632.

Additional copies of the Quality Report can also be downloaded from the Trust website: www.bfwhospitals.nhs.uk

3.7 Our website

The Trust's website gives more information about the Trust and the quality of our services. You can also sign up as a Trust member, read our magazine or view our latest news and performance information. http://www.bfwh.nhs.uk/about/performance/

Statements from Commissioning Primary Care Trusts (PCTs), Local Involvement Networks (LINks) and Overview and Scrutiny Committees (OSCs) in relation to the Qualiy Report 2011/2012

1.1 Statement from Commissioner NHS Blackpool - 15-05-2012

NHS Blackpool has reviewed this document and is pleased to offer comments on the Blackpool Teaching Hospitals NHS Foundation Trust quality account. We can confirm that the account is an accurate reflection of the work undertaken to improve quality and outline relevant priorities for quality improvement in 2012 -13.

NHS Blackpool commends Blackpool Teaching hospitals NHS Foundation Trust in relation to the actions taken to reduce the rates of Methicillin-Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile. We have been impressed with the improvements in reducing health care acquired infections and the work around improving patient dignity and respect. The Trust has made many improvements within the hospital sites to make sure that patients are placed in single sex accommodation and the staff have been fully committed to making sure that privacy and dignity is maintained for all patients. Commissioners regularly monitor the Trust for single sex accommodation as we believe this is a good marker for privacy and dignity and will remain a contractual requirement in 2012-13

In terms of overall quality the Trust has delivered positive outcomes against the Commissioning for Quality and Innovation (CQUIN) schemes during 2011 - 2012. For example the Venous Thromboembolism (VTE) trajectory target was 90% throughout the year and good improvement was reported by the Trust in year as part of the CQUIN scheme. This now means that all relevant patients on admission are assessed for the risk of VTE; hence patients are being cared for safely and in line with best practice.

We welcome confirmation that the Trust will participate in the 2012 -13 National Diabetes Audit, as this is a priority area for NHS Blackpool.

We welcome the increased focus on improving the care for patients with Diabetes; Chronic Obstructive Pulmonary Disease (COPD) and patients who are at the end of their lives. During 2012 -13 the Trust plans to build on the work undertaken during 2011 - 2012.

We look forward to continuing our partnership working with the Trust and supporting the amalgamation and integration of the local Community Health Services.

1.2 Statement from Commissioner NHS North Lancashire Teaching Primary Care Trust - 08-05-2012

As a significant commissioner of services from the Blackpool Teaching Hospitals NHS Foundation Trust, NHS North Lancashire was invited to review the Quality Account and provide a supporting statement for inclusion in the report.

NHS North Lancashire has taken reasonable steps to validate the information contained within the document and we can confirm that based on the knowledge and information available to us, the Blackpool Teaching Hospital NHS Foundation Trust's 2011/2012 Quality Account provides an accurate representation of the quality of services provided by the Trust.
This is the third year that the Quality Account has been produced and the report outlines the improvements achieved against last year's priorities. It provides a detailed account of improvements in quality across a number of clinical areas and describes achievements in many areas of patient safety, patient experience and clinical effectiveness. The information contained in the Quality Account is very comprehensive and we are concerned that at times the presentation and vocabulary is over complicated and may not be widely understood.

Our involvement in the development of the content and priorities of the report has been limited, and we would expect the Trust to engage the new Clinical Commissioning Groups as they develop the content of next year's Quality Account.

Overall, the content of the report provides patients and the public with a significant amount of information relating to the quality and effectiveness of the services provided by the Trust. It would be beneficial for the Trust to consider how it can increase the way in which the views of patients are used to influence the priorities of the Trust.

1.3 Statement from Blackpool Local Involvement Network - 08-05-2012

Blackpool Local Involvement Network (LINk) welcomes the third publication of this report. We are pleased to read about the work done to improve Clinical Effectiveness, Patient Experience and Patient Safety.

Please see our comments:-

Clinical Effectiveness

- We are pleased to see the improvements achieved in Acute Myocardial Infarction (Heart Attack), Hip and Knee Replacement Surgery, Coronary Artery, Bypass Graft (CABG) Surgery, Heart Failure and Community Acquired Pneumonia
- Additional work is required in Stoke targets to pass both thresholds
- The work done around 'Nutrition Mission' is excellent. Blackpool LINk are very interested in this and a representative from Blackpool LINk attended the launch event
- The range of initiatives used to prevent falls is excellent. By ensuring patients are wearing correct footwear, or by providing the patient with the footwear, this is helping to reduce the number of falls
- End of Life Pathway needs to be more active in GP surgeries.

Patient Experience

- We acknowledge the results from the National Inpatient Experience Survey and National Outpatient Experience Survey
- Congratulations to all at BTHFT on the PEAT Survey Results. Blackpool LINk is pleased to be involved in the audits that are undertaken
- By Blackpool LINk being involved in monthly audits on Single Sex Accommodation, we congratulate the Trust on the work they have done to eliminate mixed sex accommodation.
- Requires noting that Blackpool Victoria Hospital strive to be excellent in Patient Environment Action Team (PEAT) Survey Results (Table 12)
- It's recognised as a positive that more training has been given to staff.

Patient Safety

- As a whole staff at the Trust have worked hard to reduce MRSA infection rates to two - congratulations
- It is disappointing to read about the number of Patient Medication Errors and hope that staff will take more care to ensure that patients receive the correct medication at all times
- Graph 15/16 - we do not feel that reviewing twenty sets of patient case notes is representative of the number of patients that pass through the Trust each month. More sets should be reviewed each month and details given on which department the patient was in.

We would like to invite a representative from the Trust to attend a Blackpool LINk meeting to explain in more detail about the National Inpatient Experience Survey, National Outpatient Experience Survey, work being done to reduce slips, trips and falls and more information about medication errors.
Blackpool LINk would like to thank and congratulate the Trust on the improvements made over the last year.

1.4 Statement from Lancashire Local Involvement Network - 18-05-2012

Lancashire LINk welcomes the third year of Quality Accounts in which the Trust reviews its 2011 / 2012 priorities.

The Trust performed well in meeting CQUIN targets for improved interventions for Heart Attacks and Heart Failure, Hip and Knee Replacements, Coronary Artery Bypass Grafts and Community Acquired Pneumonia. They implemented programmes that reduced rates of in-hospital cardiac arrests and Venous Thromboembolism (deep vein thrombosis); reduced the number of pressure ulcers; implemented a Nutrition Mission; took effective measures for Fall Prevention (with reductions in falls of the Elderly) and carried out patient-centred work to Improve End of Life Care.

There were good results for the National Inpatient Survey (mostly above the national average) and the Environment Action annual audits (table 12); reductions of MRSA and Clostridium Difficile cases and a low level of single sex accommodation breeches. Progress reported around National Outpatient Survey indicators is positive. The Trust had no 'Never Events' and a large number of compliments. The Trust won National Patient Safety Awards and is an Investor In People Gold employer. The Trust has consulted on its new 2012 / 15 priorities which are clearly explained.

The Trust missed its CQUIN targets for both Stroke Treatment (despite its high North West rating) and also for Patient Experience Measure. Reasons why are given for both but no outline of measures taken to rectify performance are given. The referral protocols to the TIA clinics / Stroke Unit appear very rigorous but in graph 1 there is no reference to the reduction / variation after May 11.

While performance appears very good, we must point out that many of the measures used are process-based (with few outcome-based). We welcome the focus on Patient Reported Outcome Measures (PROMs) for some indicators. Total Harms comparisons may need more cases sampled to be representative.

There is no analysis of why some figures in Tables 3 – 6 fall below last year's levels nor why the Survival Index on Table 3 is lower this year. Particular concerns are that Surgical Site Infections rates rose this year for hip replacements, caesarean section and vascular surgeries (although rates for cardiac surgery reduced); and also with the levels of Medication Errors reported the Trust doesn't provide an outline of measures to improve performance.

The local patient experience survey monitoring and 'Being with Patients' programme demonstrates a desire to listening to patients but there could be more evidence of wider Stakeholder Involvement in the document. Complaints levels are similar to previous years but there is a very big increase in PAL's cases and reference is made to lessons learnt from both.

The format, layout and use of tables / comparisons are generally good and the tone constructive. But the text is small, the language sometimes too complex, some conditions need defining in lay terms. Summaries for parts 2 and 3 would help the reader. It is positive that sample sizes / percentages are included but this could happen for every graph / table and graphs 10 and 12 are confusing.

1.5 Statement from Lancashire Health Overview and Scrutiny Committee - 29-05-2012

In January 2011 the Trust undertook a transfer of all services from Wesham Hospital to Clifton Hospital without any prior knowledge of, or consultation with, the Lancashire Health Scrutiny Committee.

The members of the Committee were extremely disappointed that the Trust did not feel it necessary to engage with them at the outset and as a consequence the Trust was summoned to attend a meeting of the Health Scrutiny Committee in February to explain their actions

The Trust stated that although they were going to carry out a public consultation later in the year to look at the five year health strategy for the Fylde Coast, including a review of the NHS estate, they were of the view that they needed to focus on how to make best use of their estate in order to provide best value for money at the present time. Their actions were based on their view that they needed to consolidate the Trusts community bed stock in the short term, until such time as the future of all the NHS estate on the Fylde Coast was determined. They stated that this would be via a public consultation and would actively seek the views of patients, staff and Health and Social Care Partners.

The Committee however were not satisfied that consultation on the proposal had been adequate in relation to content and time allowed, and it was not in the interests of the health service in the area and agreed that the relocation of services from Wesham Hospital be referred to the Secretary of State for Health, for independent review.

This issue had already been the subject of debate by Blackpool Health Scrutiny Committee and informal discussions had taken place between Blackpool and Lancashire Health Scrutiny Committee Chairs to determine a way forward. It was therefore suggested, that prior to the public consultation taking place, a joint working group be formed between the two Committees to consider the content and process of that consultation exercise. The remit of the task group was to ensure that a comprehensive and fully inclusive consultation exercise was planned and delivered and that the feedback from stakeholders would be taken into consideration when a preferred option was taken forward. The outcome of the task group was published and they made a number of recommendations relating to how the public consultation should be delivered.

The actual consultation exercise is still awaited and the Health Scrutiny Committee will maximise every opportunity to make their views known and determine the eventual future of Wesham Hospital.

As improving services for the people of Lancashire and holding the providers of those services to account is a key responsibility of the Health Scrutiny Committee, members will continue to have an overview on the progress and impact of the Fylde Coast Health Strategy on the services delivered by the Trust.

1.6 Statement from Blackpool Health Overview and Scrutiny Committee - 30-05-2012

'Blackpool Council's Health Scrutiny Committee was pleased to be given the opportunity to review and comment upon the Quality Account for 2011 / 12. The Committee has enjoyed a high level of cooperation with the Trust, together with good communication links during the period in question. Officers from the Trust have attended Committee meetings on a regular basis, whenever requested, in order to present items and to be held to account by the Committee.

The Quality Account was formally considered at the Health Committee meeting on 24th May. Representatives from the Trust, presented the Committee with an explanation of the key issues that were contained within the Account, together with a summary of what the Account was designed to provide in terms of information. This was considered to have been a helpful presentation.

A number of questions from the Committee were addressed in connection with certain elements of the Account. The Committee noted that recorded complaints at the Trust had increased during 2011/12 and asked why that was. It was explained that in terms of patient experience, patients were now encouraged to report any issues. Reports on complaints were taken on a quarterly basis to the Trust Board. Over 50% of complaints were related to clinical treatment, although no particular areas of concern had been noted.

The Committee noted that the Trust had recorded a rating of 'average' in the National In-Patient survey and asked questions in relation to that rating. The process of evaluation was explained, where the Trust was initially compared to 73 other Trusts and then a comparison exercise was undertaken by the Care Quality Commission. A system was in place to learn from other organisations and in addition, monthly patient surveys were carried out, all of which were closely monitored by the Trust Board.

The Committee raised questions concerning priorities for improvement within the Account, in particular staffing concerns. It was explained that those concerns had now been addressed, with over 100 nurses being recruited into the Trust. Delays in the recruitment process had taken place due to the lengthy pre-employment check process, but a significant improvement of the system within the organisation had now been implemented and the situation was monitored on a monthly basis by the Trust Board.

The Committee looks forward to continuing its scrutiny role in relation to the work of the Trust during the next 12 months'.

Table 24 Glossary of Abbreviations	
Abbreviation	**Meaning**
AMI	Acute Myocardial Infarction
AQ	Advancing Quality
ACEI	Angiotension Converting Enzyme Inhibitors
ARB	Angiotension Receptor Blocker
BVH	Blackpool Victoria Hospital
CABG	Coronary Artery Bypass Graft
CAP	Community Acquired Pneumonia
CC	Clinical conditions.
CDI	Clostridium Difficile Infection
CDU	Clinical Decisions Unit
CEMACH	Confidential Enquiry into Maternal and Child Health. This is a national enquiry to improve the health of mothers, babies and children by carrying out confidential enquires on a nationwide basis and by disseminating the findings and recommendations as widely as possible.
CHKS	Name of the Company which is used for benchmarking
CHP	Combined Heat and Power
CRC	Carbon Reduction Commitment
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CQS	Composite Quality Score
CQUIN	Commissioning for Quality and Innovation
DoH	Department of Health
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
ERIC	Estates Returns Information Collections
GHG	Green House Gas
GP	General Practitioners
HCAI	Healthcare Acquired Infection
HES	Hospital Episode Statistics
HPA	Health Protection Agency
HRG	Healthcare Resource Group
HSMR	The Hospital Standardised Mortality Ratio (HSMR)
IRMER	Ionising Radiation Medical Exposure Regulations 2000
LAC	Looked After Children
LSCB	Local Safeguarding Children's Board
LVSD	Left Ventricular Systolic Dysfunction
LVS	Left Ventricular Systolic Function Assessment
Medusa	Electronic version of the Injectable Medicines Guide
MRSA	Methicillin Resistant Staphylococcus Aureus

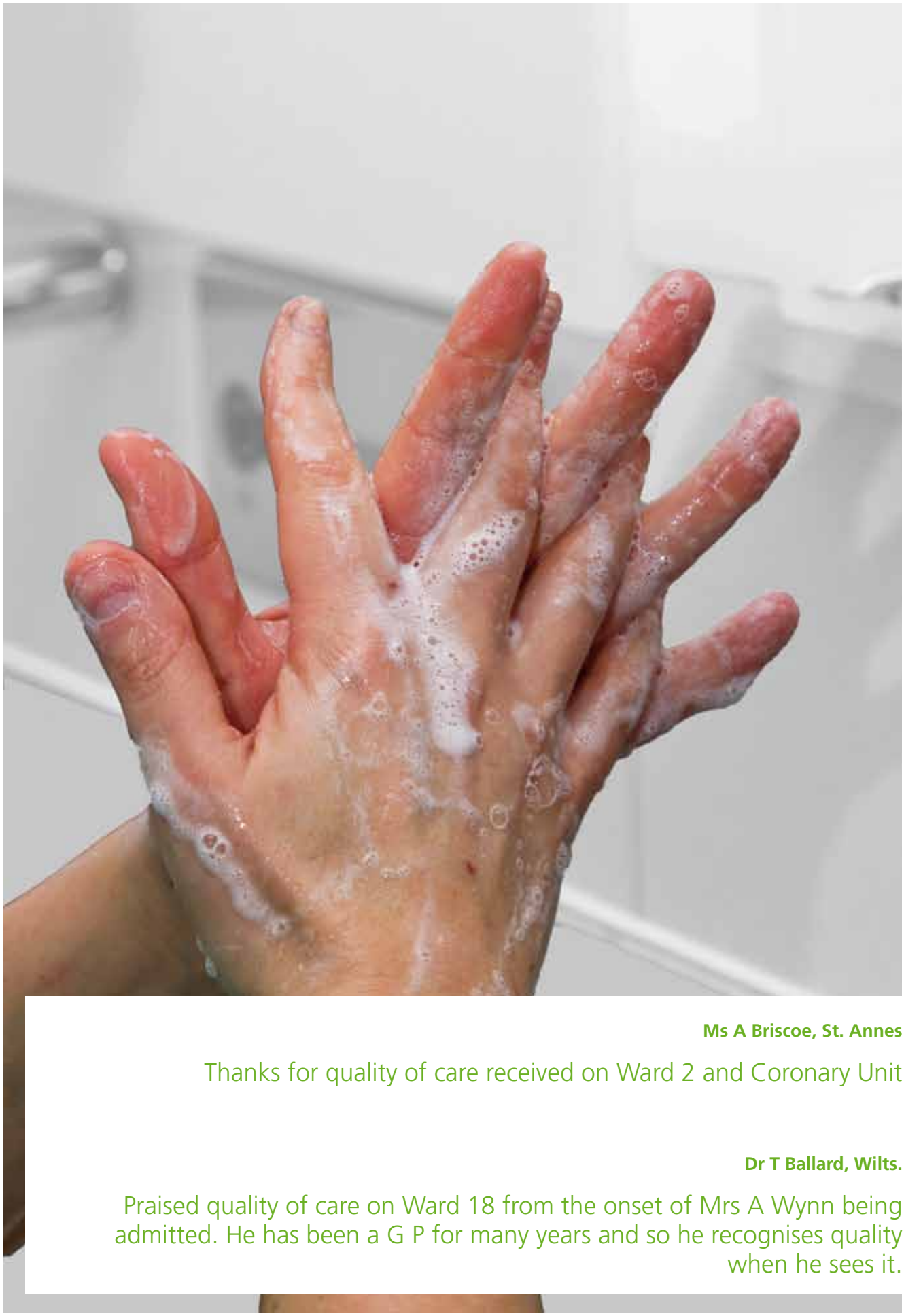
Table 24 Glossary of Abbreviations	
Abbreviation	**Meaning**
NCEPOD	National Confidential Enquiries into Perinatal Outcomes of Death
NICE	National Institute for Health and Clinical Excellence
NCI	Nursing Care Indicators
NHSLA	NHS Litigation Authority
NIHR	National Institute for Health Research
NHS OF	The NHS Outcomes Framework
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning Service
PbR	Payment by Results
PCI	Primary Coronary Intervention
PCT	Primary Care Trust
PEAT	Patient Environment Action Team
RAMI	Risk Adjusted Mortality Index
SBAR	Situation Background Assessment Recommendations
SHMI	Summary Hospital Level Mortality Indicator
SUS	Secondary Uses System
TIA	Trans Ischemic Attack
VTE	Venous Thromboembolism

Table 25: Glossary of Terms	
Abbreviation	**Glossary of meaning**
Antibiotic Prophylaxis	Antibiotic Prophylaxis is preventive treatment given to patients in order to protect them from developing an infection.
Cardiac Arrest	Cardiac arrest, (also known as cardiopulmonary arrest or circulatory arrest) is the cessation of normal circulation of the blood due to failure of the heart to contract effectively.
Clinical Conditions	JD042: Minor Skin Disorders category 3 without CC "CC" means clinical conditions. Therefore in this context the patient had no other clinical conditions or co-morbidities.
Clostridium Difficile	Clostridium Difficile (C. diff) is a bacterium that is present naturally in the gut of around two thirds of children and 3% of adults. C. diff does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C. diff bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever. At this point, a person is said to be 'infected' with C. diff.
Endoscopy Accreditation	Accreditation within Endoscopy is enabling the Trust to prove that all processes around the use of endoscopes within Gastroenterology, Cardiac Directorate and ENT are conducted to the highest standard. Systems are now in place to prove that all areas, within the Trust, conform to the same standards and Trust has passed the second stage which shows that we do what we have documented. Extremely good feedback was received during all visits by the inspector.

