Blackpool, Fylde and Wyre Hospitals
NHS Foundation Trust

Quality Accounts Report 2009/2010

Quality Accounts Report

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Quality Accounts Report

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Part 1: Quality Narrative

1.1 A Statement on Quality from the Chief Executive

I am delighted to present the Trust's second Quality Accounts Report for the 2009/10 period, which gives the Trust the opportunity to demonstrate to our patients and staff how we have worked over the past year to continually improve the quality of care we provide to our patients.

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 Accounts Report sets out how we are progressing with this ambition and where we are focusing our attention to make further progress.

This report provides an overview of the quality of care delivered in 2009/10 as well as describing how we have responded to challenges faced by the Trust. The report identifies how we are performing against targets that enable us to measure quality, outlines the priorities for improvement over the coming year and our plans for 2010/11.

Over the last three years great progress has been made in delivering on our vision and values. This has been achieved by the implementation of The Blackpool Way which is our Organisational Development Programme focusing on engaging staff and harnessing their potential.

The Trust continues to make great progress in delivering 'Best in NHS' Care. This progress was recognised through the Trust emphasising quality of care, patient safety and reduction in infection, which you can read more about in the pages of this Quality Accounts Report. For the second consecutive year, the Trust has been named in the CHKS UK's Top 40 Hospitals, which celebrates the best performing Trusts in the country. Hospitals are rated on 24 key performance indicators which are identified in Table 10. These are critical to delivering high quality patient care. These include waiting times, mortality rates, length of stay, hospital readmissions and infection rates. The Trust has won a number of awards for improving quality and patient safety. These awards include:

- Communicating Patient Safety Award 2010
- Best communications that has improved Patient Care

Also to ensure our Trust is a great place to work, the Trust was awarded the Investors in People Gold Standard Award and was named in the Sunday Times 75 Best Places to Work in the Public Sector.

The Trust participated in the Advancing Quality Programme which focuses on five key clinical areas. In two of these areas the Trust under performed in pneumonia and heart failure. The data published related to October 2008 to September 2009 and since then our performance has improved in all areas. We are working with our clinicians with detailed action plans to ensure further improvements.

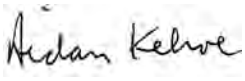
Our plans for continuing to improve and demonstrate quality in everything we do will evolve throughout the year. We aim to work with our staff, service users, their families and carers, Commissioners, stakeholders, Governors, Members and the wider public in continuing to drive up the quality of our services. Contributions to develop the quality accounts report have been received from the Governors, Local Involvement Networks, Overview and Scrutiny Committees together with the Corporate Governance Team.

The Trust aims to achieve excellence in everything it does and its challenges and aspirations for quality improvement are identified in the Quality Strategy which sets ambitious targets for the next three years in relation to direct patient care, as set out below:

- 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 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. This approach gives an organisational focus to our key quality measures and will ensure that we continue our journey towards delivering the 'Best in NHS' care.

The Quality Accounts Report April 1st 2009 – March 31st 2010 to the best of my knowledge and belief contains accurate information in relation to NHS Services provided by the Trust.



Aidan Kehoe, Chief Executive

Part 2: Review of Quality of Performance identifying Priorities for Improvement against 2009/10

In light of the NHS, 'High Quality Care for All', Lord Darzi review, the Trust developed a quality Framework which was approved by the Board of Directors and launched in November 2008, which identified three key elements in the quality of care it delivers to its patients. These define specific targets for action.

These are:

- Patient safety
- Clinical effectiveness
- Patient experience

Details of the priorities for quality improvement that were agreed by the Board of Directors as outlined in the Annual Report and Accounts 2008/09 are detailed in Table 1.

Table 1

Quality Improvement Priorities 2008/09 - 2009/10	Quality Improvement Performance/ Outcome Measures
Patient Safety	Reduce hospital mortality rates from 103 to 73 by 2011/12 Reducing infection rates by 50% by 2011/12 Reducing avoidable harms through the following strands of work: – Global Trigger Tool to be used to measure adverse events and reduce incidents which may cause harm to our patients – Falls reduction project – Reducing Medication errors by 50% by 2011/12
Clinical Effectiveness	Conformance to best practice through application of the following interventions to improve patient outcomes: Phase 1 site for the North West Advancing Quality initiative that seeks compliance with best practice in five clinical areas: – Acute Myocardial Infarction (Heart Attack) – Hip & Knee Surgery – Cardio by-pass Surgery – Heart Failure – Community Acquired Pneumonia Implementing 100,000 Lives and Saving Lives Programme. This initiative has been adopted by the Trust with the aim of reducing patient harm. Identifying measurable indicators of best practice resulting in reduced mortality and improved patient experience
Patient Experience	• Improving the patient experience which will be measured through an improvement in the Patient Satisfaction rating for the quality of services • Improving local patient experience survey results • Customer care programme launched to improve performance and customer satisfaction • Nursing care indicators used to assess and measure standards of clinical care and patient experience • Seeking patients' views to improve End of Life Care

2.1 Progress of Performance on Quality Improvement Priorities against 2009/10

The Trust has continued to work throughout the year to embed a culture of patient safety and has made considerable progress and improvements in key quality measures through a number of programmes to improve quality during 2009/10.

A programme of work has been established that corresponds to each of the four areas we are targeting. Each individual scheme within the programme will contribute 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 will be delivered through the use of The Blackpool Way, which is the Trust's organisational development programme and this will be achieved by engaging with staff and supporting them to implement changes that will have a positive impact on patient care. The quality improvement priorities will continue to be monitored and reported to the Board of Directors as part of the Board Performance Business Monitoring Report and to the Committee of the Board where appropriate.

The following information provides an overview of the quality of care provided by the Trust based on performance in 2009/10 against the indicators for patient safety; clinical effectiveness and patient experience.

2.1.1 Patient Safety

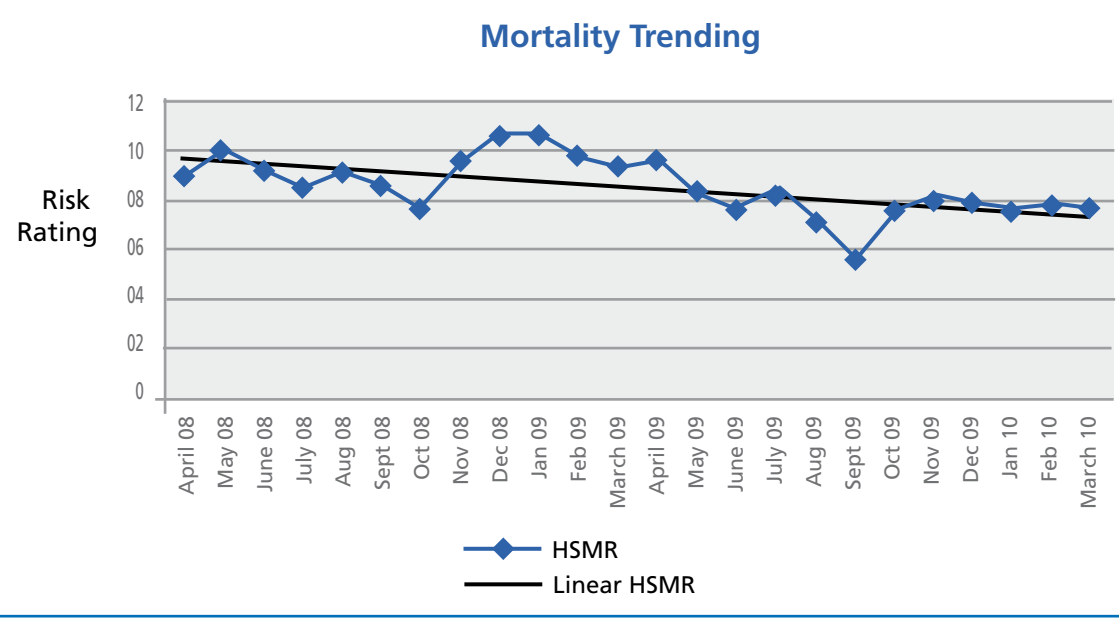
Reduced Hospital Mortality Rates

The Trust received negative publicity around the publication of the Dr Foster's reports on mortality. Since its publication we have made further improvements to our mortality rates as outlined below.

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. In October 2008 the Trust had a Risk Adjusted Mortality Index (RAMI) score of 103. The graph below identifies the Trust now has a RAMI of 79. We believe that we can improve on this and achieve a 10-point reduction in our RAMI, year on year for the next three years. We therefore set ourselves the goal of delivering a RAMI of 73 by the financial year 2011/12. Based on 2007/08 RAMI data achieving our goal will result in 573 fewer deaths occurring in hospital per year. The Trust is well on the way to delivery of its goal with a 22-point reduction in the RAMI from the October 2008 baseline as identified in graph 1 below.

The reduction in RAMI was achieved by identifying those schemes which would enhance patient safety by improving the management of the deteriorating patient and by implementing harm reduction strategies such as reducing medical outliers, hospital acquired infections and medication errors. Progress on all those 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.

Graph 1



Reducing Infection Rates

Methicillin Resistant Staphylococcus Aureus (MRSA)

Following the significant reductions in Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia (78%) in 2008/2009, 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. The Department of Health continues to monitor MRSA bacteraemia rates; the agreed trajectory target for 2009/2010 is 26, although the Trust has adopted a local trajectory target of 13.

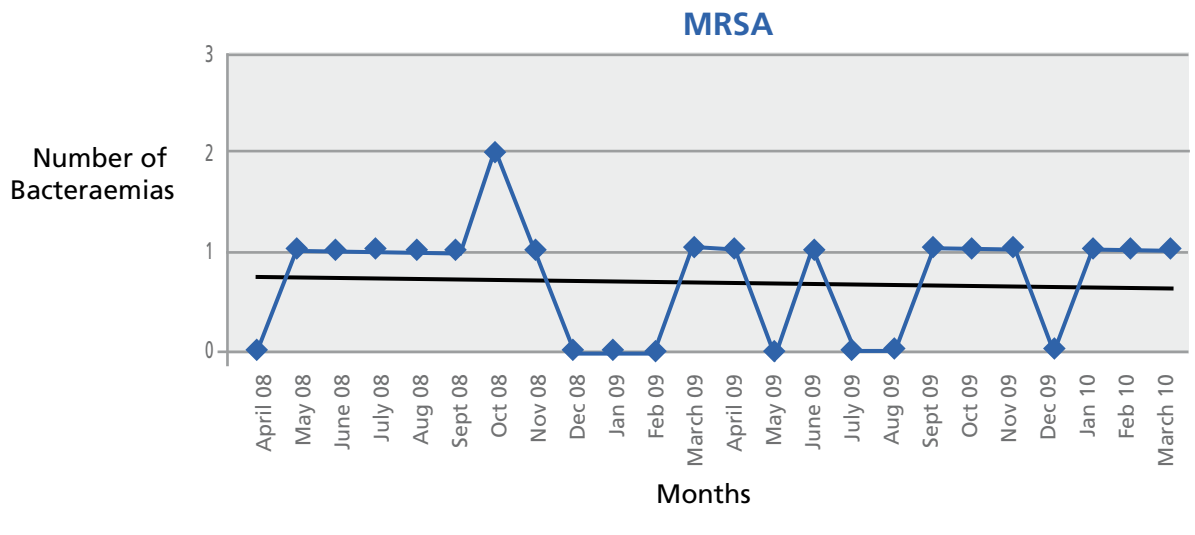
MRSA Bacteraemia rates continue to fall and from April 2009 – March 2010 there have been eight MRSA Bacteraemias, only three of which are attributed to the Acute Trust. The remaining five are attributed to the relevant Primary Care Trusts as an infection that developed in the community as opposed to occurring in the hospital. During the same time period in 2008/2009 there had been eight cases of MRSA Bacteraemia which demonstrates a reduction in 2009/10 as shown in graph 2 below.

