Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Quality Report
2012 - 2013

CELEBRATING SUCCESS

COMMUNITY CARE

PLANNED CARE

COMPASSIONATE CARE

PATIENT SAFETY

EMERGENCY CARE

Contents

Quality Report 2012/13

Part 1: Statement on Quality from the Chief Executive

Blackpool Teaching Hospitals NHS Foundation Trust aims to be the safest organisation within the NHS. This means that patient safety and quality are at the heart of everything that we do. As Chief Executive, I am incredibly proud of what we, at the Trust have achieved so far. We hope that you find that this Quality Account describes our achievements to date and our plans for the future.

Our staff are committed to providing safe, high quality care to every patient every time. We believe that staff who enjoy their work and have pride in it, will provide patients with better care.

I am delighted to introduce our third Quality Account which highlights the excellent progress we have made over the past 12 months in ensuring our patients receive the highest quality care possible.

Each year NHS Foundation Trusts are required to include a report within their annual report on quality standards within their organisation.

Ensuring patients receive high quality and safe care is our Trust's key priority. Our services are constantly changing and improving to meet the needs of the community and we have introduced new initiatives to improve the quality of care and patient experience.

The Quality Account for the 2012/13 period highlights the work we have been doing over the past 12 months to ensure our patients receive the highest quality and safest care possible. It includes a detailed overview of the improvements we have made during 2012/13 and sets out our key priorities for the next year 2013/14.

In last year's Quality Account we set ourselves a number of specific quality objectives and I am pleased to report that we have made significant progress against these objectives.

Infection rates have continued to fall and are now at their lowest levels with a 47.17% reduction in incidents of clostridium difficile. We have also seen significant reductions in pressure ulcers and patient falls.

Ensuring our patients receive a positive experience of care was another priority and we are pleased that we have made improvements in our local results of the national patient survey in areas such as; privacy and dignity, cleanliness, waiting times and communication between staff and patients.

Once again we received national recognition for our work to improve patient safety and quality through a number of prestigious awards. We were the proud winner of the Cancer Care category of the Care Integration Awards 2012 for the work we have been doing to improve the service we provide for patients at the end of life. We were also the overall winner of the Data and Information Management category of the Patient Safety Awards 2012 for the Trust's 'Knowing How We are Doing' project which ensures ward staff, patients and visitors are aware of their area's performance in safety measures such as infections, falls, untoward incidents and pressure ulcers.

We have continued to make progress on reducing mortality rates and this is something the Trust is totally committed to achieving. Following the publication of the Francis Report in February 2013 we were named as one of 14 Trusts to be reviewed for having consistently high mortality rates using the Standardised Hospital Mortality Indicator (SHMI). This relates to the period June 2010 to March 2012. In March 2012 we commissioned the Advancing Quality Alliance (AQuA) to carry out an independent review of our mortality which concluded there was no cause for clinical concern. Further information regarding actions taken to improve mortality performance is outlined in section 3.4.1. We look forward to working with the national review team to give us further assurance.

Since the Transfer of Community Services on the 1st April 2012, a new Community, Adults and Long Term Conditions Division and Families Division have been established in order to enhance the integration of community and acute services. Work is also ongoing to integrate clinical pathways to provide seamless end-to-end pathways of care which will benefit the patient experience and improve clinical outcomes.

This is just a flavour of some of the excellent progress that has been made over the past 12 months. The full report contains many more facts and figures and I would encourage you to read about the numerous initiatives and measures that are in place to improve quality and reduce avoidable harm.

Our plans for 2013/14 aim to build on the progress we have made as well as new improvement targets in relation to patient care. In February 2013 we launched our five strategic aims for 2020: 100% patients and carers included in decisions about their care, 100% compliance with agreed patient pathways, Zero inappropriate admissions, Zero patient harms and Zero delays. Whilst these targets are ambitious they will underpin everything we do.