Healthcare Resource Groups	Developed by The Case mix Service, Healthcare Resource Groups (HRGs) are standard groupings of clinically similar treatments which use common levels of healthcare resource. Healthcare Resource Groups offer organisations the ability to understand their activity in terms of the types of patients they care for and the treatments they undertake. They enable the comparison of activity within and between different organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time. Healthcare Resource Groups are currently used as a means of determining fair and equitable reimbursement for care services delivered by Health Care Providers. Their use as consistent 'units of currency' supports standardised healthcare commissioning across the NHS. They improve the flow of finances within - and sometimes beyond - the NHS. HRG4 has been in use for Reference Costs since April 2007 (for financial year 2006/7 onwards) and for Payment by Results (PbR) since April 2009 (for financial year 2009 onwards). HRG4 was a major revision that introduced Healthcare Resource Groups to new clinical areas, to support the Department of Health's policy of Payment by Results. It includes a portfolio of new and updated HRG groupings that accurately record patient's treatment to reflect current practice and anticipated trends in healthcare.
Investors In People Gold Standards	Investors in People is all about business improvement to help transform the organisation's performance by targeting chosen business priorities
Hospital Standardised Mortality Ratio	The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect. HSMR compares the expected rate of death in a hospital with the actual rate of death. Dr Foster looks at those patients with diagnoses that most commonly result in death for example, heart attacks, strokes or broken hips. For each group of patients we can work out how often, on average, across the whole country, patients survive their stay in hospital, and how often they die.
JACIE Accreditation	The Joint Accreditation Committee is a non profit body established in 1998 for the purpose of assessment and accreditation in the field of haematopoietic stem cell (HSC) transplantation. JACIE's primary aim is to promote high quality patient care and laboratory performance in haematopoietic stem cell collection, processing and transplantation centres through an internationally recognised system of accreditation.
Microbial Contamination	Inclusion or growth of harmful microorganisms (such as clostridium botulinum) in an item used as food, making it unfit for consumption.
Methicillin Resistant Staphylococcus Aureus	MRSA stands for Methicillin-Resistant Staphylococcus Aureus. It is a common skin bacterium that is resistant to some antibiotics. Media reports sometimes refer to MRSA as a superbug. Staphylococcus Aureus (SA) is a type of bacteria. Many people carry SA bacteria without developing an infection. This is known as being colonised by the bacteria rather than infected. About one in three people carry SA bacteria in their nose or on the surface of their skin. MRSA bacteraemia – An MRSA bacteraemia means the bacteria have infected the body through a break in the skin and multiplied, causing symptoms. If SA bacteria.
NHS Outcomes Framework	The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on: • Domain 1 Preventing people from dying prematurely • Domain 2 Enhancing quality caring of life for people with long-term conditions • Domain 3 Helping people to recover from episodes of ill health or following injury; • Domain 4 Ensuring that people have a positive experience of care; and • Domain 5 Treating and for people in a safe environment • Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance
Risk Adjusted Mortality Index	Risk Adjusted Mortality Index – is a measure of the outcomes of care for patients. Risk Adjusted Mortality compares us to what is expected from the types of cases we manage and compares us to other similar hospitals in the country.
Summary Hospital Level Mortality Indicator	Summary Hospital Level Mortality Indicator measures whether mortality associated with hospitalisation was in line with expectations
Trans Ischemic Attack	Trans Ischemic Attack – A transient stroke that lasts only a few minutes. It occurs when blood to the brain is briefly interrupted
Venous Thrombo embolism	Venous Thromboembolism (VTE) is the collective term for deep vein thrombosis (DVT) and Pulmonary Embolism (PE). A DVT is a blood clot that forms in a deep vein, usually in the leg or the pelvis. Sometimes the clot breaks off and travels to the arteries of the lung where it will cause a pulmonary embolism (PE).We can avoid many VTEs by offering preventative treatment to patients at risk.

Criteria	Criteria for Indicators
VTE Prophylaxis	Venous Thromboembolism (VTE) Prophylaxis is preventive treatment given to patients in order to protect them from developing a blood clot that forms in a deep vein.
62 day Cancer waiting time standard	Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP referral as a percentage of the total number of patients receiving first definitive treatment for cancer following an urgent GP referral.
62 day cancer screening waiting time standard	Number of patients receiving first definitive treatment for cancer within 62 days referral from the screening programme as a percentage of the total number of patients receiving first definitive treatment for cancer following a referral from the screening programme.
MRSA Target	Number of patients identified with positive culture for MRSA bacteraemia
Clostridium. Difficile Target	Number of patients identified with positive culture for C. Difficile.
Mortality Rate	http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/summary-hospital--level-mortality-indicator-shmi
Patient reported outcome scores	The patient reported outcome scores are for i) groin hernia surgery, ii) varicose vein surgery, iii) hip replacement surgery, and iv) knee replacement surgery http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/patient-reported-outcome-measures-proms
Emergency readmissions to hospital within 28 days of discharge	http://www.ic.nhs.uk/pubs/hesemergency0910
National Patient Survey Results	The patient survey question to be monitored by the Trust is in relation to 'Responsiveness to inpatients' personal needs' http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_126972
National Staff Survey Results	The staff survey question to be monitored by the Trust is in relation to the 'Percentage of staff who would recommend the provider to friends or family needing care' http://www.nhsstaffsurveys.com/
Percentage of admitted patients risk-assessed for Venous Thrombo embolism	http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_131539
Rate of Clostridium Difficile	http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/ClostridiumDifficile/EpidemiologicalData/MandatorySurveillance/cdiffMandatoryReportingScheme/ The following information provides an overview on how the criteria for measuring this indicator has been calculated: • Patients must be in the criteria aged 2 years and above • Patients must have a positive culture laboratory test result for Clostridium Difficile which is recognised as a case • Positive specimen results on the same patient more than 28 days apart are reported as a separate episode • Positive results identified on the fourth day after admission or later of an admission to the Trust is defined as a case and the Trust is deemed responsible
Rate of MRSA	The following information provides an overview on how the criteria for measuring this indicator has been calculated: • An MRSA bacteraemia id defined as a positive blood sample test for MRSA on a patient (during the period under review); • Reports of MRSA cases includes all patients who have an MRSA positive blood culture detected in the laboratory; whether clinically significant or not, whether treated or not; • The indicator excludes specimens taken on the day of admission or on the day following the day of admission; • Specimens from admitted patients where an admission date has not been recorded or where it cannot be determined if the patient was admitted, are attributed to the Trust; and • Positive results on the same patient more than 14 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where the specimens were taken.

Criteria	Criteria for Indicators
Maximum 62 days from urgent GP referral to first treatment for all cancers	The following information provides an overview on how the criteria for measuring this indicator has been calculated: • The indicator is expressed as a percentage of patients receiving their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer; • An urgent GP referral is one which has a two week wait from the date that the referral is received to first being seen b y a consultation (see http://www.dh.gov.uk/prod-consum-dh/groups/dh-digitalassets/documents/digitalassset/dh-103431.pdf); • The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait); • The clock start date is defined as the date the referral is received by the Trust; and • The clock stop date is defined as the date of first definitive cancer treatment as defined in the NHS Dataset Change Notice (A copy of this can be accessed at: http://www.ish.nhs.u/documents/dscn/dscn2008/dataset/202008.pdf. In summary this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.
Rate of patient safety incidents and percentage resulting in severe harm or death	http://www.nrls.npsa.nhs.uk/resources/?entryid45=132789



Ms A Briscoe, St. Annes

Thanks for quality of care received on Ward 2 and Coronary Unit

Dr T Ballard, Wilts.

Praised quality of care on Ward 18 from the onset of Mrs A Wynn being admitted. He has been a G P for many years and so he recognises quality when he sees it.

Annex B – Statement of Directors' Responsibilities in Respect of the Quality Report

The Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporates the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, the Board of Directors can confirm that it has the appropriate mechanisms in place to prepare its Quality Report and is satisfied that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual:
- The content of the report of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2011 to March 2012;
  - Papers relating to Quality reported to the Board over the period April 2011 to March 2012;
  - Feedback from the Commissioners – NHS North Lancashire dated 08/05/12 and NHS Blackpool dated 15/05/2012;
  - Feedback from Governors dated 06/02/2012 and 08/05/2012
  - Feedback from Blackpool LINk dated 08/05/12 and Lancashire LINk dated 18/05/2012;
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 24/05/2012;
  - The latest national patient survey dated 28/03/2012;
  - The latest national staff survey dated 29/02/2012;
  - The Head of Internal Audit's annual opinion over the trust's control environment dated May 2012; and
  - Care Quality Commission quality and risk profiles dated April 2011, June 2011, 30/06/2011, 31/07/2011, 30/09/2011, 25/10/2011, 30/11/2011, 31/01/2012, 29/02/2012 and 02/04/2012;
- 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at http://www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at http://www.monitor-nhsft.gov.uk/annualreportingmanual).

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:

Ian Johnson
Chairman:

Date: 24th May 2012

Chief Executive:
Aidan Kehoe

Date: 24th May 2012

Annex C: External Auditor's Limited Assurance Report on the Contents of the Quality Report

Independent Auditor's Limited Assurance Report to the Council of Governors of Blackpool Teaching Hospitals NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Blackpool Teaching Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Blackpool Teaching Hospitals NHS Foundation Trust's Quality Report (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators in the Quality Report that have been subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 62 day cancer wait; and
- MRSA.

We refer to these national priority indicators collectively as the "specified indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the assessment criteria referred to in Annex B of the Quality Report (the "Criteria"). The Directors are also responsible for their assertion and the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") issued by the Independent Regulator of NHS Foundation Trusts ("Monitor"). In particular, the Directors are responsible for the declarations they have made in their Statement of Directors' Responsibilities.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is materially inconsistent with the sources specified below; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2011 to March 2012;
- Papers relating to Quality reported to the Board over the period April 2011 to March 2012;
- Feedback from the Commissioners – NHS North Lancashire dated 08/05/12 and NHS Blackpool dated 15/05/2012;
- Feedback from Blackpool LINk 08/05/12 and Lancashire LINk 18/05/2012;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 24/05/2012;
- The national patient survey dated 28/03/2012;
- The national staff survey dated 29/02/2012;
- Care Quality Commission quality and risk profiles dated April 2011, June 2011, 30/06/2011, 31/07/2011, 30/09/2011, 25/10/2011, 30/11/2011, 31/01/2012, 29/02/2012 and 02/04/2012; and
- The Head of Internal Audit's annual opinion over the trust's control environment dated May 2012.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Blackpool Teaching Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Blackpool Teaching Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Blackpool Teaching Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the FT ARM to the categories reported in the Quality Report; and
- Reading the documents.

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

Limitations

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

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

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts/organisations/entities.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Blackpool Teaching Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that,

- The Quality Report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is materially inconsistent with the sources specified above; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Chartered Accountants
101 Barbirolli Square
Lower Mosley Street
Manchester
M2 3PW

29 May 2012

The maintenance and integrity of the Blackpool Teaching Hospitals NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Ms Z Jackson, Chorley

Passing on thanks for care and attention by all staff on Ward 37B.

Mr T Barry, Morecambe.

Thanks for all the professionalism and genuine care during his stay in Intensive Care and Ward 38.

Annex D: A Statement of the Chief Executive's responsibilities as the Accounting Officer

Statement of the Chief Executive's responsibilities as the Accounting Officer of Blackpool Teaching Hospitals NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed Blackpool Teaching Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Blackpool Teaching Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements, and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities are set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed: Date: 24th May 2012

Aidan Kehoe
Chief Executive

Mrs J Summersgill, Manchester.

Thanks to staff on A&E, AMU Unit and Ward 25 for all their care and attention given to her father, Mr L Forshaw, during November 2011.

Annex E: Annual Governance Statement 2011/12

ANNUAL GOVERNANCE STATEMENT 2011/12

BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST

1. Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

2. The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Blackpool Teaching Hospital NHS Foundation Trust (the Trust), to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

3. Capacity to Handle Risk

3.1 Leadership

As Accounting Officer, I have overall accountability and responsibility for ensuring that there are effective risk management and integrated governance systems in place within the Trust and for meeting all statutory requirements and adhering to guidance issued by Monitor in respect of governance and risk management. I lead the Risk Management process as Chair of the Trust's Healthcare Governance Committee, which meets on a quarterly basis. I also set clear measurable Risk Management objectives for the Executive Directors with delegated responsibility for Risk Management and governance.

The Trust has a Risk Management Strategy which clearly defines the responsibilities of individual Executive Directors specifically and generally and is reviewed and endorsed by the Board of Directors annually. The Risk Management Strategy applies to all employees and requires an active lead from managers at all levels to ensure risk management is a fundamental part of the total approach to quality, safety, corporate and clinical governance, performance management and assurance. There is a clearly defined structure for the management and ownership of risk through the development of the Board Assurance Framework and Corporate Risk register.

A lead Executive Director has been identified for each principal risk defined within the Board Assurance Framework and Corporate Risk Register and each risk is linked to the Care Quality Commission Quality and Safety Standards. These 'high level' risks within the Board Assurance Framework and Corporate Risk register are subject to ongoing, iterative review by the Healthcare Governance Committee and the Board of Directors on a quarterly basis.

The Board of Directors has overall responsibility for setting the strategic direction of the Trust and managing the risks to delivering that strategy. All committees with risk management responsibilities have reporting lines to the Board. Some aspects of risk are delegated to the Executive Directors:

- The Deputy Chief Executive provides the strategic lead for financial risk and the effective coordination of financial controls throughout the Trust.
- The Medical Director (jointly with the Director of Nursing and Quality) is responsible to the Board for Clinical and Physical Risk and is the professional risk lead for all Doctors within the Trust. The Medical Director is also responsible for health and safety;
- The Director of Nursing and Quality has shared responsibility for Clinical and Physical Risk Management with the Medical Director and is the professional risk lead for Nurses, Midwives and Allied Health Professionals within the Trust. The Director of Nursing and Quality is responsible for infection prevention and is also responsible for information governance risks. The Director of Nursing and Quality is supported by the Deputy Director of Corporate Affairs and Governance who is responsible for reporting to the Board of Directors on the development and progress of the Risk Management Strategy and for ensuring that the strategy is implemented and evaluated effectively.
- The Director of Operations is responsible for developing risk based operational Key Performance Indicators and for monitoring performance and reporting to the Board on a monthly basis.
- The Director of Human Resources is responsible for workforce planning, staffing issues, education and training;
- The Deputy Director of Corporate Affairs and Governance is the management lead to ensure a fully integrated and joined up system of risk and control management is in place and embedded on behalf of the Board;
- All Divisional Directors, Clinical Directors, Assistant Directors of Nursing, and ward/departmental managers have delegated responsibility for the management of risk in their areas. Risk is integral to their day-to-day management responsibilities. It is also a requirement that each individual division produces a divisional/directorate risk register, which is consistent and mirrors the Trust's Corporate Risk Register requirements and is in line with the Risk Management Strategy.
- Governors will be responsible for providing leadership in order to operate effectively, represent the interests of members and influence the strategic direction in light of the new Health and Social Care Bill.

3.2 Training

Staff are trained or equipped to manage risk in a way appropriate to their authority and duties. The Trust has in place a programme of systematic induction for new employees which includes awareness of the Trust's Risk Management Strategy. Governance is a dedicated session on the corporate mandatory training programme and each Division and Corporate Directorate has a responsibility to develop specific departmental local induction programmes which includes awareness of the Division/Directorate Risk Management Strategy. The Trust has in place a mandatory training programme. All staff are required to attend this programme and risk management is a dedicated session in the programme. The Trust has achieved 87% compliance against NHSLA Risk Management Standards which demonstrates the commitment of staff to attend mandatory risk management training. Trust Board members have participated in bespoke risk management training.

To ensure the successful implementation and maintenance of the Trust's approach to risk management, staff at all levels are appropriately trained in incident reporting and root cause analysis training. The Trust uses an integrated electronic risk management system, known as Ulysses. The system is used to record and manage risk registers both at Corporate and Divisional level. The system allows for the recording and assessment of risks using a generic scoring matrix. The risk management leads within each Division and Corporate Directorate are responsible for coordinating the ongoing review and management of risks identified, collated, reported and reviewed locally through the Trust Governance structures.