Clostridium Difficile

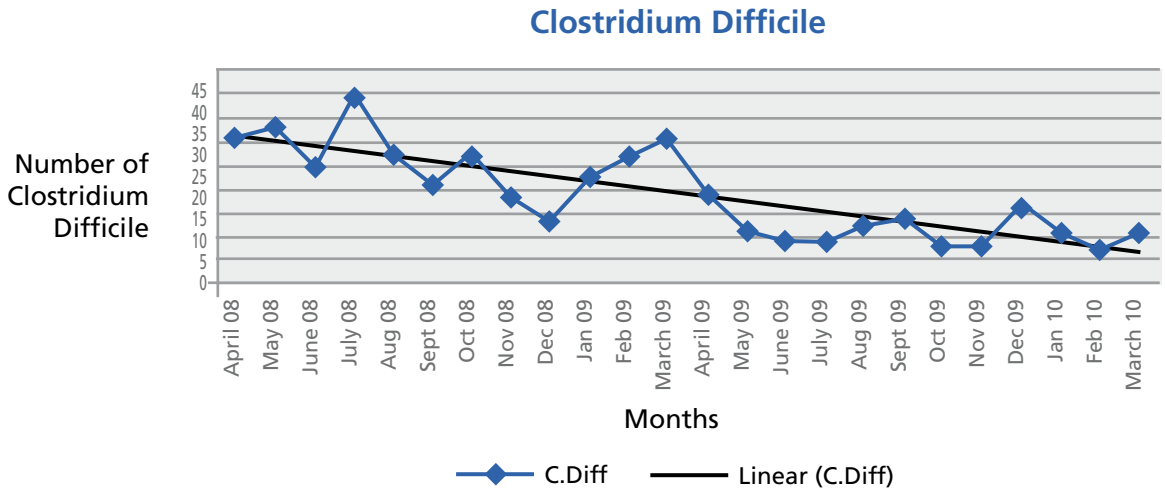
Clostridium Difficile is an organism which may be present in the faecal flora of asymptomatic carriers. Clostridium Difficile is found in approximately 2% of normal adults. This percentage rises with age and the elderly have colonisation rates of 10-20%, depending on recent antibiotic exposure and time 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 (33%) in 2008/2009, the Trust has continued to embed measures to reduce levels further within the organisation. There were 241 cases of Clostridium Difficile Infection (CDI) between April 2009 and March 2010, in comparison to 315 in the same period last year. This demonstrates a percentage reduction of 24% which is above the 17% yearly reduction incorporated into the three-year plan trajectories. Of the 241 cases for 2009/10, 134 have been attributed to the Acute Trust. The Trust is required to achieve a 52% reduction in CDI rates from the 2007 level, by 2011.

Graph 2



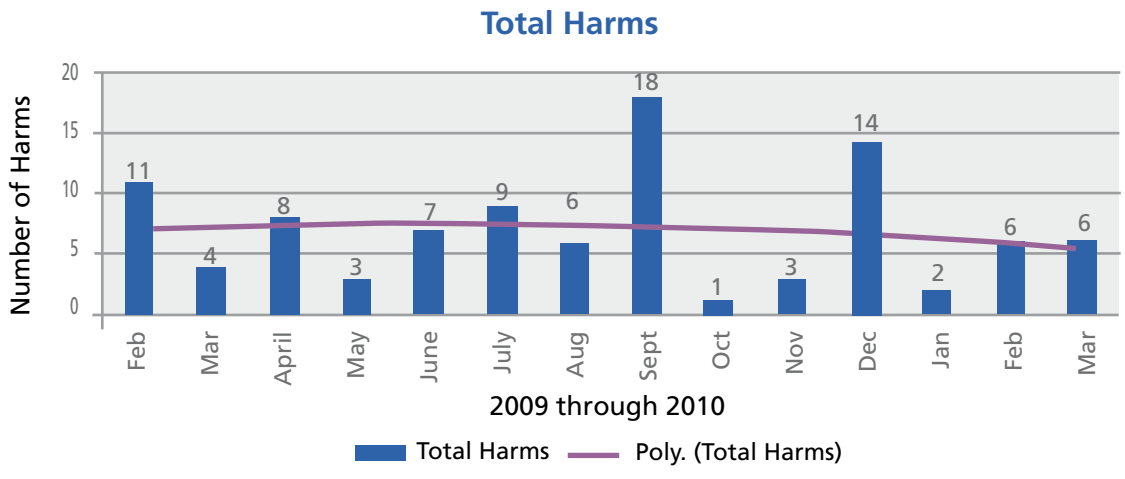
Graph 3



Global Trigger Tool

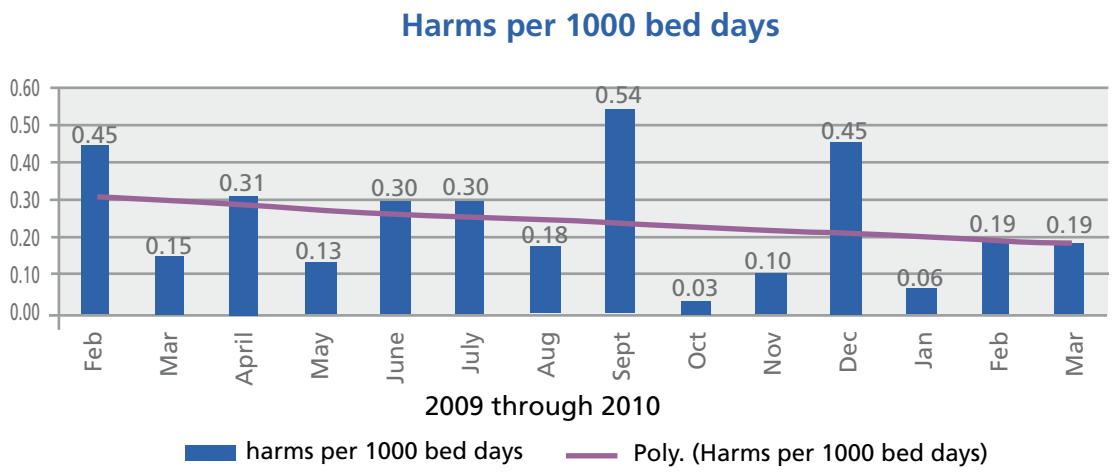
Traditionally the Trust's efforts to detect and deal with adverse events have focused on reporting and tracking of errors. However, research published by the Institute for Healthcare Improvement has shown that only 10 to 20% of errors are reported and of those, 90 to 95% cause no harm to patients. The Trust has therefore decided to adopt the IHI Global Trigger Tool to measure adverse events. The Global Trigger Tool is a method to measure events of harm that may happen to a patient during their admission and stay in an acute hospital. This 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. Data collection commenced in February 2009 therefore no annual comparative data is yet available, however, graph 4 and 5 identifies the data available of the total number of harms from February 2009 – March 2010. We have implemented a monthly review of 20 sets of case notes using the Global Trigger Tool. We now have an effective way to identify events that do cause harm to patients in order to quantify the degree and severity of the harm, and to select and test changes to reduce them. To date we have reviewed over 300 sets of case notes. A quarterly report is produced and submitted to the Board for monitoring.

Graph 4



The purple curves are 12 month trend lines and show a steady decrease in harms per thousand bed days over the year

Graph 5



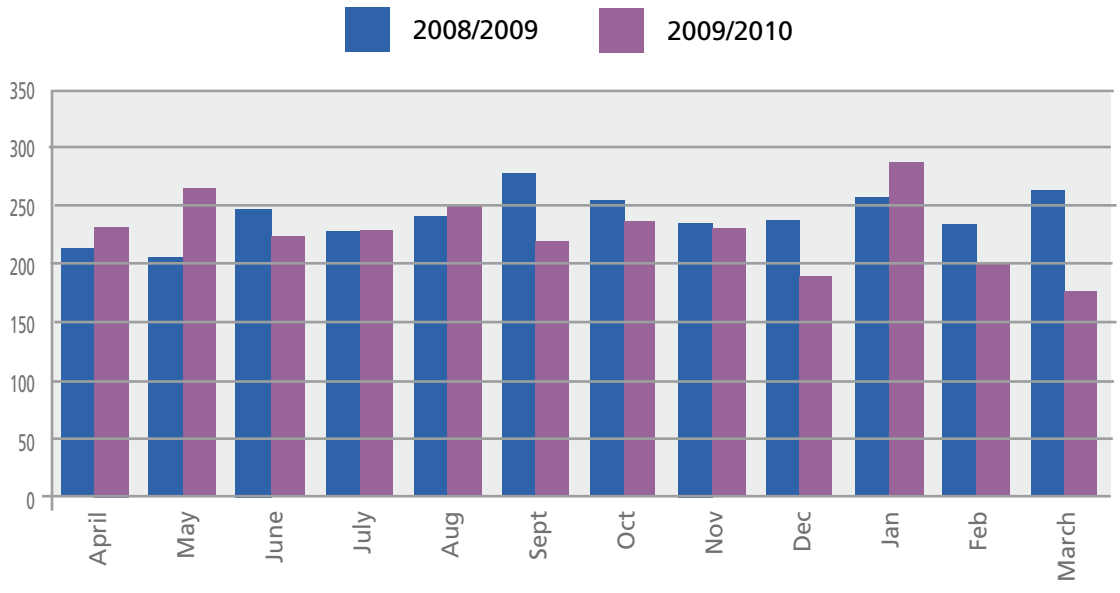
Falls Reduction Project

A patient falling in hospital is the most common patient safety incident reported to the National Patient Safety Agency. Although the majority of falls cause no harm, even falls without injury can lead to poor mobility and lack of confidence for the patient. Between April 2008 and April 2009, 2,888 patients experienced a slip, trip or fall while in hospital. There are many initiatives within the Trust to assist in the prevention and reduction of patient falls and the table below shows a comparison of the slips, trips and falls between 2008/09 and 2009/10. The data identifies an overall reduction in slips, trips and falls for each consecutive month apart from the months in April, May and August 2009, which demonstrated a slight increase. A number of patient falls initiatives have contributed to the reduction in in-patient falls as identified in graph 6 below:

- Intensive support and training has been given to a particular ward within the Medical Division to raise awareness of falls prevention. This has resulted in a 44% reduction in the number of falls from 25 to 11 in a five month period June – October 2009 compared to the same period last year. This intensive support is being rolled out across other areas within the Trust.

- The Medical Division has introduced movement sensors 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 sat out. The sensors alert the nurses via a pager system if a patient attempts to get out of bed unaided. The sensors have already helped prevent potential injury to patients as the nursing staff have been alerted swiftly and assistance can be given.