Looking forward to the year ahead, we intend to increase our efforts even further towards driving quality and safety improvements across the organisation. Although we are pleased with our achievements we strive continuously to improve both the quality and safety of our care and want to share with you our story of continuous improvement in our annual Quality Account. I hope that you will see that we care about, and are improving, the things that you would wish to see improved at our Trust.

We aim to be responsive to patients needs and will continue to listen to patients, staff, stakeholders, partners and Foundation Trust members and your views are extremely important to us. We are pleased that Governors and other local stakeholders have played a part in shaping our priorities for the future. They have shared their ideas and comments so that we can continue to improve the quality of care and patient experience in areas when needed.

To the best of my knowledge the information in the Quality Account 1st April 2012 – 31st March 2013 is a balanced and accurate account of the quality of services we provide.

Gary Doherty
Chief Executive

Date: 23rd May 2013

Part 2: Our Quality Achievements

In this section the Trust's performance in 2012/13 is reviewed and compared to the priorities that were published in the Trust's Quality Account in 2011/12. Priorities for improving the quality of services in 2013/14 that were agreed by the Board in consultation with stakeholders are also set out in this section. Legislated statements of assurance from the Board of Directors complete Section 2.

2.1 How we performed on Quality in 2012/13 against Priorities in 2011/12 Quality Account

This section tells you about some of the quality initiatives we progressed during 2012/13 and how we performed against the quality improvement priorities and aims we set ourselves last year.

A programme of work has been established that corresponds to each of the quality improvement areas we are targeting. Each individual scheme within the programme has contributed to one, or more, of the overall performance targets we have set. Considerable progress and improvements have been delivered through staff engagement and the commitment of staff to make improvements.

Wherever applicable, the report will refer to performance in previous years and comparative performance benchmarked data with other similar organisations. This will enable the reader to understand progress over time and as a means of demonstrating performance compared to other Trusts. This will also enable the reader to understand whether a particular number represents good or poor performance. Wherever possible, references of the data sources for the quality improvement indicators will be stated, within the body of the report or within the Glossary of Terms, including whether the data is governed by national definitions.

The following symbols will tell you how we are performing and whether we met our aims. When we set our aims these were either set in year or to cover a three-year period. This was part of our quality journey. We are therefore pleased to report the significant progress made against our aims. An overview of performance in relation to the priorities for quality improvement that were detailed in the 2011/12 Quality Account is provided in Table 1. A more detailed description of performance against these priorities for clinical effectiveness of care, quality of the patient experience and patient safety will be reported on in detail in Part 3, section 3.4.

Table 1: Performance Against Priorities

Key	Target Achieved /On Plan	Close to Target	Behind Plan	2010/11	2011/12	2012/13	Actual Target 2012/13	Expected Score 2012/13
Priority 1: Clinical Effectiveness of Care								
Reduce premature mortality from the major causes of death - Reduce 'preventable' mortality by reducing the Trust's Hospital Mortality Rates / Summary Hospital Mortality Indicators				No target in 2010/11			< 1.18	Provisional 1.16 Results due Oct 2013
North West Advancing Quality initiative that seeks compliance with best practice to improve patient experience in seven clinical areas:							**CQS Target 2011/12**	**Result Achieved 2011/12**
– Acute Myocardial Infarction						Data not available until Sept 2013	95%	98.17%
– Hip and Knee Surgery							95%	96.25%
– Coronary Artery Bypass Graft Surgery							95%	97.23%
– Heart Failure							75.08%	88.37%
– Community Acquired Pneumonia							84.81%	85.74%
– Stroke							90%	92.07%
– Patient Experience Measures							25%	22%
Implementing 100,000 Lives and Saving Lives Programme:							**Actual Result Apr 2011–June 2011**	**Actual Result Apr 2012–June 2012**
Reducing the incidence of surgical site infections.							Hip 1.47% NOF 1.9%	Hip 6.8% NOF 2.4%