All members of staff have responsibility for participation in the risk management system through awareness of risk assessments which have been carried out in their place of work and to compliance with any control measures introduced by these risk assessments. The Trust recognises the importance of supporting staff. The risk management team act as a support and mentor to staff who are undertaking risk assessments and managing risk as part of their role.

The overarching performance management system within the Trust ensures that controls are in place to identify and manage any risks to the delivery of key performance targets. This process is utilised as a further assurance mechanism to maintain an effective system of internal control.

Employees, contractors and agency staff are required to report all adverse incidents and concerns. The Trust supports a learning culture, ensuring that an objective investigation or review is carried out to continually learn from incidents, only assigning 'blame' to individuals where it is clear that policies

and procedures have not been appropriately followed.

The Learning from Incidents and Risks Committee (comprising senior staff) meets on a monthly basis to ensure concerns identified from incidents, complaints and claims, are investigated to ensure that lessons are learned and as a method of improvement and sharing good practice. The Trust fosters an environment where individuals are treated in a fair and just way, and where lessons are learned rather than blame being attributed.

The Trust seeks to learn from good practice and will investigate any serious incidents, complaints and Serious Untoward Incidents Requiring Investigation via the serious Incident Review and Action Team. The findings are reviewed by the Action Team to ensure learning points are implemented. Assurance is gained by presenting an overview of the investigation reports to the Trust's Healthcare Governance Committee, the Learning from Incidents and Risks Committee and the Board of Directors. Any learning points for staff are published via the Staff Lessons Learned Newsletter and via the Risk Management and the Knowledge Management Website for all staff to access.

In addition to the Trust reviewing all internally driven investigation reports, the Trust also adopts an open approach to the learning derived from third party investigations and audits, and/or external reports. During 2011/12, the Trust has taken on board recommendations from a number of external reports including the Independent Inquiry Report on Stockport NHS Trust and continues to take on board the Frances report on Mid Staffordshire NHS Foundation Trust. The monitoring of the action plans implemented to address these recommendations was undertaken at Board level.

The Trust actively seeks to share learning points with other health organisations, and pays regard to external guidance issued. Accordingly, the Trust will undertake a gap analyses and adjust systems and processes as appropriate in line with best practice.

All procedural documents are available to staff on the Trust's Intranet and there is an annual programme for monitoring the working of each procedural document to improve practice, with a quarterly review of action plans in line with the requirements of the NHSLA Risk Management Standards.

4. The Risk and Control Framework

4.1 Key Elements of the Risk Management Strategy

The Risk Management Strategy is validated by the Healthcare Governance Committee and approved by the Board of Directors. It covers all risks and is subject to an annual review to ensure it remains appropriate and current. The Risk Management Strategy assigns responsibility for the ownership, identification and management of risks to all individuals at all levels in order to ensure that risks which cannot be managed locally are escalated through the organisation. The process populates the Board Assurance Framework and Corporate Risk Register, to form a systematic record of all identified risks. The control measures, designed to mitigate and minimise identified risks, are recorded within the Board Assurance Framework and Corporate Risk Register.

Risks are identified from risk assessments and from the analysis of untoward incidents. The Risk Management Strategy is referenced to a series of related risk management documents, for example, Patient Safety Strategy, Investigating an Untoward Incident and Serious Incident Reporting Procedure. The Risk Management Strategy is available to all staff via the Document Library on the Trust Intranet.

The Trust's vision and values identifies the accepted culture within the organisation, these are linked to the corporate objectives and therefore supports the risk management framework.

4.2 Key Elements of the Quality Governance Arrangements

Quality Governance arrangements are monitored via the Committees within the Corporate Governance Structure with clear Terms of Reference. The subordinate Committees report to the Board following each of the meetings and the effectiveness of this is confirmed by an annual Internal Audit.

Information reported to the Board, regarding performance against nationally mandated targets, is collated from the dataset submitted to the Department of Health. Likewise data to support compliance with locally commissioned services and targets is reported to the Board from the dataset provided to commissioners.

The Board of Directors receive a quarterly report regarding compliance with the Care Quality Commission Quality and Safety standards together with a quarterly progress on actions taken to demonstrate improvements for those areas identified as worse or much worse than peers.

Assurance on the quality of performance information is provided by the Care Quality Commission Quality and Risk profile. Further assurance is provided by Internal Audit and External audit.

Performance against key mandatory, local/contractual indicators/ measures is monitored monthly by the Divisional Performance Board and by the Board of Directors. The Board report clearly identifies indicators/measures included within the Corporate Risk Register and Board Assurance Framework.

A Trust-wide integrated governance monitoring dashboard has been designed and implemented in July 2011. The dashboard reflects performance on key external and local quality standards.

4.3 How Risks to Data Security are Being Managed

The Information Governance Committee (IGC) reports to Healthcare Governance Committee. The IGC is responsible for all aspects of Information Management, Information Governance, Information Communications Technology and Knowledge Management throughout the Trust known collectively as Information Management; this includes the identification and management of information risks. The IGC is chaired by the Deputy Chief Executive, who is also the nominated Board Lead for Information Governance and the Senior Information Risk Owner for the Trust.

During the financial year 2011/12, the Trust had 74 Personal Data Information Security related incidents reported all of which were severity rated from level 0 - 2. (Note: Personal Data Information Security incidents are rated on a severity scale from 0 - 5). All were thoroughly investigated and reported upon. Incidents classified as a severity rating of 3 - 5 are reported as a Serious Untoward Incident and reported to Monitor and the Information Commissioner. The table below provides a summary of the incidents that were reported during the year:

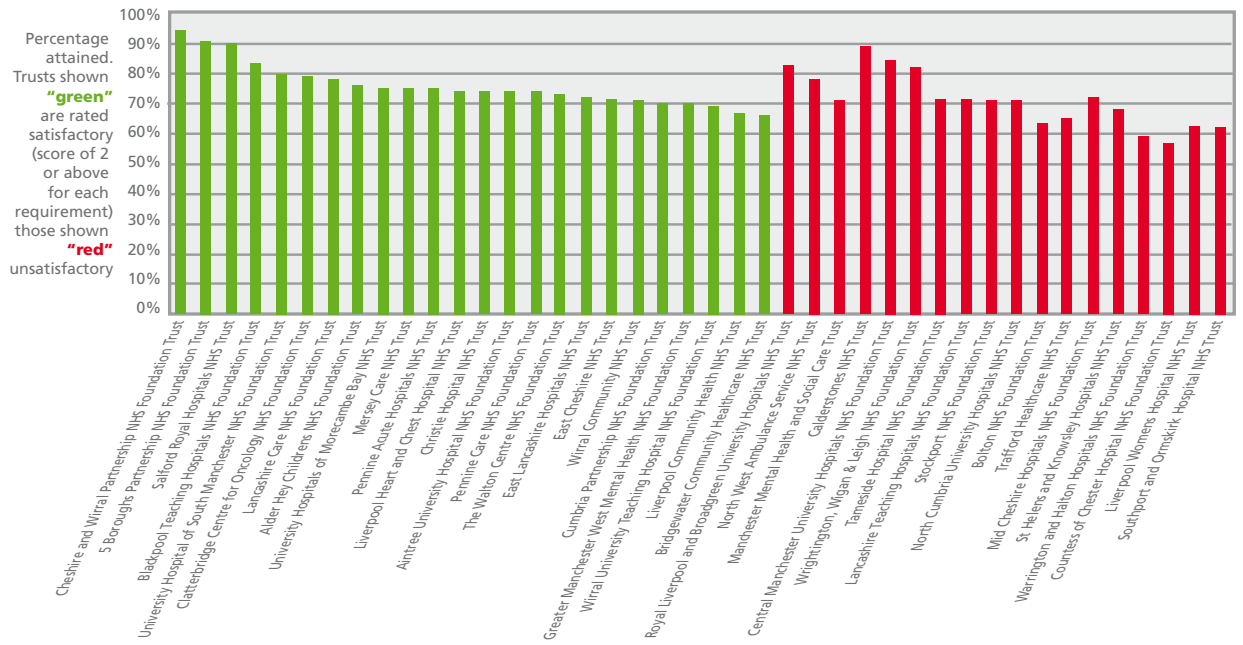
The Trust achieved Information Governance Toolkit (IGT) assessment compliance score of 83%. The IGT submission is subject to independent audit. In addition to this a review by Audit North West has reviewed evidence and provided an overall Significant Assurance opinion in respect of our process of Self Assessment.

The Trust achieved an Information Governance Toolkit (IGT) Version 9 assessment compliance score of 83% scoring level 2 or above in all requirements and as such is rated as satisfactory. A review of the North West Provider Trusts showed that the percentage attained ranged from 57% to 94% with 24 being rated as satisfactory and 18 as unsatisfactory. See table below. The IGT submission is subject to independent audit. The audit for IGT V9 was undertaken by Audit North West who reported an overall "Assurance Opinion" of Significant.

Table: Summary of Personal Data Related Incidents 2011/12

Category	Nature of Incident	Total
i.	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises.	3
Ii.	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	3
iii.	Insecure disposal or inadequately protected electronic equipment, devices or paper documents	26
iv.	Unauthorised disclosure	31
v.	Other	11

Table: IGT Toolkit Version 9 Compliance North West Provider Trusts



4.4 Organisations Key Risks

The key organisational risks for the year were identified from the corporate strategic objectives for 2011/12, forming part of the Board Assurance Framework and included the following:

In-Year Risks 2011/12	Future Major and Significant Clinical Risks 2012/13
• Failure to prevent Significant Breach of Authorisation (Monitor Nov 2010) • Failure to maintain financial balance • Failure to recognise quality and safety of patient care deteriorating • Failure to provide sufficient workforce competence, skill mix and capacity • Failure to achieve the Transfer of Community Services on 1st April 2012 • Failure to reduce the risk of patients acquiring Clostridium Difficile • Failure to reduce the risk of patients acquiring MRSA bacteraemia • Failure to reduce hospital mortality rates • Failure to implement the electronic patient record • Failure to recruit sufficient staff to meet basic establishment needs • Failure to comply with Health and Safety regulations • Failure to meet Transformation of Community Services due diligence requirements and achieve appropriate risk rating from Monitor • Failure to achieve CNST Level 2 • Failure to achieve QuIPP improvements • Failure to achieve Monitor Compliance Framework • Failure to achieve Health and Social Care Hygiene Code Standards • Failure to reduce Smoking in Pregnancy • Failure to increase Breast Feeding Rates in Relation to National Standards and National Target • Failure to implement VISION in compliance with Clinical Governance Standards • Failure to achieve of CQUIN Local Contractual Measures • Failure to prevent loss of Income due to Actual Activity Levels below Plan as a Result of Demand Management Schemes • Failure to achieve Cash Balances / The Organisation Requires Sufficient Liquidity to meet Monitor's Compliance Framework - Top Risk • Failure to maintain NHSLA Level 3 Risk Management Standards	• Failure to prevent Significant Breach of Authorisation • Failure to achieve QuIPP improvements • Failure to achieve Monitor Compliance Framework • Failure to achieve Health and Social Care Hygiene Code Standards • Failure to implement VISION in Compliance with Clinical Governance Standards' • Failure to achieve of CQUIN Local Contractual Measures • Failure to comply with Current Health and Safety regulations • Failure to reduce the risk of patients acquiring MRSA bacteraemia • Failure to reduce the risk of patients acquiring Clostridium Difficile • Failure to prevent Dr Foster and CHKS data showing that risk adjusted mortality rates are high compared to Peer group. Monitor highlighted mortality rates as high risk • Failure to maintain Quality and Safety of Patient Care • Failure to recognise the Deterioration of Quality and Safety – Top Risk • Failure to maintain CNST Level 1 and 2 • Failure to prevent loss of Income due to Actual Activity Levels below Plan as a Result of Demand Management Schemes • Failure to achieve Cash Balances / The Organisation Requires Sufficient Liquidity to meet Monitor's Compliance Framework - Top Risk • Failure to maintain a Safe and Sufficient Workforce - Top Risk • Failure to achieve Transformation of Patient Pathways • Failure to maintain NHSLA Level 3 Risk Management Standards

The above risks have been risk assessed within impact scores validated by the Board of Directors. Mitigating actions are monitored at a minimum on a quarterly basis by the reporting committees identified in the risk management strategy. Escalation and de-escalation of risks is dependent upon progress to achieve outcomes.

4.5 How Risk Management is Embedded in the Activity of the NHS Foundation Trust

Risk Management is embedded in the activity of the organisation through Induction Training, regular Risk Management Training and ad-hoc training when need is identified. An Untoward Incident and Serious Incident reporting system is in place and incidents are entered onto a database for analysis. Root cause analysis is undertaken and all identified changes in practice are implemented.

Risk Management is embedded within the Trust through key committees identified in the Corporate Governance Structure and consists of clinical and non-clinical committees, which report to the Healthcare Governance Committee on a quarterly basis. The Trust has a zero-tolerance approach to fraud and the service for our Counter Fraud is provided by Audit North West. This helps to embed and tackle fraud and potential fraud in several ways:

- developing an anti-fraud culture across the Trust's workforce;
- fraud proofing of all of our policies and procedures;
- conducting Fraud detection exercises into areas of risks;
- investigating any allegations of suspected fraud; and
- obtaining, where possible, appropriate sanctions and redress.

Each Division and Department has undertaken a self assessment and completed a fraud risk assessment which is monitored on a local level and existing controls continue to mitigate the risk.

The Audit Committee is a sub-committee of the Board of Directors and provides independent assurance on aspects of governance, Risk Management and internal controls. The Healthcare Governance Committee links to the Audit Committee and the Clinical Governance Committee and also reports direct to the Board of Directors.

The Trust has been carrying out Equality Impact Assessments (EIA) since 2007. Since their inception within the Trust all policies, procedures, guidelines, schemes, strategies etc have to have a completed EIA attached before being sent to the relevant committee for discussion and signing off. Likewise completion of an EIA is expected when there is a new service to be implemented, a change to a service or cessation of a service along with the relevant consultation and engagement with service users. Where an adverse impact is identified during the completion of the initial assessment, a full EIA is carried out. This involves consulting and engaging with people who represent protected characteristics groups and other groups if required to do so.

An action plan is drawn up after completing the full assessment which details the actions to be taken, along with a time frame, to eliminate or reduce as far as possible any adverse impact. A copy of the action plan is sent to the Trust's Equality Diversity and Human Rights Steering Group for monitoring on its progress.

Equality and Diversity training is part of the Trust's Induction Programme and the Trust's overall mandatory training programme.

4.5.1 Elements of the Assurance Framework

The Board Assurance Framework has been fully embedded during 2011/12. The Assurance Framework:

- Covers all of the Trust's main activities.
- Identifies the Trust's corporate objectives and targets the Trust is striving to achieve.
- Identifies the risks to the achievement of the objectives and targets.
- Identifies the system of internal control in place to manage the risks.
- Identifies and examines the review and assurance mechanisms, which relate to the effectiveness of the system of internal control.
- Records the actions taken by the Board of Directors and Officers of the Trust to address control and assurance gaps; and
- Covers the Care Quality Commission essential Quality and Safety Standards on which the Trust has registered with the CQC with no conditions during 2011/12.

The Healthcare Governance Committee considers high/significant risks and if appropriate, recommends their inclusion on the Corporate Risk Register and/or Board Assurance Framework. This is presented to the Board of Directors for formal ratification.

Risk prioritisation and action planning is informed by the Trust's corporate objectives which have been derived from internal and external sources of risk identified from national requirements and guidance, complaints, claims, incident reports and Internal Audit findings. This also includes any other sources of risk derived from Ward, Departmental, Directorate and Divisional risk assessments, which feed up to Divisional and Corporate level management. Action plans are developed for unresolved risks.

Lead Executive Directors and Lead Managers are identified to address the gaps in control and assurance and are responsible for developing action plans to address the gaps. The Board Assurance Framework serves to assure the Board of Directors that the Trust is addressing its risks systematically. The action plan arising from each risk also serves as a work plan for the Trust through the Lead Managers to ensure mitigation against risks and closure of any gaps in control or assurance.

The 'elements' of the Board Assurance Framework are monitored and reviewed on a quarterly basis by the Healthcare Governance Committee and the Audit Committee followed by the Board of Directors. This demonstrates that the document is live and continuous and provides evidence to support the Annual Governance Statement.

The Finance Director (who also acts as the Deputy Chief Executive), and the Deputy Director of Corporate Affairs and Governance are also members of the Healthcare Governance Committee and provide Governance and Risk Management assurance to the Audit Committee at each of its meetings, thus ensuring an integrated risk management approach.

The Trust manages gaps in assurance by way of the Audit Committee who will review these gaps and assess the required assurances to review systems and processes.

4.6 How Public Stakeholders are Involved in Managing Risks Which Impact on Them

The Governance Framework requires the Trust to involve both patients and public stakeholders in the Governance agenda. This has been achieved through engagement with the Trust membership and Governors, NHS Blackpool, NHS North Lancashire, Blackpool Overview and Scrutiny Committee, Lancashire Overview and Scrutiny Committee, Blackpool Local Safeguarding Children's Board, Blackpool Vulnerable Adults Board, Blackpool Domestic Abuse Strategic Board, Learning Disability Partnership Board and Local Involvement Networks (LINk). The Trust has a Patient Public Involvement Strategy in place and this has been continuously implemented throughout 2011/12. This is now a core component of the Trust Membership Strategy. Public Stakeholders are consulted with regarding future service developments and changes in service development.

Patient feedback is actively solicited through the monthly local in-patient survey and patient feedback is reviewed on an ongoing basis with summary reports reviewed regularly by the Board.

The Trust has also engaged with Staff and Public Governors to provide them with assurance that the risks across the organisation are being managed and mitigated. The Trust has also worked with Deloitte LLP, an independent Management Company, to undertake a review of the effectiveness of the Governors in preparation for the new Health and Social Care Act Legislation and the the Trust is looking forward to working with the Governors in their new role.

Issues raised through the Trust's Risk Management processes that impact on partner organisations, for example, NHS Blackpool, NHS North Lancashire, and Lancashire Care NHS Foundation Trust, would be discussed at the appropriate forum in order that appropriate action can be agreed.