Graph 6 Slips, Trips and Falls

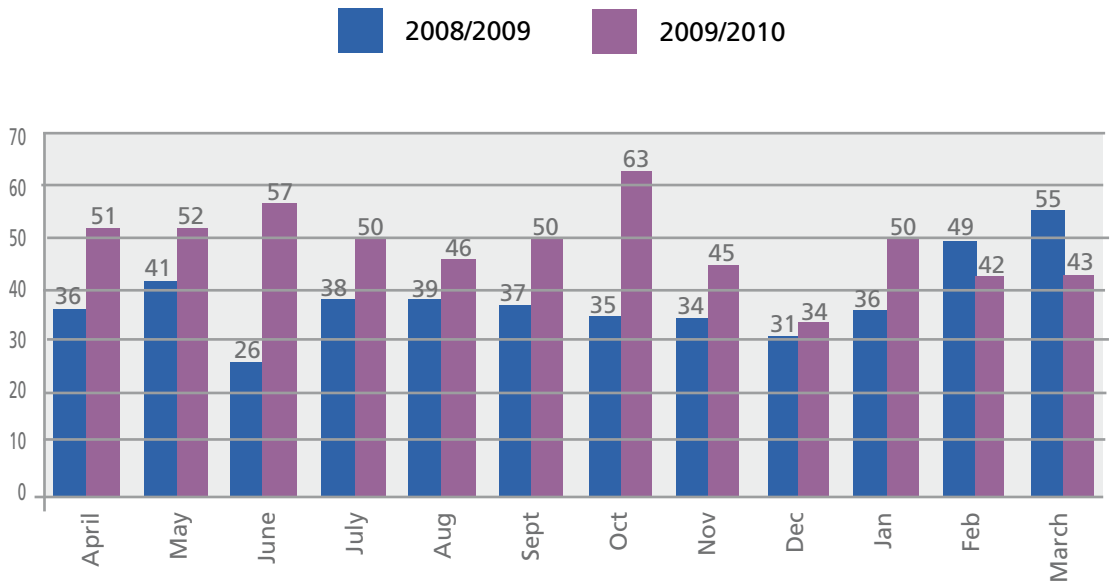


Reducing Medication errors by 50% by 2011/12

Incidents involving medicines were the third largest group (9%) of all incidents reported to the National Reporting and Learning Service (NRLS) after patient accidents (35%) and treatment / procedure (9%) from a total of 811,746 incidents of all types reported during 2007.

Much work has been undertaken within Pharmacy to improve the safety of Medicines within the Trust. As stated in the previous year's Quality Accounts Report we have continued to work within clinical professions encouraging a culture through which medication incidents are reported in a timely manner. The number of medication incidents that are reported is increasing as identified in graph 7 below, thus acknowledging the increased awareness and commitment of staff to ensure that patient safety and professional accountability is maximised with the safe management of medicines within the Trust.

Graph 7 Medication Errors



Increased training

The Practice Development Sister has reviewed and updated both the Administration of Medicines and the Intravenous Administration of Medicines Training packages. These now include new professional standards, and reflect current changes in legislation and organisational policies. The training sessions have been increased to further engage professionals with the National Patient Safety Agency Alerts and the impact on ensuring the safe delivery of medicines to in-patients and outpatients.

To ensure a collaborative and standardised approach to the safer management of medicines the training packages are now designed to meet the needs of other Allied Health Professionals, and training is now provided for radiographers and physiotherapists who administer medicines as part of their duties. This has developed a very inter-professional approach to medicines management at all stages of the patients journey.
The number of training sessions has been increased to monthly to allow access to the increasing number of professional staff who are involved in medicines and to ensure that staff are equipped with the knowledge and skills that ensure medicines are administered to patients safely.

In response to the Nursing and Midwifery Council (NMC) requirements regarding Pre-registration student nurses, training is provided at 1st 2nd and 3rd year stages of the students' progression throughout the course. The Practice Development Sister has ensured that the contents of the training packages not only reflect the learning outcomes of the Higher Education Institution at each key stage, but also ensure that at point of registration the student has met the essential skills clusters and is prepared for practice.

Medicines Management Training is given to all FY1 and FY2 Doctors as part of their Induction Training on commencement with the Trust.

The Administration of Medicines/Medicines Management Training has now become Mandatory for nurses and allied health professionals within the Trust.

Bulletin Safety alerts involving medicines

All safety alerts are cascaded to clinical areas through designated Medicines Management Liaison Link Nurses in the form of Medicines Matter Bulletins. This ensures that information regarding high-risk medicines or practice is disseminated at point of care.

Introduction of new products to improve patient safety

The introduction of pre-filled saline medical devices is being rolled out across all clinical areas. This device will reduce the risks associated with the preparation of an injectable medicine and the risk of microbial contamination associated with this procedure. This will also reduce the use of needles being used and therefore, the risk of needlestick injuries to staff. This meets best practice guidelines as identified in the National Patient Safety Agency (NPSA) Safer Use of Injectable Medicines.

Medicine Audits

Current audits that have been undertaken by Medicines Management are:-

- All National Patient Safety Agency (NPSA) alerts are audited annually to demonstrate sustained compliance with all alerts.
- Omission of medicines was initiated last year and will be audited again in response to the NPSA alert for omitted or delayed medicines.
- The General Medicines Management Audit is undertaken on an annual basis and includes the safe storage of medicines and the competencies of staff administering medicines within the Trust.
- A Controlled Drugs audit has been undertaken on a three monthly basis.
- Prescribing Audit. Undertaken annually to ensure compliance with policies and procedures and to ensure that safety within prescribing is maximised.

All audit results are presented through the Medicines Management Committee Meetings and then disseminated to each Division along with requests for action plans to address any issues or concerns. These are then reviewed at the following Medicines Management Committee meeting to ensure improvements are made.

Information resources

Increased resources have been made available via the Medicines Management Intranet site; these include updates, National Patient Safety Agency (NPSA) alerts and Medusa which is an electronic version of the Injectable Medicines Guide.

Audit Improvement

For all prescribed drugs, omission without reason or appropriate action should be avoided. All efforts should be made to ensure patients receive all medicines as prescribed to ensure that the efficacy and safety of their care is maximised. It is apparent from the outcome of the audit that the correct omission codes are not being utilised within clinical practice. This practice increases the potential for medication errors to occur within our wards causing potential harm to our patients.

Medication errors have serious consequences to the wellbeing and recovery of our patients. Documenting an incorrect code is a medication error, which should be reported via usual Untoward Incident Reporting Systems.

Documenting a code without ascertaining the facts e.g. recording a code 6 which is in relation to when the patient is unable to self administer or when the patient does not have the medication is not only an error but a falsification of patient records.

Despite this, the results highlight that there is some room for improvement. All staff involved in medicines administration are encouraged to reflect on current practice and identify areas for improvement.

All Divisions have been supplied with electronic audit results for individual wards, it is anticipated the audit will be repeated within an agreed time. The PD Sister is available to all wards that require advice, support or educational sessions.

The importance of correct documentation and omission coding is included in training packages at induction and ongoing professional development for Trust employees.
A future Medicines Matters bulletin is planned to highlight the correct documentation processes required to provide safe medicines administration and management within the Trust.

This will be disseminated to all areas via Medicines Management Liaison Links and general distribution lists.

This practice was reviewed and practice audited prior to the introduction of a National Patient Safety Alert issued in Feb 2010 RRR009 Reducing harm from omitted and delayed medicines in hospital, which reflects the findings of the audit itself.

Action has already been taken in the provision of Training and Clinical Support for staff in clinical areas as the Trust continues to improve patient safety in relation to safer medicines management within the Trust.

2.1.2 Clinical Effectiveness

North West Advancing Quality Initiative

The Trust is one of the first sites to assist in the development of the North West Strategic Health Authority Advancing Quality Programme, which focuses on 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:

- Acute Myocardial Infarction (Heart Attack)
- Hip and Knee Replacements
- Coronary Artery Bypass Graft
- Heart Failure
- Community Acquired Pneumonia

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. The Trust is on track to achieve top 25% performance for Acute Myocardial Infarction Measures and top 50% performance for Hip and Knee. Work is ongoing to improve and implement measures and achieve top 25% performance across all conditions. Approximately 2,700 patients a year will benefit from this programme.

The Patient Experience aspect of the Advancing Quality programme is now being measured. As soon as robust data is available the Trust will identify and implement any actions required to improve the patient experience.

Comparison of Data

For each of the key areas (a series of appropriate patient care measures have been determined which are known as Composite of Score (CQS). Data is 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. From this data the performance thresholds for top 25% and 50% performance are identified and applied to each Trusts performance).

Trusts in the top 25% performer group will receive an incentive payment of 4% of tariff, whilst Trusts in the top 50% performer group (who are not in top 25% group) will receive an incentive payment of 2% to be used to improve patient care.

A Trust's score must exceed the threshold in order to receive payment.

Trust on track for top 25% payment
Trust on track for top 50% payment
Not on Track for payment

Trust performance against each of the five key areas is detailed below. A Clinical Lead and Operational Manager have been identified for each key area and meetings are held to identify the actions required to improve scores achieved to date.

Acute Myocardial Infarction

Review

The performance of the Cardiologists in treating the Acute Myocardial Infarction patients is excellent. There will always be a number of patients who will be unable to receive Aspirin and Beta-Blockers. The Cardiac Division will endeavour to improve on the counselling of people to stop smoking.

Acute Myocardial Infarction	Trust Performance			
Measure	Oct 08 - Dec 08	Oct 08 – Mar 09	Oct 08 – June 09	Oct 08 – Sept 09
Aspirin at arrival	100.00%	100.00%	100.00%	100.00%
Aspirin prescribed at discharge	100.00%	98.97%	99.20%	99.40%
ACEI or ARB for LVSD	100.00%	100.00%	100.00%	100.00%
Adult smoking cessation advice/counselling	100.00%	95.45%	96.00%	92.86%
Beta Blocker prescribed at discharge	100.00%	97.73%	97.35%	98.03%
Beta Blocker at arrival	100.00%	100.00%	99.07%	99.07%
Fibrinolytic therapy received within 30 minutes of hospital arrival	100.00%	100.00%	100.00%	100.00%
Primary Coronary Intervention (PCI) received within 90 minutes of hospital arrival	100.00%	100.00%	100.00%	100.00%
Survival Index			96.00%	96.76%
Acute Myocardial Infarction (AMI) Composite Quality Score (CQS)	**100.00%**	**98.99%**	**98.47%**	**98.55%**
Top 25% CQS Threshold	**95.82%**	**96.33%**	**96.79%**	**97.02%**
Top 50% CQS Threshold	**93.1%**	**92.74%**	**92.82%**	**94.40%**
Trusts in top 25% performer group will receive an incentive payment of 4%				
Trusts in top 50% performer group (who are not in top 25% group) will receive an incentive payment of 2%				
A Trusts score must exceed the threshold in order to receive payment.				
Trust on track for top 25% payment				
Trust on track for top 50% payment				
Not on Track for payment				

Hip and Knee Replacement Surgery

Review

Both antibiotic and Venous Thrombo-Embolism prophylaxis is the subject of a set of Departmental protocols. Compliance with the Venous Thrombo-Embolism prophylaxis protocol is 99% or better as would be expected. With regard to antibiotic prophylaxis we have recently developed a new protocol, involving both flucloxacillin and gentamicin as a first line for patients without penicillin/cepahalosporin allergy.

It was expected that compliance with antibiotic prophylaxis within the prerequisite time would be 100% and that failure of the data to reflect this figure may be an act of failure to record the administration of the medication rather than non-compliance. A prospective audit of administration of antibiotic prophylaxis is being set up.