Key	Target Achieved /On Plan	Close to Target	Behind Plan	2010/11	2011/12	2012/13	Actual Performance 2012/13	Expected Score 2012/13
Priority 1: Clinical Effectiveness of Care (continued)								
Enhancing quality of life for people with dementia:								
Improve the outcome for older people with dementia by ensuring 90% of patients aged 75 and over are screened on admission				Not reported in 2010/11	Not reported in 2011/12		90%	75%
Improve outcomes of care								
Improve referral to treatment times for patients who suffer a Trans Ischemic Attack (TIA)							60%	>60%
Nursing Care Indicators used to assess and measure standards of clinical care and patient experience							95%	>95%
Implement Nursing and Midwifery high impact actions to improve the quality and cost effectiveness of care				Not reported in 2011/12	Not reported in 2011/12		Achieve Implementation	Implemented
Improving outcomes from planned procedures by Improving Patient Reported Outcomes Measure (PROMs) scores for the following elective procedures:								
i Groin hernia surgery						Data not available until Sept 2014	0.085	0.089
ii Varicose veins surgery							0.091	0.097
iii Hip replacement surgery							0.405	0.366
iv Knee replacement surgery							0.298	0,297
Reduce emergency readmissions								
Reduce emergency readmissions to hospital (for the same condition) within 28 days of discharge				Not reported in 2010/11	Not reported in 2011/12		16.77%	n/a
Priority 2: Quality of the Patient Experience								
Improve hospitals' responsiveness to inpatients' personal needs by improving the CQC National Inpatient Survey results in the following five areas:							**National average**	**BTHFT actual**
– Were you involved as much as you wanted to be in decisions about your care and treatment?							88.3%	82.6% said definitely or to some extent
– Did you find someone on the hospital staff to talk to about your worries and fears?							43.7%	46% said definitely or to some extent
– Were you given enough privacy when discussing your condition or treatment?							91%	91.3% said always/ sometimes
– Did a member of staff tell you about medication side effects to watch for when you went home?							44.9%	39.8% said yes completely or yes to some extent
– Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?							70%	66.7% said yes
Improve staff survey results in the following area:								
– Percentage of staff who would recommend their friends or family needing care				Not reported in 2010/11	Not reported in 2011/12		To be the Best 20% of Trusts	89.90% (Best 20% of Trusts)
Improving the experience of care for people at the end of their lives:							**Actual Target 2012/13**	**Expected Score 2012/13**
– Seeking patients and carers views to improve End of Life Care							Patient views to be sought	Patient views sought
– Ensure that patients who are known to be at the end of their lives are able to spend their last days in their preferred place across all services.							Facilitate preferred place	Preferred place
Patient Environment Action Team (PEAT) Survey								
– To improve PEAT survey results/standards							Excellent	Excellent

Table 1: Performance Against Priorities continued								
Key	Target Achieved /On Plan	Close to Target	Behind Plan	2010/11	2011/12	2012/13	Actual Target 2012/13	Expected Score 2012/13
Priority 3: Patient Safety								
Reduce The Incidence of Avoidable Harm to our patients through the following strands of work:								
– Safety Thermometer to be used as a measure to prevent harm				Not reported in 2010/11	Not reported in 2011/12		Measure to be used	Implemented
– Reduce the incidence of MRSA infection rates in the Trust as reflected by national targets							3	3
– Reduce the incidence of Clostridium Difficile infection rates in the Trust as reflected by national targets							53	28
– Improve the percentage of admitted patients risk assessed for Venous Thrombo-Embolism (VTE)							90%	99.79%
– Reduce the incidence of inpatient Falls by 30% resulting in moderate or major harm							30% improvement	5% improvement
– Reduce the incidence of Medication Errors by 50% resulting in moderate or major harm							50% improvement	50% improvement
– Reduce the incidence of newly-acquired category 2, 3 and 4 pressure ulcers by 30% in the Trust							82	76
– To monitor the rate of patient safety incidents and reduce the percentage resulting in severe harm or death				Not reported in 2010/11			12	17 16% increase

2.2 Selected Priorities for Quality Improvement in 2013/14

This section tells you about how we prioritised our quality improvements for 2013/14. This section also includes a rationale for the selection of those priorities and how the views of patients, the wider public and staff were taken into account. Information on how progress to achieve the priorities will be monitored, measured and reported is also outlined in this section.