An established communications framework is in place in the form of a Major Incident Plan, and cross-community emergency planning arrangements are in place.

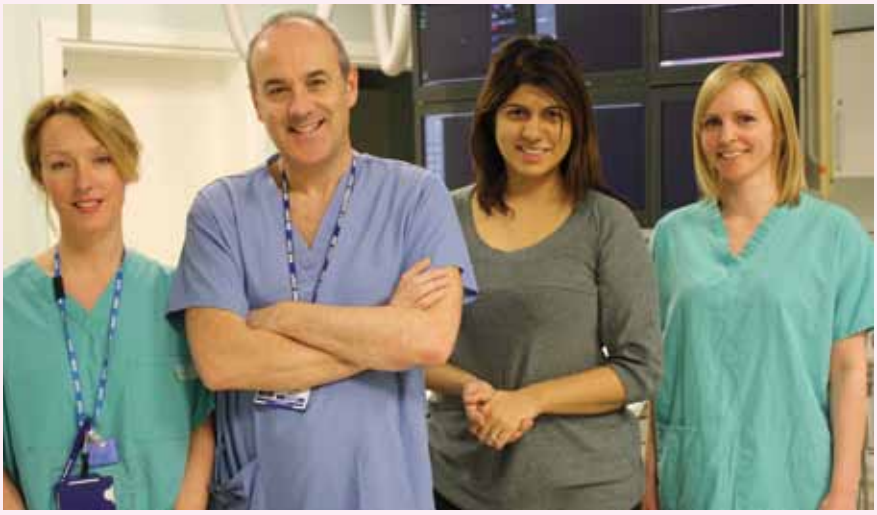
4.7 Disclosure of Registration Requirements

The NHS Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

The CQC carried out an unannounced visit on 27 September 2011 on regulated activity for surgical procedures in order to review the Trust's compliance with the essential standards of quality and safety. The outcome of the visit was very positive. The formal report was received on 17 January 2012, an action plan has been developed and progress report will be submitted to the January Board.

The CQC report provided positive feedback. However the Trust received three improvement actions in order to maintain compliance for three essential standards of quality and safety in relation to Outcome 07: Safeguarding people who use services from abuse; Outcome 14: Supporting staff and Outcome 16: Assessing and monitoring the quality of service provision. The Trust developed an action plan and implemented the recommendations to address the above actions to maintain compliance in relation to Outcomes 07; 14; and 16. This has been achieved by providing increased Deprivation of Liberty Safeguard (DoLs) training; Root Cause Analysis Training; and the increased uptake of appraisal training/ supervision support, coaching skills/ conversations training for clinical leaders in the Surgical Division. The Trust have now addressed the three improvement actions and are declaring compliance with Outcomes 07, 14 and 16 with no further improvements required.

The Trust also received one compliance action as one standard had been identified as not being met. This was in relation to Outcome 02 Consent



to care and treatment. The Trust developed an action plan and commenced implementation of the recommendations to address the compliance action in relation to Outcome 2 prior to the receipt of the final report from the CQC. Due to a number of improvement initiatives including Mental Capacity Act (MCA) training policy review; and ward/departmental support from the MCA Implementation Lead, the Trust are now declaring compliance with Outcome 02 criteria. All actions have been implemented and the action plan and progress report has been submitted to the CQC following approval by the Board on 28 March 2012.

4.8 Compliance with the NHS Pension Scheme Regulations

As an employer with staff entitled to membership of the NHS Pension Scheme control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules and regulations, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

4.9 Compliance with Equality, Diversity and Human Rights Legislation

Control measures are in place to ensure that all Trust's obligations under equality, diversity and human rights legislation are complied with. This is evidenced by the annual review during the year of the Single Equality Scheme at the Equality and Diversity and Human Right Steering Committee which reports to the Clinical Governance Committee. This is also evidenced by demonstrating that all procedural documents incorporate an equality impact assessment prior to ratification by the relevant committee.

4.10 Compliance with Climate Adaptation Requirements under the Climate Change Act 2008

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Trust is continuing to monitor its performance with regards to the Trust's position in relation to the notice served by the Independent Regulator, Monitor, under Section 52 of the National Health Service Act 2006. Under this Notice, dated November 24th 2010, It was of the opinion of Monitor's Board that the Trust was not meeting its statutory duties to put in place proper arrangements to exercise its functions economically, efficiently and effectively and is in significant breach of conditions 2 and 5:

- Condition 2: the general duty to exercise its functions effectively, efficiently and economically and
- Condition 5: governance of the Trusts Terms of Authorisation.

Each month Monitor continues to hold a formal Progress Review Meeting to assess sufficient and sustained progress towards achieving a timely return to compliance with the Terms of its Authorisation. The Trust has received official confirmation from Monitor on the 24th May 2012 that the Trust has been de-escalated from significant breach. It is the opinion of Monitor's Compliance Board Committee that the Trust is now meeting its statutory duties and has put into place proper arrangements to exercise its function economically, efficiently and effectively.

The Trust has arrangements in place for setting objectives and targets on a strategic and annual basis. During 2011-12 the Trust has consolidated and developed a number of systems and processes to help achieve an improvement in the financial performance which includes the following, namely: -

- Approval of the annual budgets by the Board of Directors.
- Monthly Finance and Business Monitoring Committee to ensure Directors meet their respective financial targets reporting to the Board.
- Bi-monthly Finance Reviews.
- Monthly Cash Committee is actively continuing with measures to further improve cash balances which reports to the Finance and Business Monitoring Committee. The Cash Committee has minimised the risk of the Trust using the Working Capital Facility. The measures taken include creditor stretch and improvements in receivables processes and improvements to cash forecasting.
- The Trust has strengthened the Programme Management Office structure with the permanent appointment of a Head of Programme Management Office to scrutinise QuIPP planning and delivery. In addition, the Trust is utilising external support to identify areas of improvement and develop/implement the action plans to deliver the required efficiency.
- The Divisional Plans will continue to be reviewed on a fortnightly basis by Executive and Non Executive Directors through the gateway review meeting.
- The Divisions play an active part in ongoing review of financial performance including Cost Improvement Requirements/ Quality, Innovation, Productivity and Prevention (QuIPP) delivery.
- Monthly performance management of Divisions by the Executive Team is undertaken for key areas.
- Monthly reporting to the Board of Directors on key performance indicators covering Finance activity; Quality and Safety activity and Human Resource targets.
- Weekly reporting to the Executive Team on key influences on the Trust's financial position including activity on quality and safety performance and workforce indicators.
- One of the key variances in 2011/12 was underperformance in elective activity income in the Scheduled Care Division, however, since monitoring and managing activity on a daily basis by the Director of Operations and Deputy Chief Executive, elective activity returned to normal levels in the latter part of the year.

The Trust also participates in initiatives to ensure value for money, for example:

- Value for money is an important component of the Internal and External Audit plans that provide assurance to the Trust regarding processes that are in place to ensure the effective use of resources.

- In-year cost pressures are rigorously reviewed and challenged, and mitigating strategies are considered.
- Weekly QuIPP Theme meetings are held by each of the Executive Directors to monitor staff to ensure the delivery of the cost saving initiatives. Improvements to QuIPP processes include: -
  - Improvements to QuIPP governance including continuation of the QuIPP Gateway meetings and QuIPP Programme Board
  - Improvements to QuIPP planning
  - Strengthening the PMO through the appointment of a permanent Head of PMO
- The Trust subscribes to a national benchmarking organisation (CHKS). This provides comparative information analysis on patient activity and clinical indicators. This informs the risk management process and identifies where improvements can be made.
- The Trust uses lean methodology to optimise the efficient and effective use of resources whilst enhancing the patient experience and improving the quality of care provision into the delivery of our day to day services. The Lean methodology principles focus on developing a culture of continual improvement and reducing duplication and waste from processes
- The Trust has a standard assessment process for future business plans to ensure value for money and to ensure that full appraisal processes are employed when considering the effect on the organisation Procedures are in place to ensure all strategic decisions are considered by the Board of Directors.
- Successful renegotiation of the Contract with the Commissioners

6. Annual Quality Report

The Trusts Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of Annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Trust has built on the extensive work undertaken to develop the Quality Account and has drawn on the various guidance published in-year in relation to the Quality Account. We developed our vision, values and priorities through wide involvement and in consultation with patients, staff, external stakeholders and Governors. The consultation of the Quality Account was launched and included a number of presentations made to the Council of Governors on Quality Accounts, a workshop session with representatives from the Council of Governors and LINk as well as members of the public. In addition a website has been developed to obtain the views of the public regarding the quality accounts priorities for 2011/12. 'Through this engagement', the Trust has been able to ensure the areas chosen provide a balanced view of the organisations priorities for 2011/2012. In the preparation of the Quality Account, the Trust appointed a Quality Account Project Lead to develop the Quality Account, reporting direct to the Director of Nursing and Quality, and a Quality Account Steering Group was established. A formal review process was established, involving the submission of our initial draft Quality Report to our external stakeholders (Commissioners; Overview and Scrutiny Committees and Local Involvement Networks). The Quality Account drafts were formally reviewed through the Trusts governance arrangements, formal Executive Directors meeting and the Board of Directors. The Trust set 2012/13 priorities for improvement for clinical effectiveness, patient experience and patient safety. Priorities were developed to embed and monitor quality improvement processes, set against the needs of our patients in the delivery of our services.

The Board of Directors can confirm that they have met the necessary requirements under the Health Act 2010 and the National Health Service (Quality Accounts) Regulations 2010 to prepare its Quality Accounts for the financial year 2011/12. Steps have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data. These steps cover the following areas as detailed below:

- **Governance and Leadership**
  The quality improvement system is led directly by the Board of Directors which also exercises its governance responsibilities through monitoring and review of the Trust's quality performance. The Healthcare Governance Committee reporting directly to the Board leads the quality improvement strategy and reviews quality improvement projects on a regular basis.

- **Policies**
  Key policies for quality improvement are in place and these are linked to risk management and clinical governance policies. Trust data quality policies and procedures, score highly on the national Information Governance Toolkit and all evidence is delivered and audited. Data quality reports are developed and submitted through the Information Governance Committee, Performance Board and through to the Trust Board. Data quality staff are in post with relevant job descriptions whose remit is to provide training, advice and review and (where applicable) correct anomalies.

- **Systems and Processes**
  The Board of Directors ensures that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery. The Board regularly reviews the performance of the Trust in these areas against regulatory requirements and approved plans and objectives.

- **People and Skills**
  The 'Blackpool Way' outlines and reinforces the culture across the Trust and actively encourages and supports employees to gain the skills and qualifications that will support their future employability and meet the needs of the organisation. Locally the focus in 2011/12 was to continue developing managers in coaching and leadership skills particularly for those colleagues who lead our clinical teams to ensure that all staff are safe to practice and to care for our patients.

  The Learning and Development Team continues to provide skills support through widening access to education for staff in the workforce. The purpose is to ensure that all staff are skilled, competent and able to make a full contribution to the success of the organisation.

- **Data use and Reporting**
  The Trust is provided with external assurance on a selection of the quality data identified within the Quality Report which was taken from national data submissions, CHKS and national patient survey results, Patient Survey results and Information Governance Toolkit results. Local internal assurance is also provided via the analysis of data following local internally led audits in relation to nursing care indicators, analysis of data following incidents in relation to medication errors and slips, trips and falls incidents for patients. The quality and safety metrics are also reported monthly to the Board through the business monitoring report and the quality and safety report.

  The Trust has a fully controlled process for the provision of external information with control checks throughout the process. Formal sign off procedures and key performance indicators on data are submitted through the Information Management Department.

  Data reporting is validated by internal and external control systems involving Clinical Audit, the Audit Commission and Senior Manager and Executive Director reviews.

The Trust has reviewed its objectives and re-emphasised its commitment to quality, with the aim of achieving excellence in everything it does. Its aspirations for quality improvement in 2011/12 were to:

- Improve our hospital standardised mortality rate.
- Conform to best practice by fully implementing Advancing Quality, 100,000 Lives and Saving Lives interventions.
- Reduce avoidable harms.
- Improve the patient experience.

The Trust believes quality should be supported at every level of the organisation and has ensured that all Divisions have implemented the actions required to meet the quality standards. Monitoring was overseen through a number of forums.

The Board of Directors at the Trust can confirm it has the appropriate mechanisms in place to prepare, approve and publish its Quality Report for 2011/12. The Board of Directors is satisfied that the Quality Report provides a balanced view and the appropriate controls are in place to ensure accuracy of data and a true reflection of overall quality within the organisation.

7. Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their Management Letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Healthcare Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I have drawn on the content of the Quality Report and other performance information available to me. My review is also informed by comments made by the external auditors in their Management Letter and other reports.

In describing the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control I have detailed below some examples of the work undertaken and the role of the Board of Directors, the Audit Committee, Healthcare Governance Committee, Internal Audit and External Audit in this process. My review has been informed by:

- The self-assessment of the maintenance of compliance against NHSLA Level 3 Risk Management Standards status that provided assurance on controls.
- The achievement of compliance attaining CNST Maternity Level 2 on 28 February 2012.
- Self-assessment against the Audit Commission's Auditors Local Evaluation (ALE) criteria.
- Internal Audit reviewed the Board Assurance Framework and the effectiveness of the overall system of internal control as part of the Internal Audit Annual Plan which is agreed by the Deputy Chief Executive and the Audit Committee.
- The Head of Internal Audit Opinion gave an overall Significant Assurance opinion on the system of internal control for 2011/12. Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk.
- The process of arriving at the Trust's self-assessment of compliance against the CQCs Quality and Safety Standards, demonstrates continuous improvement against the standards. Supporting evidence is available for all members of the Board of Directors to review as a source of assurance and is an essential part of the Trust's verification for the system of internal control.
- The Trust received registration with the CQC without conditions on 16 March 2010 and continues to remain registered without conditions for 2011/12.
- The Trust's assessment of 83% compliance with the Information Governance Toolkit standards for 2011/12 (version 9) demonstrates continuous improvement against these standards.
- The Annual Risk Management Report and the Quality and Safety Report, which evidence action on all aspects of governance including, risk management.

- The Board Assurance Framework itself provides the Trust with evidence of the effectiveness of the system of internal controls that manage the risks to the organisation. The Board of Directors also monitor and review the effectiveness of the Board Assurance Framework on a quarterly basis. Internal Audit provided a Significant Assurance opinion on the Board Assurance process.

- The Board of Directors, Audit Committee, Executive Directors Meeting and the Healthcare Governance Committee have advised me on the implications of the result of my review of the effectiveness of the system of internal control. These committees also advise outside agencies and myself on serious untoward events.

- All of the relevant committees within the Corporate Governance Structure have a clear timetable of meetings and a clear reporting structure to allow issues to be raised.

- The Healthcare Governance Committee manages and reviews the Board Assurance Framework in conjunction with Executive Directors. The minutes of the Healthcare Governance Committee are presented to the Board of Directors. The Healthcare Governance Committee produce an annual Risk Management report, which is presented to the Audit Committee followed by the Board of Directors and this provides assurance on controls.

- The Audit Committee review the establishment and maintenance of an effective system of Integrated Governance, Risk Management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the overall Trust objectives. The Audit Committee review the Board Assurance Framework on a quarterly basis.

- Comments made by External Auditors and other review bodies in their reports. For example on 01 February 2012, the Trust had a re-assessment of performance by the Information Standards EMQC against national standards in relation to developing patient information leaflets and maintained Accreditation in February 2012.

The Trust has a robust process for ensuring recommendations made in assurance reports are implemented on a timely basis.

External reports relating to a follow-up Board Effectiveness Review was undertaken by Deloitte LLP in December 2011/January 2012 to ascertain whether the recommendations contained in Deloitte's initial detailed action plan 2010/11 had been implemented. The outcome of the follow-up review was that "the Board has responded positively and promptly to the points raised and significant improvements in the effectiveness of the Board have been made and that decision making is effective with no material concerns noted." Internal Audit provided overall Significant Assurance opinions in 27 areas although there are areas of Limited Assurance opinions in three areas that have been identified which related to:

- Staff Appraisals;
- Venous Thromboembolism Prophylaxis (VTE); and
- Estates and Facilities Competitive Procurement and Contract Award.

These were as a result of weaknesses in design and operation of the controls therein. Actions have been agreed to improve the systems of control and the Management Team have already implemented or are in the process of implementing these actions in order to improve systems of internal control in the areas identified. Progress is monitored by the Clinical Governance Committee and the Healthcare Governance Committee. The Audit Committee will also monitor the implementation of the action plans and progress against the recommendations made in order to be provided with assurance that improvements are made.

The reduction in Hospital Standardised Mortality Index (Dr Foster) and the Summary Hospital Mortality Indicators remain a clinical risk. The Trust has shown a sustained improvement in its Risk Adjusted Mortality Index (RAMI) over the last three years and the RAMI remains below the predicted figure of 100. However other measures of hospital mortality including the Hospital Standardised Mortality Index (Dr Foster) and the Summary Hospital Mortality Indicators (SHMI) have shown mortality rates higher than the expected and in response to them the Trust has commissioned AQuA to undertake an independent external review of hospital mortality. Following the review an action plan has been developed and progress monitored by the Mortality Board and the Board of Directors on a monthly basis to ensure improvements are made.

The delivery of the MRSA Bacteraemia and Clostridium Difficile targets remain a clinical risk. In relation to Monitor's Compliance Framework which identifies an MRSA trajectory of six cases for the reporting period. Striving for excellence, the Trust has a local MRSA target of three cases for the reporting period. The Trust has reported two MRSA cases for this year, which is under the local trajectory and remains within Monitor's Compliance Framework target.

We have significantly reduced the number of cases of Clostridium Difficile as a result of clinical engagement, new ways of working and the commitment of all staff to make improvements in this important area. The Clostridium Difficile trajectory for 2011/12 was 86, agreed with the Strategic Health Authority and with NHS Blackpool Commissioning Primary Care Trust the Trust has 53 cases reported in total.