Hip and Knee Replacement Surgery	Trust Performance			
Measure	Oct 08 - Dec 08	Oct 08 – Mar 09	Oct 08 – June 09	Oct 08 – Sept 09
Prophylactic antibiotic received within 1 hour prior to surgical incision	79.49%	81.79%	81.67%	82.53%
Prophylactic antibiotic selection for surgical patients	98.76%	98.63%	98.89%	98.88%
Prophylactic antibiotic discontinued within 24 hours after surgery end time	95.51%	95.34%	94.65%	95.33%
Recommended venous thrombo-embolism prophylaxis ordered	100.00%	100.00%	100.00%	100.00%
Received appropriate Venous Thrombo Embolism (VTE) prophylaxis w/I 24 hrs prior to surgery to 24 hrs after surgery	99.35%	99.64%	99.77%	99.84%
Readmission (28 Day) avoidance index			91.64%	90.31%
Hip and Knee Composite Quality Score (CQS)	**94.62%**	**95.11%**	**94.49%**	**94.52%**
Top 25% CQS Threshold	**94.59%**	**94.54%**	**94.49%**	**94.52%**
Top 50% CQS Threshold	**89.91%**	**91.52%**	**91.76%**	**92.04%**
Trusts in top 25% performer group will receive an incentive payment of 4%				
Trusts in top 50% performer group (who are not in top 25% group) will receive an incentive payment of 2%				
A Trust's score must exceed the threshold in order to receive payment.				
Trust on track for top 25% payment				
Trust on track for top 50% payment				
Not on Track for payment				

Coronary Artery Bypass Graft Surgery (CABG)

Review

The management of patients undergoing Coronary Artery Bypass Graft surgery is excellent; however, the discontinuation of antibiotics within 24 hours is low. Our practise previously has been to prescribe the antibiotics without a stop date. These prophylactic antibiotics are now only prescribed for one day. If the antibiotics have to be continued for a longer period, the prescription has to be re-written and the reason for this has to be documented in the patient's notes. The Directorate is optimistic that this will see an improvement in this parameter.

Coronary Artery Bypass Graft (CABG) Surgery	Trust Performance			
Measure	Oct 08 - Dec 08	Oct 08 – Mar 09	Oct 08 – June 09	Oct 08 – Sept 09
Aspirin prescribed at discharge	98.19%	99.08%	99.38%	99.53%
Prophylactic antibiotic received within 1 hour prior to surgical incision	93.64%	95.29%	95.26%	94.71%
Prophylactic antibiotic selection for surgical patients	96.70%	97.21%	97.74%	98.14%
Prophylactic antibiotics discontinued within 24 (48) hrs after surgery end time	82.14%	82.93%	81.57%	82.15%
CABG Composite Quality Score (CQS)	**92.74%**	**93.71%**	**93.60%**	**93.77%**
Top 25% CQS Threshold	**95.63%**	**97.56%**	**98.35%**	**98.71%**
Top 50% CQS Threshold	**92.74%**	**93.71%**	**94.65%**	**95.01%**
Trusts in top 25% performer group will receive an incentive payment of 4%				
Trusts in top 50% performer group (who are not in top 25% group) will receive an incentive payment of 2%				
A Trust's score must exceed the threshold in order to receive payment.				
Trust on track for top 25% payment				
Trust on track for top 50% payment				
Not on Track for payment				

Heart Failure

Review

Heart failure management is one of five areas highlighted by the Advancing Quality programme. It is entirely deserving of such attention. Nationally and in our own Trust, heart failure is responsible for approximately 10 hospital admissions per week, each lasting on average eight days. These patients are at high risk of in hospital mortality and following discharge are at ongoing risk of readmission or other serious event. Over recent years advances in pharmacological and non-pharmacological treatments, including simple education and lifestyle changes, offer significant improvement in prognosis and symptom control for these patients. Such benefits also translate into financial benefits for the NHS as a whole; hospital admission for patients with heart failure is responsible for 2% of the total NHS budget. Unfortunately the uptake of these treatments, not only locally but also nationally has been very poor. This is clearly evidenced on a National level by recent analysis of the National Heart Failure Database.

In this Trust, improvement in the management of in-patients with heart failure is only part of our Heart Failure Strategy. Over the last 12 months we have developed a service to manage patients from pre-diagnosis that are at risk or with symptoms in primary care, through education, increase of a new medication of medical therapy and surveillance. Our approach aims to meet all of the patient care measures highlighted by the Advancing Quality agenda, not only for in-patients but also for those currently at home and otherwise at risk of admission. Although our service is only in its infancy the systems we have in place are already beginning to offer benefit to large numbers of patients. Unfortunately this is not yet being reflected in the Advancing Quality data.

The poor performance figures highlight the fact that we are not engaging with individual patients. Only less than 70% are having their diagnosis confirmed by echocardiogram. While the majority of those with formal diagnosis do receive appropriate medical therapy (Angiotensin Converting Enzyme Inibitors), it is not all patients. The lack of education and lifestyle advice, the lack of specialist follow up is almost certainly contributing to the high readmission rate that we know exists. If a patient is identified as having, or being at risk of having, heart failure during their admission and their basic details are passed to our team we have systems in place to ensure that Advancing Quality Care measures are met

- We have expanded the role of the Cardiac Rehabilitation Team such that all patients will be assessed; receive educational materials and advice before discharge.
- Our Specialist Nursing Team will ensure echocardiogram is performed during admission
- That all patients have Angiotensin Converting Enzyme Inibitors and beta blocker therapy initiated before discharge unless contra indicated. This will be monitored as an out-patient through specialist follow up, either in hospital or in the community depending on individual need.
- Levels of surveillance will be arranged to minimise readmission rate and better supporting management of the majority of patients at home.

Unfortunately symptoms and signs of heart failure are neither specific to, or sensitive of the diagnosis. Identification of the condition requires expertise and specialist investigation. These patients present largely to General Physicians and they often have complex co-morbidities, which not only complicate but also often mask the diagnosis. Our greatest challenge is bringing all patients with heart failure as a cause of their admission to the attention of our specialist team before discharge. We have recently put the following systems in place:

- Planned daily attendance on the Clinical Decision Unit to identify patients with heart failure or with significant risk of heart failure.
- A Heart Failure Integrated Care Pathway is in print – highlighting best practice in the management of heart failure from admission to discharge and the need for referral of all to our team.
- Request of all medical ward nursing and medical staff to refer all other patients with heart failure to our team.
- Retrospective monthly audit of all patients coded as heart failure – highlighting wards from which patients are not referred.

Heart Failure	Trust Performance			
Measure	Oct 08 - Dec 08	Oct 08 – Mar 09	Oct 08 – June 09	Oct 08 – Sept 09
Discharge instructions	2.70%	1.27%	2.21%	7.33%
Evaluation of LVS Function	59.46%	66.46%	68.72%	70.20%
ACEI or ARB for LVSD	100.00%	80.00%	76.92%	76.06%
Adult smoking cessation advice/counselling	25.00%	28.57%	33.33%	27.78%
Heart Failure Composite Quality Score (CQS)	**32.69%**	**36.44%**	**38.72%**	**42.40%**
Top 25% CQS Threshold	**70.37%**	**73.91%**	**75.67%**	**74.65%**
Top 50% CQS Threshold	**57.94%**	**55.94%**	**57.50%**	**59.60%**
Trusts in top 25% performer group will receive an incentive payment of 4%				
Trusts in top 50% performer group (who are not in top 25% group) will receive an incentive payment of 2%				
A Trust's score must exceed the threshold in order to receive payment.				
Trust on track for top 25% payment				
Trust on track for top 50% payment				
Not on Track for payment				

Community Acquired Pneumonia

Review

Validated data is now available until August 2009 according to which the Trust is under-performing in all five-quality parameters.

A review of case notes and previous audits highlighted three areas of improvement in relation to: coding, documentation and process of care. Since patients with pneumonia move across various departments in two Divisions, close and collaborative working is essential.

To address these issues the following actions have been taken so far:

- Establishment of a project team, which has representation from Clinical Support Services and Medicine. This team includes clinicians, nursing staff and managers and meets on a monthly basis.
- A clear action plan identified below has been agreed and progress is followed regularly.

The following tasks have been completed so far:

- Introduction of clear clinical guidelines and posters.
- Establishment of an educational program to increase awareness among front line staff.
- Weekly meeting with coder to review notes and ensure accuracy.
- Introduction of a clearly visible sticker to alert staff and improve documentation of all five markers.
- Introduction of stop smoking stickers to be used in medical wards and stop smoking training for staff in conjunction with public health services.

The challenge now is to ensure that these initiatives are implemented at the front line and lead to improvement in care with active participation and engagement of the staff. We are now collecting real time data to better inform all those involved in the project and hope that regular feedback will provide a stimulus for improvement. Figures from December 2009 indicate some improvement as identified in the graph below. We do however, realise that further work needs to be done to fulfil our aspiration of being in the top 25% of trusts.

Community Acquired Pneumonia	Trust Performance			
Measure	Oct 08 - Dec 08	Oct 08 – Mar 09	Oct 08 – June 09	Oct 08 – Sept 09
Oxygenation Assessment	94.38%	94.64%	96.00%	96.89%
Blood cultures performed in Accident and Emergency prior to initial antibiotics received in hospital	26.09%	21.13%	16.22%	17.09%
Adult smoking cessation advice/counselling	25.00%	15.52%	11.25%	10.20%
Initial antibiotic received within 6 hours of hospital arrival	52.00%	63.71%	62.65%	54.21%
Initial antibiotic selection for Community Acquired Pneumonia (CAP) in immuno competent patients	80.77%	52.05%	52.78%	67.13%
Pneumonia Composite Quality Score (CQS)	**70.43%**	**62.76%**	**61.05%**	**62.08%**
Top 25% CQS Threshold	**81.18%**	**81.30%**	**81.93%**	**82.11%**
Top 50% CQS Threshold	**78.26%**	**74.63%**	**74.40%**	**74.77%**
Trusts in top 25% performer group will receive an incentive payment of 4%				
Trusts in top 50% performer group (who are not in top 25% group) will receive an incentive payment of 2%				
A Trust's score must exceed the threshold in order to receive payment.				
Trust on track for top 25% payment				
Trust on track for top 50% payment				
Not on Track for payment				

Table 2 identifies actions to be taken to improve the management of patients with pneumonia.

Table 2		
ISSUE	ACTION	BY WHEN
Limited awareness of Advancing Quality (AQ) within the Trust / Divisions.	Training Plan to be populated for the year to capture all medical staff within Clinical Support Services Division and the Medical Divisions.	End January 2010
	Pneumonia posters to be developed and displayed in Accident and Emergency (A&E) and Clinical Decision Unit (CDU).	End January 2010
	Guidance to be put online in the resource centre and posters to be displayed in clinical areas.	End December 2009
	Training for nursing staff on CDU/A&E	Ongoing
No suitable doctors at present to identify Clinical Champion on Clinical Decision Unit (CDU).	Identify clinical champion following upcoming interviews and interim solution.	End January 2010
Collation of baseline data	Allocate Medical Registrar to carry out retrospective audit to identify baseline for comparison of 5 markers plus mortality and length of stay.	End January 2010 due to workload / AL.
Data Collection and Premier reports 3-6 months in arrears, which prevent real time improvements.	Real time data week on week to be obtained from the information department and circulated to all the team.	Ongoing
	Reports to be analysed for areas where improvements need to be made to improve performance against 5 markers and solutions implemented.	Ongoing
	Monthly data from Premier to be validated prior to submission.	Ongoing
Poor use of Pink CAP identification stickers in patients admitted through A&E and CDU.	Pink Community Acquired Pneumonia (CAP) stickers to be inserted into notes at triage in A&E and on admission in CDU for all patients with respiratory problems.	End January
X-ray marker / diagnosis results not identified and documented in A&E and CDU.	Improved training of medical staff in A&E and CDU re AQ, documentation requirements and use of pink CAP stickers as an aide memoir.	Ongoing
Blood cultures not performed in A&E and CDU prior to administration of antibiotics and / or documented with time.	Improved training of medical staff in A&E and CDU re AQ, documentation requirements and use of pink stickers as aide memoir.	Ongoing
Oxygen saturation assessment not performed and/or documented on admission in A&E and CDU.	Improved training of nursing staff in A&E and CDU re AQ, documentation requirements and use of pink CAP stickers as aide memoir.	Ongoing
Antibiotics not received within 6 hours of hospital arrival for every patient.	Improved training of nursing and medical staff in A&E and CDU re AQ, documentation requirements and use of pink stickers as aide memoir.	Ongoing