2.2.1 How we Prioritised our Quality Improvements in 2013/4

In April 2012 we became the main provider of community services for Blackpool, Fylde and Wyre in addition to the services we already provided. This was a significant step in our aspiration to be a high performing Integrated Care Organisation. Being an Integrated Care Organisation not only describes the range of services we currently provide and aim to provide in the future, but also describes the way that we aim to deliver these services in partnership with other local providers and commissioners, and sharing responsibility for the whole patient journey.

The Board of Directors led the development of a revised Strategic Framework with managerial support which underpins the quality programme set out in this Quality Account for 2012/13. We believe the quality programme will enable us to maintain a focus on the quality and safety agenda, whilst delivering our Strategic Framework to improve the health and outcomes of our local population based on the values and principles set by the Board of Directors.

2.2.2 Rationale for the Selection of Priorities in 2013/14

The Trusts priorities for 2013/14 in relation to the key elements of the quality of care for clinical effectiveness, quality of the patient experience and patient safety, and the initiatives chosen to deliver these priorities were established as a result of consultation with patients, governors, managers and clinical staff. The Trust has shared its proposed priorities for 2013/14 with our Clinical Commissioning Groups, Blackpool Healthwatch (previously known as LINk), Lancashire Healthwatch, Blackpool Overview and Scrutiny Committee, Lancashire Overview and Scrutiny Committee and a sub group of the Council of Governors.

The Trust has taken the feedback received into account when developing its priorities for quality improvement for 2013/14 and after consultation at Board level, the following quality improvement priorities outlined in Table 2 were proposed and agreed by the Board of Directors which it believes will have maximum benefits for our patients.

These quality improvement priorities are also reinforced by the standards outlined in the NHS Outcomes Framework 2013/14 which set out the high-level national outcomes that the NHS should be aiming to improve.

Six additional quality improvement priorities that have been selected by the Board of Directors as a priority in 2013/14 are detailed in Table 2 in bold italics.

Table 2: Priorities for Quality Improvement

National Level NHS Outcomes Framework Domains of Quality	Trust Level	Key Elements in the Quality of Care	Description of Priority Indicators for Quality Improvement 2013/14
Domain 1: Preventing people from dying prematurely. Domain 2: Enhancing quality of life for people with long-term conditions.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based. To actively work in the prevention of ill health as well as its treatment.	Clinical Effectiveness of Care	Reduce premature mortality from the major causes of death - Reduce 'preventable' mortality by reducing the Trust's hospital mortality rates - The value and banding of the Summary Hospital-Level Mortality Indicator (SHMI) for the Trust - The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.
Domain 1: Preventing people from dying prematurely.	To provide patient centred care across integrated pathways with primary/community/ secondary and social care.	Clinical Effectiveness of Care	Achieve 80% compliance with agreed pathways by 2016 through the following strands of work: - ***Sepsis pathway*** North West Advancing Quality initiative that seeks compliance with best practice to improve patient outcomes in seven clinical pathway programmes: - Acute Myocardial Infarction - Hip and Knee Surgery - Coronary Artery bypass graft surgery - Heart Failure - Pneumonia - Stroke - Patient Experience Measures
Domain 2: Enhancing quality of life for people with long-term conditions.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based	Clinical Effectiveness of Care	Enhancing quality of life for people with dementia - Improve the outcome for older people with dementia by ensuring 90% of patients aged 75 and over are screened on admission
Domain 3 Helping people to recover from episodes of ill health or following injury.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based. To actively work in the prevention of ill health as well as its treatment.	Clinical Effectiveness of Care	***Medical Care Indicators*** and Nursing Care Indicators used to assess and measure standards of clinical care. Improving outcomes from planned procedures - Improve Patient Reported Outcomes Measure (PROMs) scores for the following elective procedures: I Groin hernia surgery Ii Varicose veins surgery Iii Hip replacement surgery Iv Knee replacement surgery
			Emergency readmissions to hospitals within 28 days of discharge (Quality Accounts January 2013 DH) - The percentage of patients' of all ages and genders (aged 0 to 14) and (15 or over) readmitted to a hospital which forms part of the Trust within 28 days of being discharged from hospital; and - Compare the National Average for the above percentage