Monthly levels of MRSA Bacteraemia and Clostridium Difficile are monitored by the Hospital Infection Prevention Committee and the Board of Directors.

The Trust has implemented a number of initiatives to limit hospital-acquired infections within the target level through additional investments in screening and personnel, and through participation in the Safer Patients Initiative, which has elements devoted to reducing infection. Due to the merging of Community Health Services with the Trust, this will assist in the management and influence the incidence of 'Community' acquired infection, and will enable the Trust to continue to work with and support Community Healthcare Services aim to mitigate this risk. The target remains achievable although it is noted as a clinical risk.

8. Conclusion

My review of the effectiveness of the systems of internal control has taken account of the work of the Executive Management Team within the organisation, which has responsibility for the development and maintenance of the internal control framework within their discreet portfolios. In line with the guidance on the definition of the significant control issues, I had one outstanding significant internal control issue which has been identified in the body of the Annual Governance Statement above, that is in relation to the Trust failing to meet its statutory duties to exercise its functions economically, efficiently and effectively and is in significant breach of conditions 2 and/or 5 being Condition 2: the general duty to exercise its functions effectively, efficiently and economically Condition 5: governance of the trusts terms of authorisation.

The Trust has received official confirmation from Monitor on the 24th May 2012 that the Trust has been de-escalated from significant breach. It is the opinion of Monitor's Compliance Board Committee that the Trust is now meeting its statutory duties and has put into place proper arrangements to exercise its function economically, efficiently and effectively.

Signed:

Aidan Kehoe
Chief Executive

Date: 24th May 2012

Mrs E James, Blackpool.

Thanks for all the high standard of care and kindness given to her father during his stay in Ward 25.

Mr M Bryan, Barnacre.

Personal thanks to all staff connected with the Lancashire Cardiac Unit during his stay from 8th November to 17th November 2011.

Annex F: Accounts for the Period 1st April 2011 to 31st March 2012

FOREWORD TO THE ACCOUNTS

BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST

These accounts for the period ended 31st March 2012 have previously been prepared by Blackpool Teaching Hospitals NHS Foundation Trust in accordance with Schedule 7, Sections 24 and 25 of the National Health Services Act 2006 in the form which Monitor (the Independent Regulator of foundation trusts) has directed.

Signed:

Aidan Kehoe
Chief Executive
Date: 24th May 2012

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2012

	NOTE	2011/12 £000	Restated 2010/11 £000
Income from activities	3	**256,124**	249,396
Other operating income	4	**28,081**	25,605
Operating income		**284,205**	275,001
Operating expenses	5	**(274,645)**	(290,907)
OPERATING SURPLUS / (DEFICIT)		**9,560**	(15,906)
Finance Costs			
Finance income	8	**121**	46
Finance costs	9	**(2,116)**	(1,884)
Public Dividend Capital dividends payable		**(4,248)**	(5,349)
Net Finance Costs		**(6,243)**	(7,187)
SURPLUS / (DEFICIT) FOR THE YEAR		**3,317**	(23,093)
Surplus for the financial year before exceptional items		4,487	2,100
Exceptional items			
Non current asset impairments	11	(1,079)	(18,807)
Net gain as a result of change in charitable income accounting treatment		1,691	0
Net profit / (loss) on disposal of non current assets	7	27	(175)
Redundancy	6	(1,809)	(4,793)
Mutually agreed resignation scheme	6	0	(1,418)
Surplus / (Deficit) for the financial year after exceptional items as stated above		3,317	(23,093)
Other comprehensive income:			
Revaluation losses on property, plant and equipment	11	**(1,836)**	(7,894)
Revaluation gains on property, plant and equipment	11	**375**	6,140
Reduction in the revaluation reserve following disposal of assets		**0**	(38)
TOTAL COMPREHENSIVE INCOME/(EXPENSES) FOR THE YEAR		**1,856**	(24,885)

The notes on pages vi to xxxix form part of these accounts.
All revenue and expenditure is derived from continuing operations.
Details of the 2010/11 restatement are disclosed in note 11.2

STATEMENT OF FINANCIAL POSITION AS AT 31ST MARCH 2012

	NOTE	**31st March 2012 £000**	Restated 31st March 2011 £000	Restated 1st April 2010 £000
NON-CURRENT ASSETS:				
Intangible assets	10	**4,487**	5,333	4,499
Property, plant and equipment	11	**185,392**	183,698	180,206
Trade and other receivables	14	**913**	1,145	868
Total non-current assets		**190,792**	190,176	185,573
CURRENT ASSETS:				
Inventories	13	**2,279**	2,855	4,393
Trade and other receivables	14	**9,942**	6,851	10,063
Cash and cash equivalents	15	**19,641**	15,393	11,698
Total current assets		**31,862**	25,099	26,154
CURRENT LIABILITIES:				
Trade and other payables	16	**(29,138)**	(30,436)	(22,292)
Borrowings	18	**(2,637)**	(1,223)	(126)
Provisions	19	**(4,376)**	(553)	(226)
Other liabilities	17	**(5,581)**	(7,016)	(1,818)
Total current liabilities		**(41,732)**	(39,228)	(24,462)
NON-CURRENT LIABILITIES:				
Borrowings	18	**(34,600)**	(31,637)	(17,860)
Provisions	19	**(1,162)**	(1,106)	(1,216)
Total non-current liabilities		**(35,762)**	(32,743)	(19,076)
TOTAL ASSETS EMPLOYED		**145,160**	143,304	168,189
TAXPAYERS' EQUITY				
Public dividend capital	page iii	**141,031**	141,031	141,031
Revaluation reserve	page iii	**26,094**	27,627	29,678
Income and expenditure reserve	page iii	**(21,965)**	(25,354)	(2,520)
TOTAL TAXPAYERS' EQUITY		**145,160**	143,304	168,189

Details of the 1st April 2010 and 31st March 2011 restatements are disclosed in note 11.2

The financial statements on pages vi to xxxix were approved by the Trust Board on 24th May 2012 and are signed on its behalf by:

Signed: Aidan Kehoe, Chief Executive  Date: 24th May 2012

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY AT 31st March 2012

	NOTE	Total taxpayers' equity £000	Public Dividend Capital £000	Revaluation reserve £000	Donated Asset reserve £000	Income and Expenditure reserve £000
Taxpayers' equity at 1 April 2011		**143,304**	141,031	27,627	0	(25,354)
Total Comprehensive Income for the year:						
Deficit for the financial year		**3,317**	0	0	0	3,317
Impairment of property, plant & equipment	11	**(1,836)**	0	(1,836)	0	0
Revaluation gains on property, plant & equipment	11	**375**	0	375	0	0
Transfer between reserves		**0**	0	(72)	0	72
Total Comprehensive Income for the year		**1,856**	0	(1,533)	0	3,389
Taxpayers' equity at 31 March 2012		**145,160**	**141,031**	**26,094**	**0**	**(21,965)**
Taxpayers' equity at 1 April 2010 as previously stated		**170,543**	141,031	29,678	2,824	(2,990)
Prior period adjustment	11	**(2,354)**	0	0	(2,824)	470
Taxpayers' equity at 1 April 2010 - restated		**168,189**	**141,031**	**29,678**	**0**	**(2,520)**
Total Comprehensive Expense for the year:						
Deficit for the financial year		**(23,093)**	0	0	0	(23,093)
Impairment of property, plant & equipment	11	**(7,894)**	0	(7,894)	0	0
Revaluation gains on property, plant & equipment	11	**6,140**	0	6,140	0	0
Transfer between reserves		**0**	0	(267)	0	267
Reduction in the revaluation / donated asset reserves following disposal of assets		**(38)**	0	(30)	0	(8)
Total Comprehensive Income for the year		**(24,885)**	0	(2,051)	0	(22,834)
Taxpayers' equity at 31 March 2011		**143,304**	**141,031**	**27,627**	**0**	**(25,354)**

The notes on pages vi to xxxix form part of these accounts.

CASH FLOW STATEMENT FOR THE YEAR ENDED 31st March 2012

	NOTE	Year ended 31st March 2012 £000	Restated Year ended 31st March 2011 £000
Cash flows from operations			
Total operating surplus / (deficit)		**9,560**	(15,906)
Adjusted for:			
Depreciation	11	**5,359**	5,010
Amortisation	10	**1,063**	430
Impairments	11	**1,962**	20,491
Reversal of Impairments	11	**(883)**	(1,684)
Decrease/(increase) in trade and other receivables		**(2,608)**	2,789
Decrease/(increase) in inventories		**576**	1,538
Increase/(decrease) in trade and other payables		**(955)**	11,570
Increase/(decrease) in other liabilities		**(1,435)**	5,198
Increase/(decrease) in provisions		**3,834**	194
Other movements in operating cash flows		**(2,013)**	(104)
Net cash generated from operations		**14,460**	29,526
Cash flows from investing activities			
Interest received		**86**	47
Purchase of property, plant and equipment		**(8,204)**	(32,344)
Purchase of intangible assets		**(167)**	(1,282)
Sales of property, plant and equipment		**195**	0
Net cash used in investing activities		**(8,090)**	(33,579)
Cash flows from financing activities			
Loans received		**5,600**	15,000
Loans repaid to the Department of Health		**(1,085)**	0
Capital element of on-statement of financial position PFI repaid		**(138)**	(127)
Interest paid		**(939)**	(771)
Interest paid in respect of on-statement of financial position PFI		**(1,144)**	(1,090)
Public Dividend Capital dividends paid		**(4,416)**	(5,264)
Net cash (used in) / generated from financing activities		**(2,122)**	7,748
Increase/(decrease) in cash and cash equivalents		**4,248**	3,695
Cash and cash equivalents at the beginning of the financial year		**15,393**	11,698
Cash and cash equivalents at the end of the financial year	15	**19,641**	15,393

Details of the 2010/11 restatement are disclosed in note 11.2

1. Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011/12 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (the "FReM") to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently unless otherwise stated in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of certain non-current assets.

1.1 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

The NHS Foundation Trust estimates the month 12 patient related income based on an average cost for the activity delivered in the month for each speciality, as fully coded Healthcare Resource Group (HRG) data is not available in time for the closure of the annual accounts.

The NHS Foundation Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS Foundation Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit (CRU) that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract less the carrying amount of the asset sold.

1.2 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension Costs

NHS pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.3 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.4 Exceptional items

Exceptional Items are those items that, in the Trust's view, are required to be disclosed separately by virtue of their size or incidence to enable a full understanding of the Trust's financial performance.

1.5 Property, Plant and Equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services, or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.

Additionally, for items of property, plant and equipment to be capitalised they:

- individually have a cost of at least £5,000; or

- form a group of assets which collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Land and buildings are subsequently measured at fair value based on periodic valuations less subsequent depreciation and impairment losses.

The valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, and performed with sufficient regularity to ensure that the carrying value is not materially different from fair value at the balance sheet date. Fair values are determined as follows:

- Specialised operational property
- Depreciated Replacement Cost using a Modern Equivalent Asset (MEA) approach
- Non specialised property Existing Use Value
- Land - Market value for existing use

Assets in the course of construction are valued at cost less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 (Borrowing Costs) for assets held at fair value. Assets are revalued when they are brought into use.

Operational plant and equipment are carried at depreciated historic cost as this is not considered to be materially different to fair value. Plant and equipment surplus to requirements is valued at net recoverable amount.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

Depreciation

Items of property, plant and equipment are depreciated using the straight line method over their estimated useful economic lives as follows:

Buildings & Dwellings	90 years
Plant & Machinery	5 to 15 years
Transport equipment	5 to 10 years
Information Technology	5 to 15 years
Furniture & Fittings	5 to 15 years

Freehold land is considered to have an infinite life and is not depreciated.

Management have determined that each building within the Trust's estate is one component, the whole of which is maintained to a standard such that the useful economic life of the whole building and the elements within the building is the same.

The assets' residual values and useful lives are reviewed annually, where significant.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Depreciation is charged to operating expenses from the first day of the quarter commencing 1 April, 1 July, 1 October, or 1 January, following the date that the asset becomes available for use. Depreciation is charged in full in the quarter in which an asset becomes unavailable for use or is sold and then ceases to be charged.

Where assets are revalued any accumulated depreciation is eliminated against the gross carrying amount of the asset with the net amount restated to equal the revalued amount.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefit or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.6 Leases

Finance Leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. Assets are depreciated over the lower of their useful economic life and the period of the lease.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating Leases
Payments made under operating leases (net of any incentives received from the lessor) are charged to operating expenses on a straight-line basis over the period of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.7 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for fair value of services received and;
b) Payment for the PFI asset, including finance costs

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of an asset can be measured reliably, and where the cost is at least £5,000, or form a group of assets which collectively have a cost of at least £5,000, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or for use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic service delivery benefits e.g. The presence of a market for it or its output, or, where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. An operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. Application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Intangible assets relate to development expenditure, software and licences and are carried at amortised cost which management consider to materially equate to fair value and a review for impairment is performed annually. Increases in asset values arising from impairment reviews are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised on a straight line basis over their expected useful economic lives, as follows:

Software licences 5 to 15 years
Licences and Trademarks 5 to 15 years

Amortisation is charged to operating expenses from the first day of the quarter commencing 1 April, 1 July, 1 October, or 1 January, following the date that the asset becomes available for use. Amortisation is charged in full in the quarter in which an asset becomes unavailable for use or is sold and then ceases to be charged.

1.9 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation / grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation / grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost method for drugs and the first-in first-out method for other inventories, less any provisions deemed necessary.

1.12 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made. Financial assets or liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described at note 1.6.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as 'Loans and receivables'.
Financial liabilities are classified as 'Other Financial Liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income or Expenditure'

Financial assets and financial liabilities at 'Fair Value through Income or Expenditure' are financial assets or financial liabilities held for trading. The Trust does not have financial assets or liabilities classified in this category.

Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

At each period end, the Trust reviews trade receivables for recoverability and makes provisions to the extent that recovery of specific debts is considered to be doubtful.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

Other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the statement of financial position date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the statement of financial position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income through the use of a bad debt provision.

1.13 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Provisions are recognised where it is probable that there will be a future outflow of cash or other resources and a reliable estimate can be made of the amount. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms (2010/11: 2.2%), except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.8% in real terms (2010/11: 2.9%).

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 19. A provision is held in the Trust's accounts for the excess payable by the Trust to the NHSLA and is disclosed under 'other legal claims' in note 19.

Non-clinical risk pooling
The Trust participates in the Liabilities to Third Parties Scheme. This is a risk pooling scheme under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.14 Borrowings

The Trust is permitted to borrow funds to the extent that it complies with the Prudential Borrowing Code for NHS foundation trusts. The capital sum is recognised as a liability and Interest incurred is charged to finance expenses in the statement of comprehensive income. Total borrowings of the Trust and performance against the prudential borrowing limit is disclosed in note 18.

1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 21 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 21, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) net cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.17 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Corporation Tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is power for the Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits therefrom exceed £50,000 per annum.

1.19 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.20 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.21 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, excluding provisions for future losses, but including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.22 Accounting standards not adopted

Monitor have directed that Foundation Trusts adopt International Financial Reporting Standards set out by the International Accounting Standards Board. The Trust have adopted all relevant standards as they apply to Foundation Trusts.

IAS27, 'Consolidated and separate financial statements': HM Treasury have issued a dispensation to NHS Foundation Trusts for 2011/12 and 2012/13 in relation to the consolidation of their Charitable Fund balances into the Trust's financial statements where the Trust meets the "control test" set out within IAS27. The Blue Skies Hospitals Fund (charity registration number 1051570) has its own Trustees drawn from the Trust Board and files an annual report and accounts with the Charity Commission. The due date for the filing of the 2011/12 annual report and accounts is 31 January 2013.

1.23 Accounting standards adopted early

The Trust has not adopted any accounting standards early in 2011/12.

1.24 Accounting standards not yet effective and not adopted early

The following standards and amendments to existing standards have been published and are mandatory for the Trust's accounting periods beginning on or after 1 April 2012 or later periods, but the Trust has not early adopted them:

Annual improvements 2011. This makes minor changes to 5 standards. Two of the standards IFRS 1 First time adoption of IFRS, IAS 34 Interim financial reporting are not relevant to NHS bodies. The amendments to IAS 1 presentation of financial statements, IAS 16 property plant and equipment, IAS 32 Financial instruments: presentation are minor in nature and should have little or no impact on the Trust's financial statements.

IFRS 7, Financial instruments: Disclosures. This amendment to the standard will require additional disclosures where financial assets are transferred between categories (e.g. 'Fair Value through Profit and Loss', Loans and Receivable etc). It is applicable from 2012/13. It is not expected to have an impact on the Trust's financial statements.

IFRS 9, Financial instruments. This is a new standard which will eventually replace IAS 39 Financial Instruments: Recognition and Measurement. Two elements of the standard have been issued so far: Financial Assets and Financial Liabilities. The main changes are in respect of financial assets where the existing four categories will be reduced to two: Amortised Cost and 'Fair Value through Profit and Loss'.

At the present time it is not clear when this standard will be applied because the EU has delayed its endorsement.

The following changes have been published:- IFRS 10 Consolidated Financial Statements, IFRS 11 Joint Arrangements, IFRS 12 Dicloseure of Interests in Other Entities, IFRS 13 Fair Value Measurement, IAS 1 Presentation of financial statements on other comprehensive income, IAS 27 Separate Financial Statements and IAS 28 Associated and joint ventures all have an effective date of 2013/14 and have not yet been adopted by the EU.

1.25 Accounting estimates, judgements and critical accounting policies

Component depreciation

IAS 16 (Property, Plant and Equipment) requires that "each part of an item of property, plant and equipment with a cost which is significant in relation to the total cost of the item, shall be depreciated separately". The standard also states, "A significant part of an item of PPE may have a useful life and a depreciation method that are the same as the useful life and depreciation method of another significant part of the same item. Such parts may be grouped in determining the depreciation charge".

The Trust has elected to depreciate each building and its constituent elements as a single component on the basis that this more fairly reflects the way that the Trust is managed and maintained. The appropriateness of this treatment will be reviewed annually.