CONTINUED OVERLEAF

Table 2		
ISSUE	ACTION	BY WHEN
Initial antibiotic selection for CAP immuno-competent patients not appropriate for every patient.	Improved training of medical staff in A&E and CDU re AQ, documentation requirements, use of pink CAP stickers and antimicrobial formulary as aide memoir.	Ongoing
Smokers or ex-smokers not always identified in medical or nursing notes.	Improved training of nursing and medical staff in A&E, CDU and medical wards re AQ, documentation requirements and use of green smoking Cessation stickers as aide memoir.	Ongoing
Smoking cessation advice not given to all smokers or those who have given up in last 12 months.	Identify smoking cessation champion for each medical ward and provide training.	End January 2010
	Incorporate smoking cessation awareness and include weekly audit into the role of identified Band 5.	End January 2010
Staff unaware of advice available for smoking cessation.	Stop Smoking Training for all A&E/CDU staff.	Ongoing
Patients with CAP not always admitted to respiratory wards.	Bed Managers bleep 877 to ensure Pneumonia patients are admitted to the Respiratory Wards wherever possible.	Ongoing
	Patients with Community Acquire Pneumonia to be identified on whiteboards on each medical ward.	End January 2010
	Lead Respiratory Nurse to identify patients admitted in 24-hour period from CDU each day and flagged up.	Ongoing

Implementing 100,000 Lives and Saving Lives Programme

This initiative, which was launched by the Institute for Healthcare Improvement and Department of Health, has been adopted by the Trust. As with the Advancing Quality Programme they deploy evidence-based interventions with the aim of reducing patient harm. The outcome from implementing these measures will be:

- Improving outcomes for patients who have suffered a heart attack.
- Reducing the incidence of surgical site infection.
- Early identification and treatment of patients with worsening conditions.
- Reduced infection due to central line insertion.
- Reduced surgical infections.
- Elimination of ventilator associated pneumonias in critical care.
- Reducing the risk of microbial contamination.
- Reducing the incidence of catheter related bloodstream infection.

All patients will benefit from these changes. We have put in place mechanisms to audit both compliance and impact on patient care of implementing these two initiatives and we will be monitoring their contribution to reducing mortality rates and reducing preventable harm.

In addition to the above the Trust will be seeking to continue to implement best practice as set out in the 'Map of Medicine' and National Institute for Health and Clinical Excellence (NICE) guidelines.

The first two outcomes have been reported on in this report as detailed below, however, the Trust anticipates having further data available and all outcomes will be reported in the next financial year.

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

The Trust provides data regarding in-hospital cardiac arrest calls to the Care of the Acutely Ill Group/Resuscitation Committee every meeting (two monthly) and provides a detailed presentation every six months.

We also discuss action plans for reducing in-hospital cardiac arrests and embedding Do Not Attempt Resuscitation (DNAR) principles at each meeting.

The number of in-hospital cardiac arrests for the period 1st April 2009 – 31st March 2010 is 263. This is represented in Graph 8 below.

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 from April 2009 to March 2010:

- Advanced Life Support education has been increased.
- Immediate Life Support education has been increased.
- Early Warning Score and Do Not Attempt Resuscitation (DNAR) education has been increased.
- DNAR focus groups have commenced
- Critical Care Outreach Service has been implemented.

Reducing the Incidence of Surgical Site Infection

Mandatory Orthopaedic surveillance and a rolling programme of Divisional Surgical Site infections has been conducted to monitor the levels of infections. Issues highlighted from surveillance will be utilised to improve practice across the Trust.

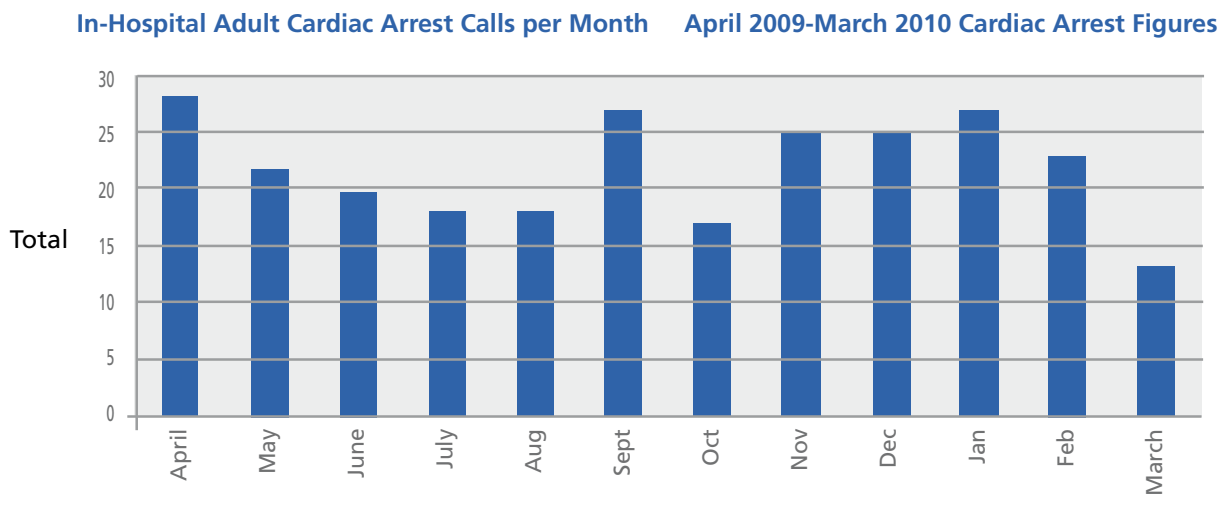
A random sample of 160 patients were audited to comply with the mandatory surveillance. From the audit two patients acquired infections whilst in-patients, this may have occurred due to the patients self interference with their wound due to their confused mental state.

The Divisional surgical site surveillance only started mid 2009 and will be reported in the next financial year 2010 / 2011.

Identifying measurable indicators of best practice resulting in reduced mortality and improved patient experience

Work is on-going with our clinical teams to identify measures considered to be indicators of best practice across a range of focus areas. These will be monitored and reported to the Board of Directors, with results expected to show reduced mortality and improved patient outcomes and provide assurance that the Trust is delivering Best in NHS care.

Graph 8



2.1.3 Patient Experience

Improving the National In-Patient Experience Survey Results

The National In-Patient Experience Survey is undertaken on an annual basis. The following information provides comparison of data taken from The National In-Patient Experience Survey results in relation to the following three indicators in which the results for 2008 in comparison to 2009 is identified in Table 3 below.

The four questions were chosen as Privacy and Dignity and Respect is high on the Trust agenda and so is the cleanliness and hygiene of the hospital. The questions in relation to noise at night and hospital food were chosen following consultation with the public. The Trust wants to ensure that these areas improve year on year and an action plan has been developed to ensure improvements are made.

Table 3 - National In-Patient Experience Survey

Indicator	2008 Result	2009 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%)
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%)
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%)
Were you bothered by noise at night from Other Patients:	Yes - 38% of our patients did experience noise at night due to other patients.	Yes – 37% of our patients did experience noise at night due to other patients (National average was 39%)
Were you bothered by noise at night from Hospital Staff	Yes - 19% of our patients did experience noise at night due to hospital staff.	Yes – 24% of our patients did experience noise at night due to hospital staff (National average was 22%)
How would you rate the hospital food ?	The majority of our patients rated the food highly with 36% rating it as very good and 38% as good.	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.

Improving Local Patient Experience Survey Results

The local In Patient Experience Surveys are conducted monthly as a measure of what our patients feel about their experience in our hospital wards. The questionnaires are completed whilst patients are still an inpatient ensuring that we have real time feedback about how our services can be improved and what we are doing well. The results of the surveys are presented to the Board and are shared with the Clinical Divisions.

The In-Patient Survey comprises of questions taken from a sample of questions from the national surveys. The questions are in four domains:

1. The Ward Environment and Infection Protection
2. The Staff at the Hospital
3. Your Care and Treatment
4. Leaving the Hospital

The results of the survey are shown in Table 4 and 5 below.

Table 4 - Local In-Patient Survey	
Domain	April – June 09
The ward environment and infection protection	95%
The staff at the hospital	90%
Your care and treatment	94%
Leaving the hospital	96%

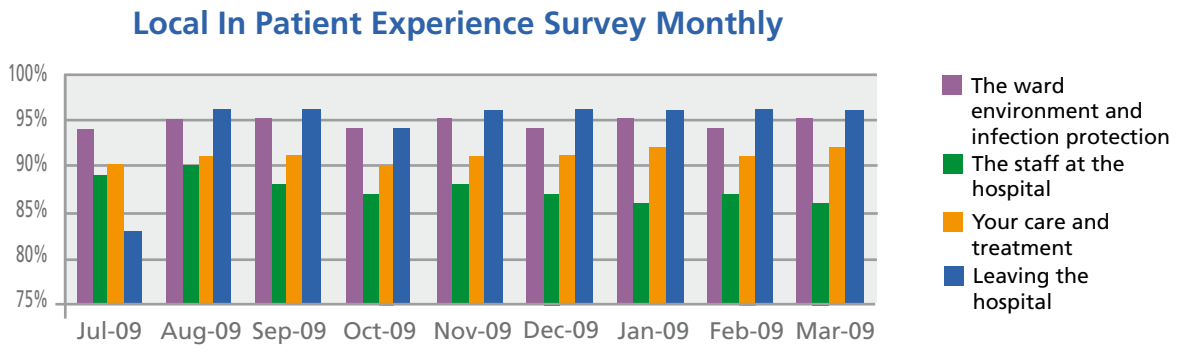
Table 5 - Local In-Patient Survey									
	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
The ward environment and infection protection	94%	95%	95%	94%	95%	94%	95%	94%	95%
The staff at the hospital	89%	90%	88%	87%	88%	87%	86%	87%	86%
Your care and treatment	90%	91%	91%	90%	91%	91%	92%	91%	92%
Leaving the hospital	83%	96%	96%	94%	96%	96%	96%	96%	96%

The above percentage relates to positive responses to questions.

The surveys have been conducted since April 2009, initially on a three monthly basis and since July 2009 on a monthly basis as shown in Graph 9 and Graph 10 below.

Graph 9

Graph 10



The Trust has consistently maintained a stable percentage of between 90% and 92%. The question "Leaving the hospital" has been consistently the highest domain between 92% and 96%. This survey has been used to measure our compliance with delivering the single sex accommodation agenda, and will continue to do so.

More work needs to be done around the quantity of forms being completed and Senior Nurses are tasked within their Divisions to find ways in which to improve this, and to address areas where further improvement is indicated.

It has been noted that forms that are currently being completed is increasing on each survey.

Customer care programme launched to improve performance and customer satisfaction

Over the last few years the Trust has been committed to improving the patient experience, of our patients. We invested heavily in a "Being With Patients" programme to improve customer service to patients, with a message about caring for them how they want to be cared for, not how we want to do it. This included effective communication methods, and physical approach. 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 we are developing this further with more training and action learning sets and this is supported by our recent staff survey results, the achievement of Investors in People Gold status, and recognition as the 49th Best Place to Work in the Public Sector.

Customer care qualities in our staff are also assessed during appraisals as part of 'Being the Blackpool Person'.