Table 2: Priorities for Quality Improvement continued			
National Level NHS Outcomes Framework Domains of Quality	Trust Level	Key Elements in the Quality of Care	Description of Priority Indicators for Quality Improvement 2013/14
Domain 4 Ensuring that people have a positive experience of care.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based.	Quality of The Patient Experience	Improve hospitals' responsiveness to inpatients' personal needs by improving the CQC National Inpatient Survey results in the following five questions: - Were you involved as much as you wanted to be in decisions about your care and treatment? - Did you find someone on the hospital staff to talk to about your worries and fears? - Were you given enough privacy when discussing your condition or treatment? - Did a member of staff tell you about medication side effects to watch for when you went home? - Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
			Improve staff survey results in the following area: - Percentage of staff who would recommend the Trust to friends or family needing care. ***Report on Friends and Family Test***
Domain 4 Ensuring that people have a positive experience of care.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based.	Quality of The Patient Experience	Improving the experience of care for people at the end of their lives - Seeking patients and carers views to improve End of Life Care - Ensure that patients who are known to be at the end of their lives are able to spend their last days in their preferred place across all services. Patient-led assessments of the care environment (PLACE) - To improve PLACE survey results/standards
Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm.	To provide and maintain high quality and safe services To deliver consistent best-practice NHS care which is evidence based. To actively work in the prevention of ill health as well as its treatment.	Patient Safety	Achieve 95% Harm Free Care to our patients by 2016 through the following strands of work: Risk-assessment for Thromboembolism (VTE) - Improve the percentage of admitted patients who were risk-assessed for VTE; and - Compare the national average for the above percentage - ***Achieve a 10% reduction on the previous year in all VTE***
			Rates of Clostridium Difficile and MRSA - *The rate of Clostridium Difficile infections per 100,000 bed days amongst patients aged two years and over apportioned to the Trust; and* - *Compare the national average for the above rate.* - Reduce the incidence of MRSA infection rates in the Trust as reflected by national targets
			Reported patient safety incidents - *To monitor the rate of patient safety incidents the Trust have reported per 100 admissions*; and - The proportion of patient safety incidents the Trust has reported that resulted in severe harm or death - Reduce the incidence of Falls by 30% at low, minor moderate and serious impact levels – resulting in patient harm - Reduce the incidence of medication errors by 30% resulting in patient harm - Reduce the incidence of new hospital acquired pressure ulcers stage 2 by 30%, stage 3 by 40% and stage 4 by 100%; and - ***Reduce stage 2, 3 and 4 community acquired pressure ulcers by 10%***
			- ***Introduce the Think Glucose Programme***
The Priority Indicators for Quality Improvement will be measured through the objectives and Strategic Aims that are identified within the Organisational Strategic Framework. The Priority Indicators for Quality Improvement will be monitored by the Board at each of its meetings through the Chief Executive Assurance Report. A number of committees. Further information can be found in section 2.2.5 and in the Glossary of Terms			

2.2.3 Rationale for the Selection of Priorities to be removed in 2013/14

This section includes a list of priorities that have been chosen to be removed by the Board of Directors from the quality improvements priorities for 2013/14. The rationale for the de-selection of the following priorities is that considerable progress and improvements have been delivered or put in place and other improvements have become a priority. Information regarding the improvements made to demonstrate evidence for their removal is outlined in Part 3. It has been agreed to remove the following four quality improvement priorities used in 2012/13. Although these will continue to be monitored by the relevant committee's detailed below, these will not be reported in the 2013/14 Quality Accounts:

- The first priority removed is in relation to improving referral to treatment times for patients who suffer a Trans Ischemic Attack (TIA) as this is now monitored at the Quality Governance Committee.
- The second priority agreed to be removed is in relation to reducing the incidence of Surgical Site Infections as these are now monitored at the Divisional Board and the Hospital Infection Prevention Committee.
- The third priority to be removed is in relation to implementing the Nursing and Midwifery High Impact actions to improve the quality and cost effectiveness of care as this is now monitored at the Quality Governance Committee.
- The fourth priority removed is in relation to the Safety Thermometer which is used as a measure to prevent harm as this indicator duplicates a number of other improvement initiatives as this is now monitored at the Quality Governance Committee.