Revaluation of land, buildings and dwellings

At 31st March 2012 the Trust's valuer carried out a desktop revaluation of the land, buildings and dwellings based on indicies movements in the RICS tables. This has resulted in a downward valuation of these non-current assets by £2.5 million, and a revaluation gain of £1.8 million of which £0.9 million was a reversal of impairments charged to operating expenses in prior years.
See Note 11 for further details on these revaluations.

Selection of asset lives

Property, plant & equipment assets are allocated an asset life as stated in note 1.5 when acquired. The useful economic lives of assets are reviewed annually by management where significant. Individual asset lives are adjusted where these are materially different to their remaining life.

Prior period adjustments

1) Accounting for donations, government grant and other grant funded assets

Following a revised interpretation of IAS 8 within the Government Financial Reporting Manual (FReM), the Trust has changed its accounting policy in relation to accounting for donations, government grant and other grant funded assets. The revised accounting policy is described in paragraph 1.9. A review of all such assets has been undertaken and a prior period adjustment has been required to:

a) Transfer the balance of the donation reserve at 1 April 2010 to the income and expenditure reserve (£2.8m).

b) Transfer deferred income at 1 April 2010 relating to a contribution received from Blackpool PCT towards the costs of building the Urgent Care Centre to the income and expenditure reserve (£1.55m).

c) Reverse other operating income recognised in 2010/11 for the release from the donation reserve in respect of depreciation and impairment of donated assets (£0.243m).

d) Recognise other operating income in respect of donations received to purchase property, plant and equipment (£0.282m).

e) Reverse deferred income released to other operating expenses in 2010/11 for the Urgent Care Centre (£0.65m).

2) Impairment review of non current assets

During 2011/12 the Trust continued a review commenced in 2010/11 to validate fixed assets which have been capitalised and reported in the financial statements. This review has identified further assets to the value of £3.9million which should have been impaired and charged to operating expenses and the Revaluation Reserve prior to 1 April 2010. A prior period adjustment to intangible, and property, plant and equipment asset values has been made as at 1 April 2010.

As a consequence of this change, depreciation and amortisation charged to operating expenses in 2010/11 was reduced by £0.7m and disposal costs increased by £0.1m.

The impact of the above changes is detailed in note 11.

Restructuring costs

The Trust has recognised termination benefits to staff of £2.3 million during the financial year arising from the efficiency programme. Where payments have not yet been made but the departure has been agreed the anticipated cost has been recognised as a current liability and in operating expenses. (see Note 6 for further details).

Going concern

These financial statements have been prepared on a going concern basis. Management have conducted an appraisal of the Trust's financial forecasts for a two year period to 31st March 2013 in support of this assessment.

2. Operating segments

2011/12	Unscheduled Care	Surgery	Cardiac	Women's & Children's	Clinical Support & Facilities Management	Corporate Services	Total
	£000	£000	£000	£000	£000	£000	£000
Income	94,459	67,866	45,522	23,745	15,588	33,571	280,751
Expenditure	(91,318)	(64,003)	(45,683)	(26,296)	(13,751)	(22,854)	(263,905)
EBITDA	**3,141**	**3,863**	**(161)**	**(2,551)**	**1,837**	**10,717**	**16,846**
Restructuring costs							(2,309)
Contribution to restructuring costs							500
Income from donations							1,997
Property, plant & equipment impairments							(1,079)
Depreciation and amortisation							(6,422)
Net gain on disposal of fixed assets							27
Interest receivable							121
Interest payable							(2,116)
PDC dividend							(4,248)
Surplus for the Financial Year							**3,317**

Operating income from continuing activities in 2011/12 reported in the statement of comprehensive income includes £0.883 million relating to the reversal of property, plant & equipment impairments recognised in operating expenses in previous years. This is excluded from Income in the above table but included as part of property, plant & equipment impairments.

2010/11 - Restated	Unscheduled Care	Surgery	Cardiac	Women's & Children's	Clinical Support & Facilities Management	Corporate Services	Total
	£000	£000	£000	£000	£000	£000	£000
Income	94,438	66,381	42,177	23,569	14,151	32,316	273,093
Expenditure	(89,075)	(64,739)	(44,740)	(25,709)	(11,491)	(22,833)	(258,587)
EBITDA	**5,363**	**1,642**	**(2,563)**	**(2,140)**	**2,660**	**9,483**	**14,445**
Restructuring costs							(6,211)
Income from donations							282
Property, plant & equipment impairments							(18,807)
Depreciation and amortisation							(5,440)
Net loss on disposal of fixed assets							(175)
Interest receivable							46
Interest payable							(1,884)
PDC dividend							(5,349)
Deficit for the Financial Year							**(23,093)**

2010/11 has been restated to reflect prior period adjustments set out in note 11.2

2. Operating segments continued

Segmental information

Financial and operational performance data is reviewed by the Trust Board of Directors on a monthly basis. The Board are responsible for setting financial performance targets for each of the divisions within the Trust. The Trust Board of Directors are therefore considered to be the Chief Operating Decision Maker (CODM).
Each of the Trust's healthcare divisions have been deemed to be a reportable segment under IFRS 8 (Segmental Reporting).

The financial performance of each segment is managed against an EBITDA target. The Trust does not report on assets or liabilities by segment.

Recharges of indirect activity based costs are recharged between divisions at unit costs. Overheads and fixed costs are apportioned on the floor area, staff numbers or expenditure levels.

The majority of the Trust's revenue is generated from external customers in England, with the exception of the bodies listed below, and transactions between segments are immaterial.

	2011/12	2010/11
	£000	£000
Scottish NHS bodies	**442**	180
Local Health Boards in Wales	**207**	157
Northern Ireland Health and Social Care Trusts	**41**	22

The Trust has three external customers which generate income amounting to more than 10% of the Trust's total income. The values of income from the largest customers are set out in note 25. The income from these customers is included in all of the segments reported above.

3. Income from activities

3.1 Income from Activities by category

	Year ended 31st March 2012 £000	Year ended 31st March 2011 £000
Elective income	**57,707**	59,237
Non elective income	**77,268**	72,424
Outpatient income	**30,530**	31,939
A & E income	**7,264**	7,099
Other NHS Clinical income	**82,127**	77,435
Private patient income	**1,228**	1,262
	256,124	249,396

3. Income from activities continued

3.2 Private patient income

Under section 44 of the 2006 Act, the proportion of private patient income to the total of patient related income of the Trust should not exceed the proportion whilst the NHS body was an NHS trust in 2002/03.

	2011/12 £000	2010/11 £000	2002/03 £000
Private patient income	**1,228**	1,262	3,184
Total patient related income	**256,124**	249,396	151,547
Proportion (as a percentage)	**0.5%**	0.5%	2%

3.3 Income from activities by source

	Year ended 31st March 2012 £000	Year ended 31st March 2011 £000
NHS Foundation Trusts	**966**	117
NHS Trusts	**1**	57
Strategic Health Authorities	**395**	55
Primary Care Trusts	**249,184**	245,202
Department of Health	**0**	38
Local Authorities	**433**	322
NHS Other	**12**	58
Non NHS:		
- Private patients	**1,228**	1,262
- Overseas patients	**27**	0
- NHS Injury scheme income	**1,300**	1,224
- Other	**2,578**	1,061
	256,124	249,396

3.4 Mandatory and Non Mandatory Income

Under the National Health Service Act (2006) the Trust is required to provide Health Services in England. The mandatory goods and services are listed in Schedule 2 of the Foundation Trust's Terms of Authorisation. Of the total income from activities, £244.2m (2010/11: £243.3m) relates to Mandatory Goods and Services and £11.9m (2010/11: £6.1m) relates to Non Mandatory Goods and Services.

The increase in income from Non Mandatory Goods and Services includes income received from NHS Blackpool for the following developments:

	£000
Private Finance Initiative contract buyout	**1,692**
Development of the Stroke Unit	**1,200**
Scanner purchase and capital funding	**1,107**
	3,999

4. Other Operating Income

	Year ended 31st March 2012 £000	Restated Year ended 31st March 2011 £000
Research and Development	**1,750**	1,126
Education, training and research *	**10,679**	10,433
Charitable and other contributions to expenditure **	**2,357**	637
Non-patient care services to other bodies ***	**6,601**	6,185
Profit on disposal of property, plant & equipment	**75**	3
Reversal of impairments of property, plant & equipment	**883**	1,684
Sales of goods and services ****	**2,462**	2,544
Income in respect of staff costs where acounted on gross basis	**697**	585
Other *****	**2,577**	2,408
	28,081	25,605

* Education, training and research income comprises income relating the North West Leadership Academy for which the Trust is the host organisation, and funding received from NHS Northwest for junior doctors training.

** Charitable and other contributions to expenditure in 2010/11 has been restated to include donations income to purchase non current assets. This restatement arises from a change in accounting policy relating to accounting for donation funded assets. Further details are provided in notes 1.25 and 11.2.

*** Non-patient care services to other bodies includes service level agreement income from other NHS bodies for estates, IT and payroll services provided by the Trust.

**** Sales of goods and services includes income from catering sales, commercial laundry services, staff accommodation rentals, and car parking.

***** Other income in 2010/11 has been restated to reverse income released from deferred income in relation to the Urgent Care Centre following a change in accounting policy relating to grant funded assets. Further details are provided in notes 1.25 and 11.2.

5. Operating expenses

5.1 Operating expenses comprise:

	NOTE	Year ended 31st March 2012 £000	Restated Year ended 31st March 2011 £000
Services from Foundation Trusts		**250**	524
Services from NHS Trusts		**175**	178
Services from other NHS bodies		**402**	355
Purchase of healthcare from non NHS bodies		**3,824**	2,723
Non Executive Directors' costs		**133**	145
Executive Directors' costs	6	**789**	902
Employee costs (excluding Executive Directors' costs)	6	**167,389**	171,403
Redundancy *	6	**2,309**	4,793
Drug costs		**18,361**	18,272
Supplies and services - clinical		**33,887**	30,628
Supplies and services - general		**7,706**	6,842
Establishment		**3,036**	3,440
Transport		**438**	1,827
Premises		**12,537**	10,855
Increase / (decrease) in provision for impairment of receivables		**412**	269
Increase in other provisions	19	**4,254**	304
Depreciation **	11	**5,359**	5,010
Amortisation **	10	**1,063**	430
Non-current asset impairments **	11	**1,962**	20,491
Loss on disposal of property, plant and equipment	11	**48**	178
Audit services - statutory audit		**83**	83
Other auditor's remuneration		**185**	87
Clinical negligence		**4,220**	4,026
Training, courses and conferences		**2,979**	2,803
Legal, professional and consultancy fees		**1,499**	2,279
Insurance costs		**247**	301
Other ***		**1,098**	1,759
		274,645	290,907

* Redundancy costs consist of amounts paid to staff and an accrual for other agreed redundancies as part of the Trust's efficiency programme.

** Depreciation, amortisation and non-current asset impairment charges for 2010/11 have been restated following a review of the Trust's asset register. See note 11 for further details.

*** Other expenditure includes costs for internal audit services, and losses and special payments.

5.2 Other auditor's remuneration

Other auditor's remuneration comprises:	Year ended 31st March 2012 £000	Year ended 31st March 2011 £000
Quality report assurance	**0**	20
Transforming Community Services due diligence	**162**	64
Consultancy services	**23**	3
TOTAL	**185**	87

5.3 Auditor liability limitation agreements

The audit engagement contract with PricewaterhouseCoopers LLP dated 15th November 2011 contains a £1million limit on their liability for losses or damages in connection with the audit contract for their audit work. This limitation does not apply in the event of losses or damages arising from fraud or dishonesty of PricewaterhouseCoopers LLP.

5. Operating expenses Continued

5.4 Operating leases

As lessee

5.4.1 Payments recognised as an expense

	Year ended 31st March 2012 £000	Year ended 31st March 2011 £000
Minimum lease payments	**2,123**	1,929
	2,123	1,929

5.4.2 Total future minimum lease payments

	Year ended 31st March 2011 £000	Year ended 31st March 2010 £000
Payable:		
Not later than one year	**2,096**	1,890
Between one and five years	**2,329**	3,170
	4,425	5,060

5.4.3 Significant leasing arrangements

The significant operating lease arrangements held by the Trust relate to medical equipment and buildings and are subject to the following terms:

- No transfer of ownership at the end of the lease term.
- No option to purchase at a price significantly below fair value at the end of the lease term.
- Leases are non-cancellable or must be paid in full.
- No secondary period rental or at best market rate.
- Lease payments are fixed for the contracted lease term.

Significant operating lease arrangements held by the Trust relate to:	**Annual commitment £000**	Lease term Years
- Cardiac centre equipment	468	7
- Catheter laboratory 1	216	7
- Catheter laboratory 2	196	5
- Telecommunications equipment	174	6
- Zoo Car Park	118	5
- MRI Scanner	164	5
- CT Scanner	162	5
- Endoscopy equipment	157	5

5. Operating expenses Continued

5.4.4 PFI Payments recognised as an expense

	Year ended 31st March 2012 £000	Year ended 31st March 2011 £000
Facility Management - Minimum lease payments	**1,049**	1,332

The Trust is committed to make the following service payments for the PFI commitment:	**Year ended 31st March 2012 £000**	Year ended 31st March 2011 £000
Within one year	**1,327**	1,280
2nd to 5th years (inclusive)	**5,308**	5,119
Later than five years	**14,597**	15,356
	21,232	21,755

The facility management charge was set at the outset of the contract and is uplifted annually from 1st April by the increase in the Retail Prices Index as at the preceding February. Costs are charged to operating expenses.

6. Employee costs and numbers

6.1 Staff costs

	Permanently employed £000	Other £000	**Year ended 31st March 2012 Total £000**	Year ended 31st March 2011 Total £000
Salaries and wages	136,428	0	**136,428**	141,207
Social security costs	9,976	0	**9,976**	9,927
Employers contribution to NHS Pension Scheme	15,133	0	**15,133**	15,652
Agency / Contract staff	0	6,641	**6,641**	4,101
Termination benefits	2,309	0	**2,309**	6,211
Total	163,846	6,641	**170,487**	177,098

Employee costs above reconciles to the total of Executive Directors' costs and Employee costs on Note 5.1 Operating expenses.

Termination benefits relate to amounts paid to staff for agreed departures under the schemes set out in note 6.2.

Termination benefits in 2010/11 include £1.418m paid to staff under the Mutually agreed resignation scheme (MARS) which are included within employee costs in note 5.1 and within termination benefits in the table above. No MARS payments have been made in 2011/12

6. Employee costs and numbers continued

6.2 Exit Packages

As part of its efficiency programme the Trust has commenced a review of its functions to reduce costs. During the year exit packages have been agreed with staff to enable a reduction in pay costs. Termination benefits consist of three types of exit package used by the Trust:

- Compulsory redundancy
- Voluntary redundancy
- Mutually agreed resignation scheme (MARS)

The following table discloses the number and cost to the Trust of all exit packages that were agreed as at 31 March 2012. (2010/11 comparatives shown in brackets).

Exit package cost band	Compulsory redundancies Number	Other departures agreed Number	**Total Number**
<£10,000	1 (3)	8 (60)	**9 (63)**
£10,000 - £25,000	3 (5)	4 (54)	**7 (59)**
£25,001 - £50,000	1 (5)	18 (41)	**19 (46)**
£50,001 - £100,000	0 (2)	10 (19)	**10 (21)**
£100,001 - £150,000	0 (2)	1 (5)	**1 (7)**
£150,001 - £200,000	0 (1)	2 (1)	**2 (2)**
£200,001 - £250,000	0 (0)	1 (1)	**1 (1)**
£250,001 - £300,000	0 (0)	0 (1)	**0 (1)**
Total number of packages by type	5 (18)	44 (182)	**49 (200)**
	£000	£000	**£000**
Total resource cost - 2011/12	91	2,218	**2,309**
Total resource cost - 2010/11	832	5,379	**6,211**

No exit packages have been agreed for non executive and executive directors of the Trust.

6. Employee costs and numbers

6.3 Average number of persons employed

			Year ended 31st March 2012	Year ended 31st March 2011
	Permanently employed WTE	Other WTE	**Total WTE**	Total WTE
Medical and Dental	319	30	**349**	336
Administration and estates	853	39	**892**	1,019
Healthcare assistants and other support staff	939	0	**939**	1,011
Nursing, midwifery and health visiting staff	1,331	8	**1,339**	1,358
Scientific, therapeutic and technical staff	475	3	**478**	483
	3,917	80	**3,997**	4,207

6. Employee costs and numbers continued

6.4 Retirements due to ill health

In the period ended 31st March 2012 there were 5 early retirements from the Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £472,918. (2010/11: 4 cases with estimated liability of £276,636) The cost of these ill-health retirements will be borne by the NHS Pension Scheme. Accordingly, no provision is recognised in the Trust's accounts.

6.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as a defined contribution scheme: the cost to the Trust of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

7. Gains/(losses) on disposal of assets

	Year ended 31st March 2012 £000	Restated Year ended 31st March 2011 £000
Gain on disposal of property, plant and equipment	**75**	3
(Loss) on disposal of property, plant and equipment	**(48)**	(178)
	27	(175)

The loss on disposal of property, plant and equipment in 2010/11 has been increased by £0.125m as arising during the asset validation exercise described in notes 1.25 and 11.2.