Nursing Care Indicators

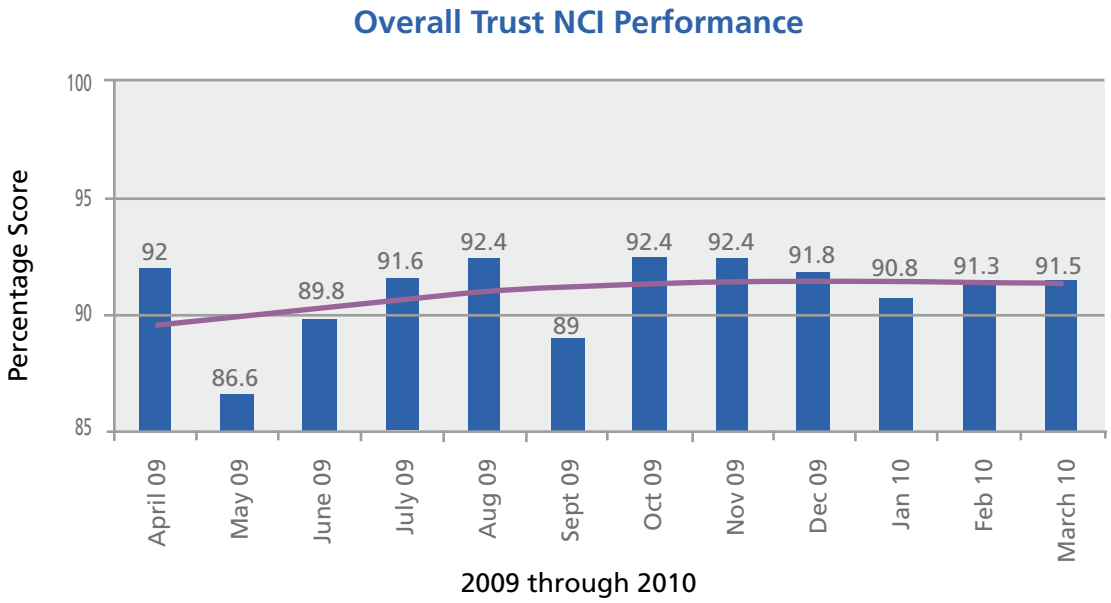
The Nursing Care Indicators are used to assess and measure standards of clinical care and patient experience. The framework for the nursing care indicators is designed to support nurses in practice to understand how they deliver care, identify what works well and where further improvements are needed.

We have been monitoring nursing care using the 'nursing care indicators' tool for the last year. The nursing care indicators are completely nursing focused. The process involves inspection of documentation, ward environments and nursing care delivered on a monthly basis, with results being fed back to senior nurse managers for action, reporting on specific issues where required. Key themes for measurement were identified from complaints, the patients' survey and results from the Trust documentation audit, the benchmarks held within the essence of care benchmarking tool, and assessments against Trust nursing practice standards. The following themes are measured monthly:

1. Patient Observations
2. Pain Management
3. Falls Assessment
4. Tissue Viability
5. Nutritional Assessment
6. Medication Assessment
7. Infection Control
8. Privacy & Dignity (Added September 2009)

For the first time we have been able to agree a standard and benchmark properly at both ward and Divisional level. We have expanded the indicators into other clinical areas to include theatres, maternity and paediatrics. The nursing care indictors are subject to internal review and we are in the process of adding to the suite of indicators in line with changing standards and requirements.

Graph 11



Care of the Dying indicators have already been written and plans are in place to trial these at the next data collection. Results generate meaningful information to enable and motivate nurses to change their practice to improve patient outcomes.

Graph 11 shows the overall Trust performance, expressed as an average percentage of all eight indicators, over the preceding 12 months. The curve is a 12 month trend line and shows that performance dipped in January, when the hospital was busier than normal and coping with unusually bad weather conditions. Since January there has been a month on month improvement in the overall performance.

End of Life Care

In order to enhance and develop our services further it is essential that we gather the views of patients and carers around end of life care in our hospitals. As part of this we have recruited two patient/carer representatives to sit alongside senior representatives from our partner organisations on the Trust's End of Life Board.

Additionally the Patient Experience work stream (which reports to the End of Life Board) will obtain feedback about quality of services and areas for further improvement over the next year.

2.1.4 Statement of Assurance from the Board relating to Quality of NHS Services

Information on the Review of Services in 2009/10

During 2009/10 the Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust provided 76 services based on the number of specialities.

The Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of the five Clinical Divisions providing healthcare.

The income generated by the NHS services reviewed in 2009/10 represents approximately 4.5 per cent of the total income generated from the provision of NHS services by the Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust for 2009/10.

The Trust has scrutinised and monitored the quality of its services by way of effective risk management systems. Issues around quality of care identified by the Global Trigger Tool or by the reporting of adverse events are reflected in the risk register of each Clinical Division. The mitigation of high and moderate risks are monitored by both the Divisional Board and the Trust Board.

The Board has used the results of this review to develop a plan for improving the quality of the Trust's services. Across 2008/09 and 2009/10, the Trust reviewed the quality of its services across the five Clinical Divisions through the 'Fit for Foundation' programme. The criteria used for this assessment were developed in conjunction with the Board of Directors, and cover seven key areas:

1. Financial management
2. Access to services and use of operational resources
3. Governance and quality
4. Workforce
5. The Blackpool Way (The Trust's organisational development programme)
6. Management capacity and processes
7. Key strategic and planning tools.

Areas 2 and 3 are particularly relevant to quality performance, with criteria relating to:

- 18-week pathways
- Cancer pathways
- A&E 4-hour operational standard
- Cancelled operations
- Theatre utilisation
- Day case rates
- Length of stay
- Hospital Community Acquired Infection (HCAI) rates
- Mortality
- Complaints
- Patient experience
- Quality of nursing care
- Patient falls
- Medication errors

Each of these criteria has a stretch target associated with it, deliberately chosen to be a greater achievement than the national target, designed to encourage clinical divisions to strive towards 'best in NHS care' as stated in the Trust's vision.

The initial assessment was undertaken in February 2008, and the results presented to the Board of Directors. Following this, areas for further development were identified and divisional action plans created to ensure that demonstrable improvements were made within six months. In addition, gaps in the criteria were identified – in particular in relation to patient experience and the quality of nursing care. As a result, a local patient experience survey has been developed to gather monthly feedback from each ward area. The Trust has also developed Nursing Care Indicators, which are used to review the quality of care provided across all wards each month.

An interim assessment was undertaken in October 2008 to review progress, and the final assessment in February 2009. The final assessment included a face-to-face review with the divisional management team and the Board of Directors, to afford the opportunity for the Board to explore in detail the areas of concern and the demonstrable improvements. This will be replicated on an annual basis.

Information on Participation in Clinical Audits in 2009/10

During 2009/10, 34 national clinical audits and five national confidential enquiries covered NHS services that Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust provides.

During 2009/10 Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust participated in 65% 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, Fylde and Wyre Hospitals NHS Foundation Trust was eligible to participate in during 2009/10 are identified in Table 6 below:

Table 6

National Audits	Status	National Audits	Status
Adult cardiac intervention (BCIS / PCI)			Ongoing
Adult Cardiac Surgery (SCTS)			Ongoing – to be completed by May 10
Bowel Cancer Audit (NBOCAP)			Ongoing
Carotid Interventions			Ongoing
Congenital Heart Disease			Ongoing
Epilepsy 12			Unknown
Head and neck cancer (DAHNO)			Unknown
Heart rhythm management (pacing and implantable cardiac defibrillators (ICDS)			Unknown
Heavy Menstrual Bleeding			Unknown
Intensive Care National Audit Research Centre (ICNARC)			Unknown
National Lung Cancer Audit			Unknown
National Neonatal Audit			Unknown
National Kidney Care Audit			Unknown
National Joint Registry			Unknown
National Sentinel Stroke Audit			Ongoing
Oesophago-gastric (stomach cancer)			Unknown
Royal College of Physicians audit to assess and improve service for people with inflammatory bowel disease			Unknown
Mastectomy and breast reconstruction			Ongoing
MINAP			Unknown
National Audit of Continence Care 2010			Completed
National Audit of Services for Falls and Bone Health in Older People			Ongoing
National Audits of Occupational Health management of NHS staff with lower back pain and depression			Informed Cons who may not wish to participate
National Comparative Audit of Blood Transfusion			
National Dementia Audit			Ongoing
National Diabetes Audit			Ongoing
National head and neck cancer audit			Ongoing

Continued overleaf

Table 6 - Continued			
National Audits	Status	National Audits	Status
National Hip fracture database			Continually ongoing
Services for people who have fallen			Unknown
Pain Database Improvement Programme			Unknown
Pacing			Unknown
Paediatric intensive care network (PICANET)			Unknown
The National Service Framework for Coronary Heart Disease			Unknown
Transcatheter Aortic Valve Implantation (TAVI)			Ongoing
The National COPD Audit			Unknown
TARN			Continually ongoing
NCEPOD Studies			
Parenteral Nutrition			Ongoing
Surgery in children			Ongoing
Cosmetic Surgery			Completed
Elective and Emergency Surgery in the Elderly			Ongoing
Peri-operative care			Ongoing

The national clinical audits and national confidential enquiries that Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2009/10, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Completed National Audits/ NCEPOD	Percentages
National Audit of Continence Care 2010	98%
Cosmetic Surgery	100%

The reports of one national clinical audit was reviewed by the provider in 2009/10 and Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. Each National Audit has its own action plan which is monitored at relevant Divisional Board meetings.

The reports of 87 local clinical audits were reviewed by the provider in 2009/10 and Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

The lead author for clinical audits are requested to produce an action plan which is monitored by the relevant committee within the corporate governance structure for monitoring and ensuring changes in practice occur.

The Trust has a Clinical Audit Department which supports clinicians undertaking clinical audit and has a very full audit calendar arising from the Trust's quality framework, NHS Litigation Authority requirements and audits of care against National Institute for Health and Clinical Excellence (NICE) standards.

There is also a comprehensive local audit agenda, which is reported through the Clinical Improvement Committee to the Board.

The Clinical Audit Committee is proposing using the Healthcare Quality Improvement Partnership tools to support Audit, including a prioritisation tool for annual forward planning and approval of audits which will ensure that all audit work undertaken will be aligned to Board, National, Clinical and Risk priorities for the Trust each year. The team are working on ensuring that audit is multi-disciplinary in nature, patient focused and can demonstrate improvements in clinical care.

Information on Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by our Trust in 2008/09 that were recruited during that period to participate in research approved by a research ethics committee was 715 of which the number of patients recruited to National Institute of Health Research (NIHR) Portfolio Studies was 602.

The number of patients receiving NHS services provided or sub-contracted by our Trust in 2009/10 that were recruited during that period to participate in research approved by a research ethics committee was 857 of which the number of patients recruited to NIHR Portfolio Studies was 736*.

The NIHR 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.

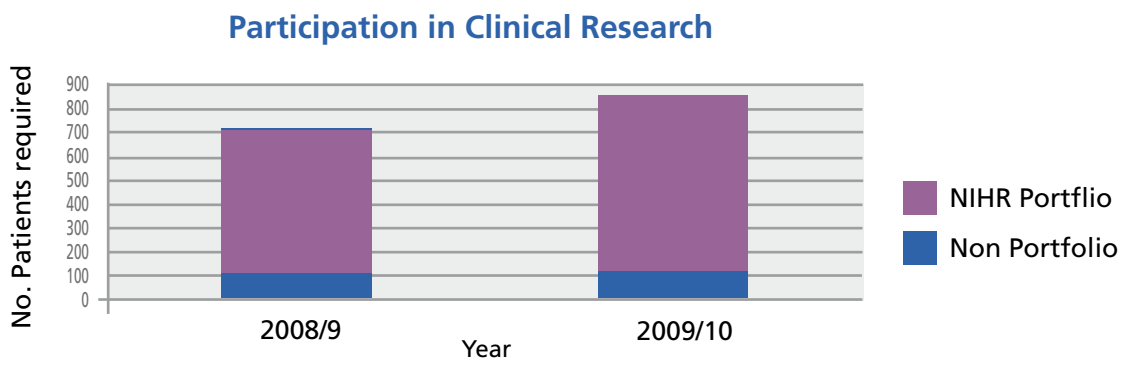
Graph 12 below demonstrates patients receiving NHS Services provided or sub-contracted by our Trust in 2008/09 and 2009/10.