2.2.4 Engagement with Patients, Public, Staff and Governors

The Trust has taken the views of patients, relatives, carers and the wider public into account for the selection of priorities for quality improvement through the completion of feedback forms which are available from the Trust's website.

Other methods of obtaining the views of patients, public, staff and governors has been through feedback from local and national patient surveys, information gathered from formal complaints, comments received through the Patient Relations Team and various local stakeholder meetings and forums.

Listening to what our staff, governors, patients, their families and carers tell us, and using this information to improve their experiences, is a key part of the Trust's work to increase the quality of our services.

The Trust wants to make sure that staff, governors, patients, their families and carers have the best possible experience when using our services.

2.2.5 How we will Monitor, Measure and Report ongoing Progress to Achieve our Priorities for Quality Improvement 2013/14

We use a number of tools to measure our progress on improving quality and these tools inform the reports we present to the Board and its Sub-Committees. The priorities for quality improvement in 2013/14 will continue to be monitored and measured and progress reported to the Board of Directors at each of its meetings as part of the Board Business Monitoring Report and the Quality and Safety Assurance Report. For priorities that are calculated less frequently, these will be monitored by the Board of Directors by the submission of an individual report. The Trust has well-embedded delivery strategies already in place for all the quality priorities, and will track performance against improvement targets at all levels from ward level to Board level on a monthly basis using the ward quality boards and the integrated divisional quality monitoring reports. The priorities for quality improvement will also be monitored through the high level Risk Register and Divisional Risk Register process and by the Sub-Committees of the Board.

The Trust will also report ongoing progress regarding implementation of the quality improvements for 2013/14 to our staff, patients and the public via our performance section of our website. You can visit our website and find up-to-date information about how your local hospitals are performing in key areas: infections, death rates, patient falls and medication errors. Improving patient safety and delivering the highest quality care to our patients is our top priority. We believe that the public have a right to know about how their local hospitals are performing in these areas that are important to them. As well as information on key patient outcomes, the website also includes data on our waiting times, length of stay, complaints, cleanliness, hospital food, and patients and staff opinion of our hospitals.

We are keen to build on the amount of data we publish but we want to make sure that the information is what you want to see and that it is easy to understand. Please have a look at these web pages and let us know if there are any areas that could be improved by completing this feedback form or alternatively visit the website: http://www.bfwh.nhs.uk/about/performance/

2.3 Statements of Assurance from the Board of Directors

The information in this section is mandatory text that all NHS Foundation Trusts must include in their Quality Account. We have added an explanation of the key terms and explanations where applicable.

2.3.1 Review of Services

During 2012/13 the Blackpool Teaching Hospitals NHS Foundation Trust provided and/or subcontracted 49 NHS Services.

The Blackpool Teaching Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 49 of these NHS services.

The income generated by the NHS services reviewed in 2012/13 represents approximately 89% per cent of the total income generated from the provision of NHS services by the Blackpool Teaching Hospitals NHS Foundation Trust for 2012/13.

The quality aspirations and objectives outlined for 2012/13 reached into all care services provided by the Trust and therefore will have had impact on the quality of all services. The data reviewed on various activities enable assurance that the three dimensions of quality improvement for clinical effectiveness, patient experience and patient safety is being achieved including:

- Divisional monthly performance reports
- Quality Boards based in our wards and departments
- Clinical audit activities and reports
- External independent audits, such as the Joint Advisory Group (JAG) Accreditation on our Endoscopy Unit
- Investors In People Diagnostic Assessment of the community services staff in January 2013

The patient safety walkabout visits undertaken by the Executive Directors on a weekly basis and the Non-Executive Directors on a monthly basis have been a powerful tool in making the Trust's quality and safety agenda tangible to ward staff, prompting us to take ownership of our services in a new way. This initiative has been of great value in assisting clinical staff in achieving the highest quality environment in a very visible way.