8. Finance income

	Year ended 31st March 2012 £000	Year ended 31st March 2011 £000
Interest from bank accounts	**121**	46

9. Finance costs

	NOTE	**Year ended 31st March 2012 £000**	Year ended 31st March 2011 £000
Interest on obligations under on-statement of financial position PFI schemes		**769**	782
Contingent rentals under on-statement of financial position PFI schemes		**375**	308
Loans from Foundation Trust financing facility		**939**	771
Unwinding of discount on provisions	19	**33**	23
		2,116	1,884

10. Intangible assets

Intangible assets comprise the following elements:

	Software Licences £000	Licences & Trademarks £000	Total £000
Cost at 1st April 2011	4,999	1,043	**6,042**
Additions purchased	188	29	**217**
Cost at 31st March 2012	**5,187**	**1,072**	**6,259**
Amortisation amortisation at 1st April 2011	493	216	**709**
Charged during the year	923	140	**1,063**
Accumulated amortisation at 31st March 2012	**1,416**	**356**	**1,772**
Net book value at 31st March 2012	**3,771**	**716**	**4,487**
Net book value			
Purchased at 31st March 2012	3,771	716	**4,487**
Total at 31st March 2012	**3,771**	**716**	**4,487**
Prior year - restated:			
Cost at 1st April 2010 - as previously stated	3,949	831	**4,780**
Prior period adjustment	0	(2)	**(2)**
Cost at 1st April 2010 - restated	**3,949**	**829**	**4,778**
Additions purchased	1,050	214	**1,264**
Cost at 31st March 2011	**4,999**	**1,043**	**6,042**
Accumulated amortisation at 1st April 2010 - as previously stated	166	114	**280**
Prior period adjustment	0	(1)	**(1)**
Accumulated amortisation at 1st April 2010 - restated	**166**	**113**	**279**
Charged during the year	327	103	**430**
Accumulated amortisation at 31st March 2011	**493**	**216**	**709**
Net book value at 31st March 2011	**4,506**	**827**	**5,333**
Net book value			
Purchased at 31st March 2011	4,506	827	**5,333**
Total at 31st March 2011	**4,506**	**827**	**5,333**
Net book value			
Purchased at 1st April 2010	3,783	716	**4,499**
Total at 1st April 2010	**3,783**	**716**	**4,499**

Prior period adjustment
During 2011/12 the Trust has carried out a review to validate fixed assets which have been capitalised and reported in the financial statements. See note 11 for further information regarding the prior period adjustment.

11. Property, plant and equipment

11.1 Property, plant and equipment

Property, plant and equipment comprises the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1st April 2011	9,209	130,411	7,279	23,979	27,752	172	7,133	328	**206,263**
Additions purchased	0	4,723	0	2,278	431	0	381	0	**7,813**
Additions donated	0	1,573	0	0	424	0	0	0	**1,997**
Impairment charges to revaluation reserve	0	(1,248)	(588)	0	0	0	0	0	**(1,836)**
Reclassifications	0	26,075	0	(26,075)	0	0	0	0	**0**
Revaluations	0	353	22	0	0	0	0	0	**375**
Disposals	0	0	(64)	0	(907)	(96)	(5)	0	**(1,072)**
Transfer of depreciation to gross book value following revaluation	0	(3,323)	(119)	0	0	0	0	0	**(3,442)**
Cost or valuation at 31st March 2012	**9,209**	**158,564**	**6,530**	**182**	**27,700**	**76**	**7,509**	**328**	**210,098**
Accumulated depreciation at 1st April 2011	0	0	0	0	19,764	164	2,528	109	**22,565**
Charged during the year	0	2,244	120	0	1,970	2	986	37	**5,359**
Impairments recognised in operating expenses / income	0	1,079	0	0	0	0	0	0	**1,079**
Disposals	0	0	(1)	0	(758)	(96)	0	0	**(855)**
Transfer of depreciation to gross book value following revaluation	0	(3,323)	(119)	0	0	0	0	0	**(3,442)**
Accumulated depreciation at 31st March 2012	**0**	**0**	**0**	**0**	**20,976**	**70**	**3,514**	**146**	**24,706**
Net book value at 31st March 2012	**9,209**	**158,564**	**6,530**	**182**	**6,724**	**6**	**3,995**	**182**	**185,392**
Net book value									
Owned									
Purchased at 31st March 2012	8,871	147,992	6,530	182	5,509	6	3,990	182	**173,262**
Donated at 31st March 2012	0	3,349	0	0	1,215	0	5	0	**4,569**
Assets under PFI arrangement									
Finance lease at 31st March 2012	338	7,223	0	0	0	0	0	0	**7,561**
Total at 31st March 2012	**9,209**	**158,564**	**6,530**	**182**	**6,724**	**6**	**3,995**	**182**	**185,392**
Protected status									
Protected assets at 31st March 2012	9,209	158,564	0	0	0	0	0	0	**167,773**
Unprotected assets at 31st March 2012	0	0	6,530	182	6,724	6	3,995	182	**17,619**
Total at 31st March 2012	**9,209**	**158,564**	**6,530**	**182**	**6,724**	**6**	**3,995**	**182**	**185,392**

As at the end of the reporting period all Land, Buildings and Dwellings are Freehold.

Protected assets are those assets required for providing the mandatory goods and services set out in the Trust's terms of authorisation approved by Monitor, the Independent Regulator of Foundation Trusts. The Trust may not dispose of any protected property without the approval of Monitor.

Prior period adjustment
During 2011/12 the Trust has carried out a review to validate fixed assets which have been capitalised and reported in the financial statements. See note 11.2 for further information regarding the prior period adjustment.

11. Property, plant and equipment (continued)

Revaluation of property, plant and equipment

Land and buildings (including dwellings) valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last desktop revaluation took place on 31 March 2012 based on modern replacement cost and was undertaken by Andrew M Wilson MRICS of DTZ.

The revaluation of some assets has resulted in market value revaluation gains that reverse market value impairments charged to operating expenses in previous years. Gains up to the value of any previous impairment on the same asset have been recognised in operating income with any excess being recognised in the revaluation reserve.

The impact of the revaluation on charges to operating expenses and reserves is as follows:

	2011/12 £000	Restated 2010/11 £000
Revaluation gains recognised in the revaluation reserve	**(375)**	(6,140)
Impairments charged to the revaluation reserve	**1,836**	7,894
Impairments recognised in operating expenses	**1,962**	20,491
Reversal of impairments recognised in other operating income	**(883)**	(1,684)
	2,540	20,561

11. Property, plant and equipment (continued)

Prior year:	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation at 1st April 2010 - as previously stated	9,209	127,765	6,772	23,293	36,033	204	5,895	599	**209,770**
Prior period adjustment	0	0	0	0	(6,023)	0	(1,086)	(237)	**(7,346)**
Cost or valuation at 1st April 2010 - restated	9,209	127,765	6,772	23,293	30,010	204	4,809	362	**202,424**
Additions purchased	0	2,599	0	23,921	118	0	2,354	6	**28,998**
Additions donated	0	0	0	0	282	0	0	0	**282**
Impairment charges to revaluation reserve	0	(7,894)	0	0	0	0	0	0	**(7,894)**
Reclassifications	0	14,391	0	(14,391)	0	0	0	0	**0**
Revaluations	0	5,537	603	0	0	0	0	0	**6,140**
Disposals	0	0	0	0	(2,658)	(32)	(30)	(40)	**(2,760)**
Transfer of depreciation to gross book value following revaluation	0	(11,987)	(96)	(8,844)	0	0	0	0	**(20,927)**
Cost or valuation at 31st March 2011	**9,209**	**130,411**	**7,279**	**23,979**	**27,752**	**172**	**7,133**	**328**	**206,263**
Accumulated depreciation at 1st April 2010 - as previously stated	0	0	0	0	22,890	192	2,435	144	**25,661**
Prior period adjustment	0	0	0	0	(2,755)	0	(616)	(72)	**(3,443)**
Accumulated depreciation at 1st April 2010 - restated	0	0	0	0	20,135	192	1,819	72	**22,218**
Charged during the year	0	2,024	96	0	2,112	4	736	38	**5,010**
Impairments recognised in operating expenses / income	0	9,963	0	8,844	0	0	0	0	**18,807**
Disposals	0	0	0	0	(2,483)	(32)	(27)	(1)	**(2,543)**
Transfer of depreciation to gross book value following revaluation	0	(11,987)	(96)	(8,844)	0	0	0	0	**(20,927)**
Accumulated depreciation at 31st March 2011	**0**	**0**	**0**	**0**	**19,764**	**164**	**2,528**	**109**	**22,565**
Net book value at 31st March 2011	**9,209**	**130,411**	**7,279**	**23,979**	**7,988**	**8**	**4,605**	**219**	**183,698**
Net book value									
Owned									
Purchased at 31st March 2011	8,870	121,187	7,279	23,979	6,928	8	4,600	219	**173,070**
Donated at 31st March 2011	0	1,924	0	0	1,060	0	5	0	**2,989**
Assets under PFI arrangement									
Finance lease at 31st March 2011	339	7,300	0	0	0	0	0	0	**7,639**
Total at 31st March 2011	**9,209**	**130,411**	**7,279**	**23,979**	**7,988**	**8**	**4,605**	**219**	**183,698**
Owned									
Purchased at 1st April 2010	8,870	117,091	6,772	23,293	8,874	12	2,984	290	**168,186**
Donated at 1st April 2010	0	1,781	0	0	1,001	0	6	0	**2,788**
Assets under PFI arrangement									
Finance lease at 1st April 2010	339	8,893	0	0	0	0	0	0	**9,232**
Total at 1st April 2010	**9,209**	**127,765**	**6,772**	**23,293**	**9,875**	**12**	**2,990**	**290**	**180,206**
Protected status									
Protected assets at 31st March 2011	9,209	130,411	0	0	0	0	0	0	**139,620**
Unprotected assets at 31st March 2011	0	0	7,279	23,979	7,988	8	4,605	219	**44,078**
Total at 31st March 2011	**9,209**	**130,411**	**7,279**	**23,979**	**7,988**	**8**	**4,605**	**219**	**183,698**
Protected status									
Protected assets at 1st April 2010	9,209	127,765	0	0	0	0	0	0	**136,974**
Unprotected assets at 1st April 2010	0	0	6,772	23,293	9,875	12	2,990	290	**43,232**
Total at 1st April 2010	**9,209**	**127,765**	**6,772**	**23,293**	**9,875**	**12**	**2,990**	**290**	**180,206**

11. Property, plant and equipment (continued)

11.2 Prior period adjustment

During 2011/12 adjusted the financial statements for the following prior period adjustments:

1. The Trust completed the asset review which commenced in 2010/11 to validate assets capitalised and reported in the financial statements. The review in 2011/12 extended the scope to include the whole asset base valued at £21.5m at 31 March 2011, and identified assets with a net book value of £3.9m which should have charged as impairments to operating expenses and the Revaluation Reserve. A prior period adjustment to intangible, and property, plant and equipment asset values has been made as at 1 April 2010.
   As a consequence of this change, depreciation and amortisation charged to operating expenses in 2010/11 was reduced by £0.7m and a disposal of £0.1m charged to operating expenses. An additional transfer of £0.25m between reserves was required to remove balances from the revaluation reserve on assets disposed as part of the exercise.

2. Following a revised interpretation of IAS 8 within the Government Financial Reporting Manual (FReM), the Trust has changed its accounting policy in relation to accounting for donations. Previously assets purchased through donations were capitalised with an equal increase in the donated asset reserve, with income being released to other operating income to offset depreciation and impairment charges. Under the revised policy, income is recognised when it is received unless the donation is conditional on one or more future events, in which case the income is deferred within liabilities to future years to the extent that the conditions have not been met.
   This has resulted in a prior period adjustment to remove the donated asset reserve by analysing the remaining cost of original donations / donated assets and amounts representing net revaluation gains on donated assets recognised in the donated asset reserve.
   There were no net revaluation gains at 1 April 2010 held in the donated asset reserve, therefore the balance of £2.8m at that date was transferred into the income and expenditure reserve. Movements arising 2010/11 of £0.3m representing a release of donated income to offset depreciation charges have been reversed into the income and expenditure reserve, and £0.2m has been recognised in other operating income relating to the purchase of assets from donations.

3. Following a revised interpretation of IAS 8 within the Government Financial Reporting Manual (FReM), the Trust has changed its accounting policy in relation to government grants. Previously grant funded assets were capitalised with the grant being deferred with liabilities and released to income to match costs. Under the revised policy, income is recognised when the grant is received unless it is conditional on one or more future events, in which case the income is deferred within liabilities to future years to the extent that the conditions have not been met.
   This has resulted in a prior period adjustment to recognise £1.55m income received from Blackpool PCT in 2007/08 as a contribution towards the construction costs of the Urgent Care Centre in the Income and Expenditure Reserve at 1st April 2010. The 2010/11 results have been restated to remove £1.55m from deferred income at 1st April 2010 and £1.485m at 31st March 2011, and £0.65m from other operating income.

The impact of the prior period adjustments on the financial statements is set out below:

	1 April 2010 Non-Current Assets		**31 March 2011** Non-Current Assets	
Non-Current Assets	Intangible £000	PPE £000	Intangible £000	PPE £000
Net book value - as previously stated	4,500	184,109	5,333	187,047
Prior year impairment:	(1)	(3,903)	(1)	(3,904)
Impact of (1) above impairment on:				
2010/11 depreciation and amortisation	0	0	1	680
2010/11 disposal	0	0	0	(125)
Net book value - restated	**4,499**	**180,206**	**5,333**	**183,698**

11.2 Prior period adjustment continued

Taxpayers' equity	**1 April 2010**		**31 March 2011**	
	Revaluation Reserve	Income and Expenditure Reserve	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Opening reserve balance - as previously stated	29,678	(2,990)	27,729	(26,612)
Prior year impairment:	0	(1,080)	0	(1,080)
Prior year recognition of Urgent Care Centre grant income	0	1,550	0	1,550
Impact of (1) above impairment on:				
Depreciation reversal	0	0	0	676
Asset disposals	0	0	0	(125)
Transfer between reserves	0	0	(267)	267
Impact of (2) and (3) above accounting policy change on				
Transfer of balances from donation reserve	0	0	165	(8)
Release of donated asset income on capital additions	0	0	0	282
Depreciation (donated asset income release reversal)	0	0	0	(239)
Urgent Care Centre deferred income release reversal	0	0	0	(65)
Opening reserve balance - restated	**29,678**	**(2,520)**	**27,627**	**(25,354)**

Statement of Comprehensive Income	**Operating income 2010/11 £000**	**Operating expenses 2010/11 £000**	**Operating deficit 2010/11 £000**
As previously stated	275,027	291,462	(16,435)
Release of donated asset income on capital additions	282	0	282
Donated asset depreciation income release reversal	(243)	0	(243)
Urgent Care Centre grant income reversal	(65)	0	(65)
Depreciation and amortisation	0	(680)	680
Asset disposals	0	125	(125)
Restated	**275,001**	**290,907**	**(15,906)**

Cash Flow - Net cash generated from operations	**2010/11 £000**
Net cash generated from operations - as previously stated	29,526
Operating deficit movement - as restated above	(529)
Depreciation and amortisation	680
Donated asset depreciation income release reversal	(243)
Increase/(decrease) in other liabilities	
- Urgent Care Centre grant income reversal	(65)
Other movements in operating cash flows	
- Release of donated asset income on capital additions	282
- Asset disposals	(125)
Net cash generated from operations - restated	**29,526**

12. Capital commitments

Commitments under capital expenditure contracts at the statement of financial position date were £0.155m. All commitments relate to the acquisition of property, plant and equipment assets.

	2011/12	2010/11
	£000	£000
Surgical Centre	**61**	5,004
Urgent Care Centre	**0**	65
Reconfiguration of Women & Children services	**0**	417
Mortuary	**7**	893
Other	**87**	89
	155	6,468

13. Inventories

	31st March 2012	31st March 2011
	£000	£000
Drugs and consumables	**2,279**	2,855

There have been no write-downs or reversal of write-downs of inventories during 2011/12 (2010/11: Nil). Management have performed a review for obsolete or slow moving stock in order to identify the need for an inventory provision and do not consider that a provision is required as at 31 March 2012.
Inventories charged to operating expenses include drugs totalling £17.681m (2010/11 £17.128m) issued through the in-house pharmacy and cardiac consumables totalling £3.441m (2010/11: £2.559m). The figure reported for drugs in operating expenses includes costs of non-inventory items.

14. Trade and other receivables

14.1 Trade and other receivables

	31st March 2012	Restated 31st March 2011
	£000	£000
NHS receivables	**1,807**	1,209
Other receivables with related parties	**113**	119
Provision for impairment of receivables	**(830)**	(528)
Prepayments	**944**	801
Accrued income	**3,940**	2,392
Interest receivable	**39**	4
PDC dividend receivable	**489**	321
VAT receivable	**549**	498
Other receivables	**2,891**	2,035
Trade and other receivables - current	**9,942**	6,851
Other receivables	**1,158**	1,373
Provision for impairment of receivables	**(245)**	(228)
Trade and receivables - non-current	**913**	1,145
Total	**10,855**	7,996

In 2010/11 accrued income from NHS bodies was included within the total for NHS receivables. The prior year figures have been restated to reclassify this as accrued income.

The Trust has declared an amount receivable of £2.4m (2010/11 £2.4m) from the Compensation Recovery Unit (CRU) in respect of charges due under the NHS Injury Scheme. The Trust recovers approximately £1.25m each year and this amount has been classified as current.