This increasing level of participation in clinical research demonstrates Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

The number of patients recruited to NIHR Portfolio Studies by speciality group was:

Speciality	2008/9	2009 /10*
Cancer	120	140
Cardiovascular	240	192
Gastrointestinal	14	47
Generic Relevance & Cross Cutting Themes	0	34
Infection	1	3
Inflammatory and Immune	0	7
Medicines for Children	0	30
Musculoskeletal	34	9
Renal and Urogenital (co-adopted by Infection)	0	114
Reproductive Health & Childbirth	53	73
Respiratory	0	3
Stroke	140	84
TOTAL	602	736

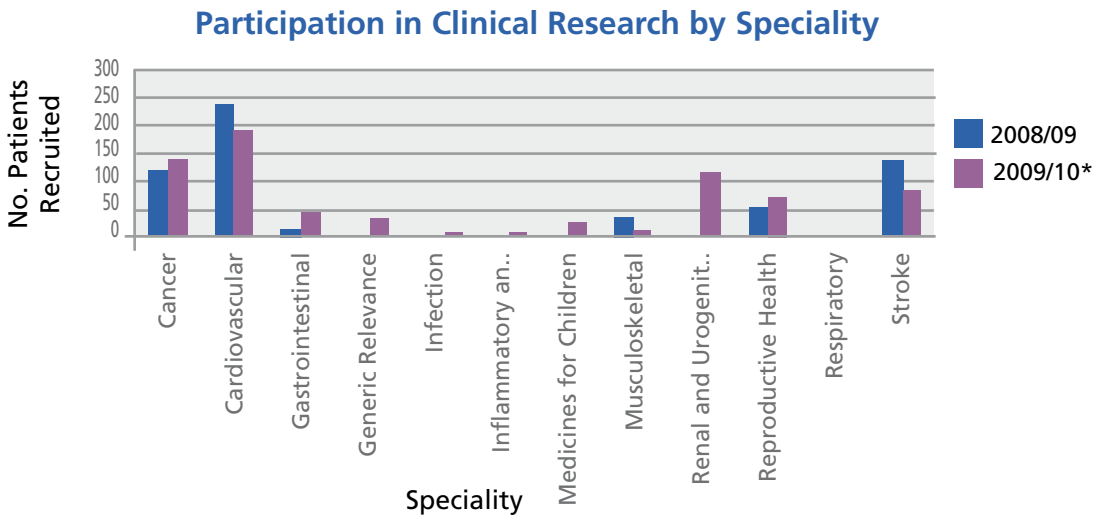
Graph 12



Graph 13 demonstrates the number of specialities that have participated in Clinical research for 2008/09 and 2009/10.

* It should be noted that 2009/10 NIHR Portfolio Study data is not signed off nationally until June 30th 2010. We therefore estimate the total patient recruitment total to be higher than currently reported (as at April 14th 2010).

Graph 13



Information on the Commissioning for Quality and Innovation (CQUIN) 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 the Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust's contracted income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between Blackpool, Fylde and Wyre 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 Improvement Payment Framework.

The payment mechanism in 2009/10 was that Contracted Commissioners paid 90% of the CQUIN value through block contracts followed by the remaining 10% upon the Trust successfully achieving the agreed goals. The values of these payments are £995,449 and £110,602 and therefore the total monetary total for the associated payments is £1,106,051.

Further details of the agreed goals for 2009/10 and new agreed goals for the following 12 months (2010/11) is available on request from the Director of Operations 01253 655550.

Information Relating to Registration with the Care Quality Commission and Periodic/Special Reviews

Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is compliant with no conditions. The Care Quality Commission has not taken enforcement action against Blackpool, Fylde and Wyre Hospitals NHS Foundation during 2009/10.

Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission and the last review was carried out in October 2009 which was the Ofsted/ Care Quality Commission joint inspection.

Following the Care Quality Commission's assessment the Inspectors noted:

- Staff in the Accident and Emergency Department pay good attention to the possible risks to children attending for treatment posed by adults visiting the department.
- A strong embedded safeguarding culture in the Accident and Emergency Department.
- An appropriate awareness of the Common Assessment Framework which is well embedded and well regarded by health staff.
- The inspection team noted a good example of the 'alert system' within the Accident and Emergency Department.
- The Victoria Safeguarding Centre was seen as a good example of partnership working to improve both the services and experience of children and young people.

Although there were no actions for health in the combined report the Care Quality Commission has produced a separate report and have added the following recommendations and made the following conclusions:

- To further develop systems that will identify outcomes and evaluation of services efficiently.

- To monitor performance in regard to timeliness, quality and interventions in health assessments for Looked After Children (LAC).

In view of this Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust has made the following progress on implementing the above recommendations.

- The Trust has developed a Safeguarding Children and Young People Work Plan to include Audit to support the Trust to evaluate the service (The work plan also includes training, child protection supervision and policy development). The ongoing work plan will take into consideration the Revised Working Together guide (March 2010). Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust has made the following progress by March 31st 2010 in taking such action. Contribution to Blackpool Local Safeguarding Children's Board (LSCB) section 11 audits, actions agreed include identifying the Named Midwife as the Common Assessment Framework Lead for the Trust, Safe Recruitment training for recruiting managers and improvements have been made to the recording of Safeguarding Children training.
- Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust has taken part in the Child Health Mapping special review by the CQC in February 2010. The Trust is awaiting the findings from that review. In the meantime, the Trust has developed an action plan based on a self-assessment of improvement to be made.

The Trust also participated in an assessment of performance by the Care Quality Commission against national standards in relation to Healthcare Associated infections on the November 25th 2009. We received no conditions on our registration. The Care Quality Commission has not taken enforcement action against us since the start of the reporting year from April 1st 2009.

The Trust retained Clinical Negligence Scheme for Trusts (CNST) Maternity Level 1 on the February 26th 2010 but unfortunately narrowly did not reach the requirements to meet CNST Maternity Level 2. The Trust failed on three criterias to achieve the overall pass rate of 40. In view of this the Trust has developed an action plan to achieve Level 2.

The Trust has not been required to participate in any special reviews or investigations by the Care Quality Commission during the reported period.

A Statement for the Local Involvement Networks, Local Authority Overview and Scrutiny Committee and Commissioning PCTs on their view of the Quality Accounts Report

The statements supplied by the above stakeholders in relation to their comments on the information contained within the Quality Accounts Report can be found on page 125.

The Quality Accounts 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 Accounts Report.

Information on the Quality of Data

NHS Number and General Medical Practice Code Validity

Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust submitted records during 2009/10 to the Secondary Uses System (SUS) for inclusion in Hospital Episode Statistics (HES), 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; 99.4% for Outpatient care; and 94.6% for Accident and Emergency Care.

- which included the Patient's valid General Practitioners Registration Code was: 99.9% for Admitted Patient Care; 100% for Outpatient Care; and 99.7% for Accident and Emergency Care.

'In records submitted to the Secondary Uses System (SUS) for inclusion in Hospital Episode Statistics (HES), the percentage of records including the valid patient's General Practitioner Registration Code was 2009/10 Admitted Patient Care to date 99.2%'.

Information Governance Toolkit attainment levels

Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust's score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 87%.

Clinical Coding Error Rate

Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were 10.7% and 5.9% respectively as shown in Table 8.

The results should not be extrapolated further than the actual sample audited. The following services were included in the sample as shown in Table 7 below.

Table 7 - Data sampled

Area audited	Specialty/ Sub-chapter/ Healthcare Resource Group	Sample size	Reason for selection
Theme	General Medicine	100	National Theme
Specialty	Accident & Emergency	100	Chosen by PCT and agreed by the Trust following local discussions
Sub-chapter	HB: Orthopaedic Non Trauma Procedures	70	Selected from benchmarking main recommendations
Healthcare Resource Group (HRG)	JD042: Minor Skin Disorders category 3 without Clinical Condition (CC)	30	

Table 8 - Data Published by the Audit Commission

Clinical Coding	Percentages
Primary Diagnoses Incorrect	10.70%
Secondary Diagnoses Incorrect	10.30%
Primary Procedures Incorrect	5.90%
Secondary Procedures Incorrect	5.10%

Part 3 Quality Improvement Priorities for 2010/11

The Trust aims to achieve excellence in everything it does and its aspirations for quality improvement are identified in the Quality Strategy which sets ambitious targets for the next three years in relation to direct patient care, as set out below:

- Improve our hospital standardised mortality rate from 103 (100 being the average) to 73 by 2011/12.
- Conform to best practice by fully implementing Advancing Quality, 100,000 Lives and Saving Lives interventions.
- Reduce avoidable harms by 50% by year 2011/12.
- Improve the patient experience, evidenced by improving our rating in the national patient satisfaction survey by five points per year, over the next three years.

After consultation at Board level the Trust confirmed the top quality improvement priorities for 2010/11 which would have maximum benefits for our patients and are reflected in the Trust's Corporate Objectives. These are detailed in Table 9 below.

Table 9 - Quality Improvement Priority 2010/2011

Quality Improvement Priorities 2010/11	Quality Improvement Performance/Outcome Measures
Patient Safety	Continue to reduce the Trust's hospital mortality rate Continue to reduce MRSA and Clostridium Difficile infection rates as reflected by national targets Reducing avoidable 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
Clinical Effectiveness	Conformance to best practice through application of the following interventions to improve patient outcomes: Phase 1 site for the North West Advancing Quality initiative that seeks compliance with best practice in five clinical areas: – Acute Myocardial Infarction – Hip and Knee Surgery – Cardio by-pass Surgery – Heart Failure – Pneumonia Implementing 100,000 lives and Saving Lives Programme: – Rapid Response Team - Reducing Cardiac Arrest calls – Reducing the incidence of Surgical Site Infections – Embed implementation of Venous Thrombo Embolism (VTE) guideline Nursing care indicators used to assess and measure standards of clinical care and patient experience

Continued overleaf

Table 9 - Quality Improvement Priority 2010/2011 - Continued	
Quality Improvement Priorities 2010/11	Quality Improvement Performance/Outcome Measures
Patient Experience	Improving the patient experience which will be measured through an improvement in the National In-Patient Survey results in the following three 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? To improve National Out-Patient Survey results in the following four key areas where the need for improvement was identified: – 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 Liverpool End of Life Care Pathway – Seeking patients and carers' views to improve End of Life Care Patient Environment Action Team (PEAT) Survey – To improve PEAT Survey results/standards Ensure single sex accommodation to provide privacy and dignity for patients

The quality improvements priorities identified in 2009/2010 will continue to be monitored in 2010/2011 to enable progress towards achievement to be demonstrated. Additional indicators have been identified to meet national healthcare directives and current local quality improvement priorities for 2010/11 with the expectation of reporting on these in the next Annual Report.

The additional quality improvement priorities for 2010/11 are listed below:

- Embed Implementation of Venous Thrombo Embolism (VTE) guideline
- To improving National Out-patient 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 time to discuss health issues
- Liverpool End of Life Care Pathway
  - Seeking patients and carers' views to improve End of Life Care
- Patient Environment Action team (PEAT) Survey
  - To improve PEAT Survey results/standards
- Ensure single sex accommodation to provide privacy and dignity for patients

The quality improvement priorities will continue to be monitored and measured and progress reported to the Board of Directors as part of the monthly Board Performance Business Monitoring Report. The quality improvement priorities will also be monitored via way of the Assurance Framework, the Risk Register process and by the Sub-Committees of the Board where appropriate.