14. Trade and other receivables continued

14.2 Ageing of receivables past their due date but not impaired

	31st March 2012 £000	31st March 2011 £000
0 - 30 days	**142**	112
30- 60 days	**70**	36
60- 90 days	**7**	9
90- 180 days	**136**	14
Over 180 days	**42**	20
	397	191

14.3 Analysis of provision for impairment of receivables

	NHS Debts £000	Non NHS Debts £000	**Total £000**
As at 1st April 2011	361	395	**756**
Amounts written off during the year as uncollectible	(48)	(45)	**(93)**
Amounts reversed unused during the year	(312)	(27)	**(339)**
Increase in allowance recognised in operating expenses	688	63	**751**
As at 31st March 2012	689	386	**1,075**

14.4 Ageing of impaired receivables

	31st March 2012 £000	31st March 2011 £000
0 - 30 days	**655**	290
30- 60 days	**1**	24
60- 90 days	**5**	48
90- 180 days	**29**	2
Over 180 days	**385**	392
	1,075	756

15. Cash and cash equivalents

	31st March 2012 £000	31st March 2011 £000
Balance at beginning of the year	**15,393**	11,698
Net change in the year	**4,248**	3,695
Balance at 31 March	**19,641**	15,393
Made up of:		
Cash with Government Banking Service	**19,591**	15,258
Cash in transit and in hand	**50**	135
	19,641	15,393

16. Trade and other payables

	31st March 2012 £000	31st March 2011 £000
NHS payables	**2,769**	4,117
Amounts due to other related parties	**1,901**	2,062
Non-NHS trade payables - revenue	**14,873**	11,564
Non-NHS trade payables - capital	**1,569**	1,912
Accruals	**4,613**	7,197
Subtotal	**25,725**	26,852
Tax & social security costs	**3,413**	3,584
Trade and other payables - current	**29,138**	30,436

17. Other liabilities

	31st March 2012 £000	Restated 31st March 2011 £000
Deferred income	**5,581**	7,016
Other Liabilities - Current	**5,581**	7,016

Following a revised interpretation of IAS 8 within the Government Financial Reporting Manual (FReM), the Trust has changed its accounting policy in relation to deferred government grant income. See note 11.2 for details of a prior period adjustment of deferred income relating to a grant received towards costs of the Urgent Care Centre from Blackpool PCT.

18. Borrowings

18.1 Borrowings

	31st March 2012 £000	31st March 2011 £000
Loans from Foundation Trust Financing Facility	**2,485**	1,085
Obligations under PFI contracts	**152**	138
Borrowings - current	**2,637**	1,223
Loans from Foundation Trust Financing Facility	**27,030**	23,915
Obligations under PFI contracts	**7,570**	7,722
Borrowings - non-current	**34,600**	31,637
Total borrowings	**37,237**	32,860

The Trust has two Foundation Trust Financing Facility loans:
Loan 1: £25m expiring on 30 March 2034 and attracts interest at a fixed rate of 3.7%. The Trust is committed to repaying 2.17% of the balance in each September and March with effect from 30 September 2011.
Loan 2: £5.6m expiring on 30 March 2016 and attracts interest at a fixed rate of 1.45%. The Trust is committed to repaying 12.5% of the balance in each September and March with effect from 30 September 2012.

18.2 Prudential borrowing limit

The Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

- The maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in Monitor's Prudential Monitoring Code (see table below). The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and
- The amount of any working capital facility approved by Monitor.
- Further information on the NHS Foundation Trust Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

The Trust performance against approved PBL ratios is as follows :-

Financial ratio	**Actual ratios 2011/12**	Actual ratios 2010/11	Approved PBL ratios
Minimum dividend cover	**3.5x**	2.4x	>1x
Minimum interest cover	**8.0x**	7.3x	>3x
Minimum debt service cover	**3.6x**	4.5x	>2x
Maximum debt service to revenue	**1.7%**	1.2%	<2.5%

18.3 Prudential borrowing limit - long term borrowing

	31st March 2012 £000	31st March 2011 £000
Long term borrowing limit set by Monitor	**53,500**	55,700
Working capital facility set by Monitor *	**19,000**	19,000
Total Prudential borrowing limit	**72,500**	74,700
Long term borrowing at 1st April	**32,860**	17,986
Net borrowing in year - long term	**4,377**	14,874
Long term borrowing at 31st March	**37,237**	32,860

The Trust has had no working capital borrowings during 2010/11 or 2011/12

* As at 31st March 2012 the Trust has a £19m working capital facility with Barclays Corporate. This agreement will expire on 1st October 2013.

19. Provisions

19.1 Provisions analysis

	31st March 2012 £000	31st March 2011 £000
Pensions relating to other staff	**16**	18
Permanent Injury Benefit	**67**	63
Other legal claims	**192**	175
Other	**4,101**	297
Provisions - current	**4,376**	553
Pensions relating to other staff	**138**	157
Permanent Injury Benefit	**1,024**	949
Other legal claims	**0**	0
Other	**0**	0
Provisions - non-current	**1,162**	1,106
TOTAL	**5,538**	1,659

19. Provisions continued

19.2 Provisions in year movement and timing of cash flows

	Pensions relating to other staff	Permanent Injury Benefit	Other Legal Claims	Other	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
At 1st April 2011	175	1,012	175	297	**1,659**
Change in discount rate	1	10	0	0	**11**
Arising during the year	9	106	92	4,101	**4,308**
Utilised during the year	(17)	(66)	(75)	(250)	**(408)**
Reversed unused	(18)	0	0	(47)	**(65)**
Unwinding of discount	4	29	0	0	**33**
At 31st March 2012	**154**	**1,091**	**192**	**4,101**	**5,538**
Expected timing of cash flows:					
Within one year	16	67	192	4,101	**4,376**
Between one year and five years	60	252	0	0	**312**
After five years	78	772	0	0	**850**
Total	**154**	**1,091**	**192**	**4,101**	**5,538**

The provisions for pensions relating to other staff and permanent injury benefit are stated at the present value of future amounts estimated as payable using life expectancy tables provided by the Office of National Statistics. Payments are made on a quarterly basis to the NHS Pension Scheme and NHS Injury Benefit Scheme respectively.

Other legal claims represent an estimate of the amounts payable by the Trust in relation to the excess on claims for clinical negligence and injury to third parties. In return for an annual contribution from the Trust to the NHS Litigation Authority, the claims are settled by the NHSLA on the Trust's behalf and excess amounts charged to the Trust at that point. £49,752,522 is included in the provisions of the NHSLA at 31 March 2012 in respect of clinical negligence liabilities of the Trust (2010/11: £46,759,004).

The other category consists of provisions for the potential return of income recognised in 2011/12 from Primary Care Trusts for the purchase of equipment (£1.1m), Stroke Unit development (£1.2m) and buyout of the Private Finance Initiative contract (£1.7m). These funds are conditional on the completion of these transactions during 2012/13. At 31st March 2012, the Trust had not placed contracts for these initiatives.

Prior to 31st March 2012 the Trust served notice to terminate the contract with the Internal Audit service provider, and a provision of £0.1m has been created for early termination costs. This transaction is expected to occur in 2012/13.

20. Private Finance Initiative (PFI) Transactions

PFI scheme deemed on-Statement of Financial Position

The Trust has a PFI Partnership Agreement for the provision of facilities for the provision of healthcare services to the public at Wesham, Rossall and Bispham. The contract runs for 27 years from April 2001. The Trust has title to the freehold land at Wesham and Rossall and the contractor has title to the land at Bispham. At the end of the agreement period the contractor will cease to have any rights, title and interest in the Wesham and Rossall sites, and the Trust has an option to purchase the Bispham facility at market value, which must be exercised not later than 12 months prior to the end of the contract. The Trust has estimated that the residual value of the Bispham property is £2.4 million. In the event that the Trust terminates the contract early the Contractor will be entitled to levy an early termination charge.

The unitary payment was set at the outset of the contract and is uplifted annually from 1 April by the increase in the Retail Prices Index as at the preceding February. These inflationary increase are charged to the statement of comprehensive income as finance expenses.

PFI scheme deemed on-Statement of Financial Position continued

Total obligations for on-Statement of Financial Position PFI contracts due:	**31st March 2012**	31st March 2011
Gross PFI liabilities - minimum lease payments:	**£000**	£000
Rentals due within one year	**908**	908
Rentals due within two to five years	**3,632**	3,632
Rentals due thereafter	**9,987**	10,895
	14,527	15,435
Future finance charges on PFI agreements	**(6,805)**	(7,575)
Net PFI liabilities	**7,722**	7,860
Net PFI liabilities are repayable as follows:		
No later than 1 year	**152**	138
Later than 1 year and no later than 5 years	**769**	701
Later than 5 years	**6,801**	7,021
	7,722	7,860
During the year the following PFI financing payments have been made to the contractor:	**£000**	£000
Repayment of borrowings	**138**	127
Finance expense - Interest	**769**	782
Finance expense - Contingent rent	**375**	308
	1,282	1,217

The Trust is also committed to make the service payments for facility management which are charged to operating expenses. These are disclosed at note 5.4.4.

21. Contingencies

Contingent liabilities	**31st March 2012 £000**	31st March 2011 £000
Employer and Occupier Liability	**108**	95

This is the maximum potential liability for Staff and Occupiers Liability, which represents the difference between the balance provided and the excess due to the NHS Litigation Authority (NHSLA) scheme of which the Trust is a member. This estimate is based on an assessment of the outcome of each case and as such may vary up to the point of settlement or withdrawal. Costs are charged to the Trust up to the value of the excess by the NHSLA as they are incurred.

The Trust has no contingent assets.

22. Financial Instruments

The Trust does not have any listed capital instruments and is not a financial institution. Due to the nature of the Trust's current financial assets/liabilities and non current financial liabilities, book value equates to fair value.
All financial assets and liabilities are held in sterling.
The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Credit Risk
The bulk of the Trust's commissioners are part of the NHS, which minimises the credit risk from these customers. Non-NHS customers do not represent a large proportion of income and the majority of these relate to bodies which are considered low risk - e.g. universities, local councils, insurance companies, etc.

Liquidity Risk
The Trust's net operating costs are incurred under service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust largely finances capital expenditure through internally generated funds and from loans that can be taken out up to an agreed borrowing limit. The borrowing limit is based upon a risk rating determined by Monitor, the Independent Regulator for Foundation Trusts and takes account of the Trust's liquidity.

Market Risk
All of the Trust's financial liabilities carry nil or fixed rate of interest. In addition the only element of the Trust's financial assets that is currently subject to variable rate is cash held in the Trust's main bank account and therefore the Trust is not exposed to significant interest rate risk.

22.1 Financial Assets by category

	31st March 2012 Loans and Receivables £000	31st March 2011 Loans and Receivables £000
NHS Trade and other receivables	**5,058**	3,042
Non-NHS Trade and other receivables	**2,161**	1,682
Cash and cash equivalents	**19,641**	15,393
Total Financial Assets	**26,860**	20,117

22.2 Other Financial Liabilities by category

	31st March 2012 £000	Restated 31st March 2011 £000
NHS Trade and other payables	**(2,769)**	(4,117)
Non-NHS Trade and other payables	**(21,756)**	(15,537)
Subtotal - Trade and other payables	**(24,525)**	(19,654)
PFI Obligations	**(7,722)**	(7,860)
Other borrowings	**(29,515)**	(25,000)
Subtotal - Borrowings	**(37,237)**	(32,860)
Total Financial Liabilities at amortised cost	**(61,762)**	(52,514)

The Trust has two loans with the Foundation Trust Financing Facility categorised within financial liabilities.
The carrying value of the liability is considered to approximate to fair value as the arrangement is of a fixed interest rate and equal instalment repayment feature and the interest rate is not materially different to the discount rate.
Non-NHS Trade and other payables at 31st March 2011 has been restated to remove £7.198m relating to accruals incorrectly disclosed as a financial liability.

23. Third party assets

The Trust held the following cash and cash equivalents on behalf of third parties which have been excluded from cash and cash equivalents in the Trust's statement of financial position:

	31st March 2012 £000	31st March 2011 £000
Patients' monies	**7**	14
Blackpool, Fylde and Wyre Hospitals Charitable Fund	**1,784**	2,692
	1,791	2,706

24. Losses and special payments

There were 107 cases of losses and special payments totalling £0.088 million in the accounting period (2010/11: 120 cases totalling £0.258 million).

25. Related party transactions

Ultimate parent
The FT is a public benefit corporation established under the NHS Act 2006. Monitor, the Regulator of NHS Foundation Trusts has the power to control the FT within the meaning of IAS 27 'Consolidated and Separate Financial Statements' and therefore can be considered as the FT's parent. Monitor does not prepare group accounts but does prepare separate NHS Foundation Trust Consolidated Accounts. The NHS Foundation Trust Consolidated Accounts are then included within the Whole of Government Accounts. Monitor is accountable to the Secretary of State for Health. The FT's ultimate parent is therefore HM Government.

Whole of Government Accounts Bodies
All government bodies which fall within the whole of government accounts boundary are regarded as related parties because they are all under the common control of HM Government and Parliament. This includes, for example, all NHS bodies, all local authorities and central government bodies.

During the year the FT has had a significant number of transactions with the other NHS bodies. The entities with which the highest value of transactions occurred are listed below:

	Income		**Receivables**	
	2011/12 £'000	Restated 2010/11 £'000	**31st March 2012** £'000	Restated 31st March 2011 £'000
Blackpool PCT	103,512	99,683	1,707	601
Central Lancashire PCT	2,900	3,685	0	162
Cumbria PCT	1,298	1,146	60	43
North Lancashire PCT	99,439	98,200	883	0
North West SHA	9,777	10,344	9	172
Western Cheshire PCT	42,251	42,624	287	337
Lancashire Care NHS Foundation Trust	2,276	2,738	196	161
Lancashire Teaching Hospitals NHS Foundation Trust	1,130	410	855	463
	263,583	258,830	**3,997**	1,939

Most income from PCTs is in respect of services provided under healthcare contracts and priced using national prices (Payment by Results).

25. Related party transactions continued

	Expenditure		Payables	
		Restated		Restated
			31st March	31st March
	2011/12	2010/11	2012	2011
	£'000	£'000	£'000	£'000
Blackpool PCT	879	1,216	206	850
North Lancashire PCT	618	375	293	801
North West Ambulance Service NHS Trust	36	1,515	3	77
Lancashire Teaching Hospitals NHS Foundation Trust	846	1,175	600	412
National Blood Authority	2,580	2,581	251	234
NHS Litigation Authority	4,220	4,026	0	0
	9,179	10,888	**1,353**	2,374

None of the receivable or payable balances are secured. Amounts are generally due within 30 days and will be settled in cash.
In addition to the amounts above, provisions in respect of the excess on legal claims have been recognised and, if due, are payable to the NHS Litigation Authority. These are disclosed and explained in note 19.

Key management personnel
Key management includes directors, both executive and non-executive.
The compensation paid or payable in aggregate to key management for employment services is shown below:

	Aggregate		Highest paid director	
	Year ended 31st March 2012 £000	Year ended 31st March 2011 £000	**Year ended 31st March 2012 £000**	Year ended 31st March 2011 £000
Salaries and other short term benefits	**1,066**	1,169	**191**	191
Pension contributions:				
Employer contributions to the NHS Pension Scheme	**127**	140	**23**	23
Accrued pension under NHS Pension Scheme	**305**	291	**72**	70
Accrued lump sum under NHS Pension Scheme	**898**	862	**216**	210
			Number	Number
Number of directors to whom benefits are accruing under the NHS Pension Scheme			**8**	8

None of the key management personnel received an advance from the Trust. The Trust has not entered into guarantees of any kind on behalf of key management personnel. There were no amounts owing to Key Management Personnel at the beginning or end of the financial year. No compensation payments for loss of office to directors has been made.

25. Related party transactions continued

Blackpool Teaching Hospitals Charitable Fund
The Trust has also received revenue and capital payments from Blackpool Teaching Hospitals Charitable Fund (formerly Blackpool, Fylde and Wyre Hospitals Charitable Fund). The Charity is registered with the Charity Commissioners (Registered Charity 1051570) and has its own Trustees drawn from the Trust Board.
Transactions with the fund are as follows:

	2011/12	2010/11
	£'000	£'000
Donations received from the charitable fund, recognised as income	**2,357**	637
Amounts receivable from the fund as at 31 March	**13**	83

The amount receivable at 31 March is not secured and is not subject to particular terms and conditions.

NHS Pension Scheme
The NHS Pension Scheme is a related party to the Foundation Trust.
Transactions with the NHS Pension Scheme comprise the employer contributions disclosed in note 6.1. At 31 March 2012 the Trust owed £1.899 million (31 March 2011: £1.987 million) relating to employees and employer contributions to the scheme. Additionally, the Trust has recognised provisions in respect of reimbursements to the NHS Pension Scheme for early retirement costs. These are explained in note 19.

26. Events after the reporting period

a) Transforming Community Services
During 2011/12 the Trust has finalised a business plan to transfer in community provider services from Blackpool Primary Care Trust and North Lancashire Teaching Primary Care Trust. On 24th February 2012 formal approval of this transfer of services was received from Monitor, the independent regulator of foundation trusts, with an effective date of 1st April 2012.

b) Wesham Park Rehabilitation Unit
In January 2011, the Trust transferred services provided at the Wesham Park Rehabilitation Unit to Clifton Hospital and the Wesham facility was temporarily closed subject to the outcome of a public consultation. The public consultation is due to commence in 2012/13.

c) Spiral Health CIC
From 1st April 2012, the Spiral Health CIC (Previously known as the Nurse Led Unit at Bispham) became a stand-alone Social Enterprise. Whilst the unit is being reviewed in shadow format during 2012-13, essentially the FT has transferred all staff and related direct costs to Spiral Health CIC and is currently sub-contracted the activity that the unit is generating.

The FT has transferred £1.5m of direct pay cost and £0.6m of non-pay costs (2011-12 outturn), which will be paid directly by the unit. All other indirect and overhead costs will be recharged on an SLA basis. Therefore in 2012-13, the Trust has contracted an SLA for activity of £3.1m and the Unit will repay £0.2k of SLA recharges.

Annex G: Notice of the Trust's Members and Annual Public Meeting

The Annual Members and Public Meeting of the Blackpool Teaching Hospitals NHS Foundation Trust will be held on Monday, 24th September 2012.

Further copies of the Annual Report and Accounts for the period 1st April 2011 to 31st March 2012 can be obtained by writing to:

Miss J A Oates
Foundation Trust Secretary
Blackpool Teaching Hospitals NHS Foundation Trust
Trust Headquarters
Blackpool Victoria Hospital
Whinney Heys Road
Blackpool
FY3 8NR

Alternatively the document can be downloaded from our website www.bfwhospitals.nhs.uk

If you would like to make comments on our Annual Report or would like any further information, please write to:

Chief Executive
Blackpool Teaching Hospitals NHS Foundation Trust
Trust Headquarters
Blackpool Victoria Hospital
Whinney Heys Road
Blackpool
FY3 8NR