3.1 Overview of Performance of the Trust against Key National Priorities and the Core Standards

An overview of the quality of care offered by Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust based on performance in 2009/10 against indicators selected by the Board in consultation with stakeholders, with an explanation of the underlying reason(s) for selection is shown in table 10 below:

The Board of Directors monitor compliance against performance against the key national priorities from the Department of Health's Operating Framework and against the Department of Health's Core Standards on a monthly basis. The table below provides an overview of performance for each of the quality standards for the last two reporting periods:

Table 10 - Performance against Key National Priorities and Core Standards

Quality Standard	2008/09	2009/10 Self Assessment
18 week referral to treatment times	Maintained greater than 90% of admitted and 95% of non-admitted patients being treated within 18 weeks.	Maintained the standard for both admitted and non-admitted care across the Trust. Achieved the standard across all Treatment functions from July 09 for admitted and September 09 for non-admitted pathways.
All cancers: one month diagnosis to treatment (including new cancer strategy commitment)	100%	First Treatment 99% (target 96%) Subsequent Treatment: Drugs 99% (target 98%) Surgery 100% (target 94%)
All cancers: two month GP urgent referral to treatment (including new cancer strategy commitment)	Qtr 1 – 97% Qtr 2 – 98% Qtr 3 – 98% Qtr 4 – 87% (revised operational standards)	62 day classic 85% (target 85%) 62 day screening 75.5% (target 90%) 62 day upgrade 90% (target to be confirmed)
All cancers: two week wait	100% (target 100%)	94% (target 93%)
Time to reperfusion for patients who have had a heart attack	Achieved 92.98% of patients treated within 60 minutes of calling for help	Achieved
Incidence of MRSA Bacteraemia	9 cases (target <26)	8 cases (target <26)
Incidence of Clostridium Difficile	315 cases (target <385)	134 cases (target <185)
Delayed transfers of care (target <3.5%)	2.49%	1.97%
Total time in A&E (target 98% of patients to be admitted, transferred or discharged within 4hrs)	98.75%	98.93%
Inpatients waiting longer than the 26 week standard	Achieved – 0 patients waiting in excess of 26 weeks	Achieved – 1 patient waiting in excess of 26 weeks

Continued overleaf

Table 10 - Performance against Key National Priorities and Core Standards - Continued		
Quality Standard	2008/09	2009/10 Self Assessment
Outpatients waiting longer than the 13 week standard	Achieved – 0 patients waiting in excess of 13 weeks	Achieved – 0 patients waiting in excess of 13 weeks
Patients waiting longer than three months (13 weeks) for revascularisation	Achieved – 0 patients waiting in excess of 13 weeks	Achieved – 0 patients waiting in excess of 13 weeks
Waiting times for Rapid Access Chest Pain Clinic	Achieved – 0 patients waiting in excess of 2 weeks	Achieved – 0 patients waiting in excess of 2 weeks
24 National Core Standards	The Trust was fully compliant with the 24 core standards for better health.	The Trust is fully compliant with the 24 core standards for better health.
Access to healthcare for people with a learning disability	N/A	Achieved
Cancelled operations	Achieved	Achieved
Patient Experience	Achieved	Achieved
Staff satisfaction	Achieved	Achieved
Participation in heart disease audits	Underachieved	Participation in heart disease audits was 100% achieved and checked on a regular basis.
Quality of Stroke care	Underachieved	Under review, possible underachievement
Ethnic coding data quality	Achieved	Achieved
Engagement in clinical audits	Achieved	Achieved
Smoking during pregnancy and breast feeding initiation rates	Failed	Underachieved
Maternity data quality	Failed	Achieved

3.2 Quality Accounts Report Production

We are very grateful to all contributors who have had a major involvement in the production of this Quality Accounts Report.

The Trust welcomes any comments you may have and asks you to help shape next year's Quality Accounts Report by sharing your views and contacting the Chief Executive Department via:

Telephone 01253 655520
Email mary.aubrey@bfwhospitals.nhs.uk

Associate Director of Corporate Affairs
Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust
Trust Headquarters, Whinney Heys Road,
Blackpool, FY3 8NR

3.3 Quality Accounts Report Availability

If you require this Quality Accounts 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 can also be downloaded from the Trust website: www.bfwhospitals.nhs.uk

Statement from External Agencies

1.1 Statement from NHS Blackpool

NHS Blackpool Trust Board as lead commissioner for Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust can confirm that a review of the Quality Accounts Report for 2009-10 has been undertaken. They are considered to be both representative and comprehensive. The Trust's aims for the coming year are both relevant and achievable.

NHS Blackpool would like to take this opportunity to commend the Trust on its service improvements and care quality achievements during 2009/2010.

Participation in the internationally recognised North West Advancing Quality initiative is evidence of a hospital-wide commitment to the Trust's Quality Improvement Plan. This initiative demonstrates that by promoting best practice and reducing variations in care, quality can be improved. The initiative has particularly shown that excellent care was delivered to patients who had suffered from a Myocardial Infarction (heart attack). It has also highlighted that the care given to patients suffering from heart failure and Community Acquired Pneumonia will require improvement. The Trust has acknowledged the need for improvement and is taking active steps to improve care delivery.

The Trust's Quality Improvement Plan also demonstrates a focus on improving the patient experience, patient safety and clinical effectiveness of care. The Trust has exceeded targets related to the reduction of Health Care Associated Infections and we anticipate continued achievement in the coming year. We fully support the improvement plans for end of life care, reduction in falls and monitoring of nursing care indicators.

To improve services, the Trust will seek patient views and also engage with staff on quality issues. NHS Blackpool supports the improvement in the four key areas related to outpatient care and anticipates improvement in the staff element of the local inpatient survey. We feel that an excellent way to improve services is by involving patients, carers and Trust staff, as they have first-hand experience of services and can provide real and honest views. The relationships developed with the Local Involvement Network and the Health Overview and Scrutiny Committee will add considerably to the engagement process.

The Trust is fully committed to improving the quality of services and is striving for excellence with a positive drive for improvement opportunities.

1.2 Statement from NHS North Lancashire

Thank you for asking NHS North Lancashire to comment on the draft Quality Accounts Report. We feel this is in itself a helpful sign of an open and reflective culture.

1. **Do you consider that the draft document contains accurate information in relation to NHS services provided by the provider?**

A. Yes, although the Quality Accounts Report is not intended to describe all the services and that is not our expectation of it.
It might be helpful to see a list of people who lead on quality and safety for the Trust.

2. **Do you consider that any other information should be included relevant to the quality of NHS services provided by the provider?**

A. We feel it would be sensible to include the Dr Foster Report and the excellent response to it that you produced earlier in the year. Until the HSMR methodology is standardised as per the 'Francis Report', we feel that it will be sensible to show both CHKS's and Dr Foster's versions. Indeed, it might be sensible for the CEO to make reference to this in the introduction.

The component parts of CQUIN and achievement against them show an important relationship between the aspirations of the commissioners and the achievements of providers. Therefore, a breakdown of achievement here – as per the AQ indicators – would be welcome.

Others it would seem sensible to include: The National Hip Fracture Data Base; TARN, Stroke Sentinel Audit.

We would like to see as much information as possible about patient experience.

We feel it would be wise to make the document as accessible as possible to all members of the public. So, for our purposes we'd like to see a rather detailed document but accept that others may want something less intricate.

3. **Do you consider that the data provided is accurate when compared with any data you have been supplied with during the year?**

A. Yes, mindful of the comments above.

1.3 Statement from Blackpool Local Involvement Network

Blackpool Local Involvement Network (LINk) welcomes the publication of this report and sees it as a positive step forward. For the first time, Blackpool LINk is able to read some comprehensive information on the quality of health care provided.

Members of the Advisory Group have spent a considerable length of time reading and responding to the two drafts. Thank you for responding positively to our concerns regarding the jargon that was used.

Please see our recommendations:-

- To continue to provide 'jargon-free' reports and glossaries in future years.
- To improve 'Falls Reduction' by extending the programme throughout Blackpool, Fylde & Wyre Hospitals.
- The Trust needs to strive to lower medical errors as most are higher than the previous year.
- Clear action plans for improving hospital mortality rate, reducing avoidable harms and improving the patient experience need to be included in the report. We are pleased to see the recommendations of the detailed action plan provided for patients with pneumonia.
- Blackpool LINk would like to monitor results of the Trust, using the Global Trigger Tool.

We look forward to receiving the official report in due course.

1.4 Statement from Blackpool Health Overview and Scrutiny Committee

Blackpool's Health Overview and Scrutiny Committee meeting held on the December 8th 2009 identified that the committee would not be providing a response in relation to the Quality Accounts Report. However, the committee will be happy to receive a copy of the Trust's published Quality Accounts Report.

1.5 Statement from Lancashire Local Involvement Network

Lancashire Local Involvement Network have not provided a response in relation to the Quality Accounts Report.

1.6 Statement from Lancashire Health Overview and Scrutiny Committee

Lancashire Health Overview and Scrutiny Committee have not provided a response in relation to the Quality Accounts Report.

Glossary of abbreviations

Page No.	Abbreviation	Meaning
2	CABG	Coronary Artery Bypass Graft
3	PCT	Primary Care Trust
4	CHKS	Clinical, Accountability, Service, Planning, Evaluation) Healthcare Knowledge Systems (CHKS). Name of the Company which is used for benchmarking
6	RAMI	Risk Adjusted Mortality Index
6	HSMR	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, they survive their stay in hospital, and how often they die.
7	MRSA	Methicillin Resistant Staphylococcus Aureus MRSA stands for meticillin-resistant Staphylococcus aureus. It's a common skin bacterium that's 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 get into the bloodstream, they can cause more serious infections, such as blood poisoning.
7	CDI	Costridum Difficile Infection 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.
10	NRLS	National reporting and Learning Service
10	NMC	Nursing and Midwifery Council
11	NPSA	National Patient Safety Agency
11	Medusa	Electronic version of the Injectable Medicines Guide

Page No.	Abbreviation	Meaning
12	CQS	Composite Quality Score
13	PCI	Primary Coronary Intervention
13	AMI	Acute Myocardial Infarction
13	ACEI	Angiotensin Converting Enzyme Inibitors
13	ARB	Angiotensin Receptor Blocker
13	LVSD	Left Ventricular Systolic Dysfunction
14	VTE	Venous Thrombo Embolism
17	LVS	Left Ventricular Systolic Function Assessment
18	CAP	Community Acquired Pneumonia
19	AQ	Advancing Quality
19	CDU	Clinical Decisions Unit
20	NICE	National Institute for Health and Clinical Excellence
21	DNAR	Do not Advance Resuscitation
26	HCAI	Hospital Community Acquired Infection
29	NIHR	National Institute for Health Research
30	CQUIN	Commissioning for Quality and Innovation
31	LSCB	Local Safeguarding Childrens Board
31	CQC	Care Quality Commission
31	LAC	Looked after Children
31	CNST	Clinical Negligence Scheme for Trusts
32	SUS	Secondary Uses System
32	HES	Hospital Episode Statistics
32	HRG	Healthcare Resource Group
32	CC	Clinical Conditions
34	GP	General Practitioners
34	PEAT	Patient Environment Action Team

Glossary of Terms

Page No.	Abbreviation	Glossary of meaning
32	HRG	"Developed by The Casemix 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 PATIENTS treatment to reflect current practice and anticipated trends in healthcare."
32	CC	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.

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