2.3.2 Participation in Clinical Audits and National Confidential Enquiries

During 2012/13, 46 national clinical audits and 3 national confidential enquiries covered NHS services that Blackpool Teaching Hospitals NHS Foundation Trust provides.

During 2012/13 Blackpool, Teaching Hospitals NHS Foundation Trust participated in 86% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2012/13 are detailed in Column A of Tables 3 and 4.

The national clinical audits and national confidential enquiries that Blackpool Teaching Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2012/13, are listed in Column B of Tables 3 and 4 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry identified in Column C and D of Tables 3 and 4.

Table 3					
List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2012/13					
Number	National Clinical Audit Title	Column A Eligible to participate in	Column B Participated In	Column C Number of cases submitted	Column D Number of cases submitted as a percentage of the number of registered cases required
1	NNAP: neonatal care	✓	✓	322	100%
2	ICNARC CMPD: adult critical care units	✓	✓	1048	100%
4	NJR: hip and knee replacements	✓	✓	440	100%
5	DAHNO: head and neck cancer	✓	✓	81	100%
6	MINAP (inc ambulance care): AMI & other Acute Coronary Syndrome	✓	✓		100%
7	Heart Failure Audit	✓	✓	334	115%
8	NHFD: hip fracture	✓	✓	450/500	100%
9	TARN: severe trauma	✓	✓	100	Ongoing
10	National Sentinel Stroke Audit	✓	✓		100%
11	National Audit of Dementia: dementia care (n=40)	✓	✓	40	100%
12	British Thoracic Society: National Bronchiectasis Audit	✓	✓	25	100%
13	RCP: National Care of the Dying Audit	✓	✓	30	100%
14	National comparative audit of blood transfusion in adult cardiac surgery	✓	✓	309	100%
15	Coronary angioplasty	✓	✓		100%
16	Oesophago-gastric cancer (National O-G Cancer Audit)	✓	✓	130	100%
17	CCAD: Adult cardiac interventions	✓	✓	1223	100%
18	CCAD: Heart rhythm management (pacing and implantable cardiac defibrillators (ICDS)	✓	✓	569	100%
19	CCAD: Congenital Heart Disease	✓	✓	5	100%
20	Adult cardiac surgery: CABG and valvular surgery	✓	✓	1223	100%
21	NDA: National Diabetes Audit (Outpatients)	✓	✘		
22	NBOCAP: bowel cancer	✓	✓	218	100%
23	NLCA: lung cancer	✓	✓	270	100%
24	RCP: Audit to assess and improve service for people with inflammatory bowel disease	✓	✓	50	100%
25	Adult community acquired pneumonia (British Thoracic Society)	✓	✓	21 Open until end of May 2013	100% Open until end of May 2013
26	Emergency use of oxygen (British Thoracic Society)	✓	✓	29	100%
27	Renal colic (College of Emergency Medicine)	✓	✓	28	56%
28	Non-invasive ventilation - adults (British Thoracic Society)	✓	✘	20 Open until end of May 2013	100% Open until end of May 2013
29	Potential donor audit (NHS Blood & Transplant)	✓	✓		

Table 3					
List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2012/13					
Number	National Clinical Audit Title	Column A Eligible to participate in	Column B Participated In	Column C Number of cases submitted	Column D Number of cases submitted as a percentage of the number of registered cases required
30	National Cardiac Arrest Audit (NCAA)	✓	✓	388	100%
31	National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, AAA, NVD)	✓	✘		
32	Pulmonary hypertension (Pulmonary Hypertension Audit)	✓	✘		
33	Adult asthma (British Thoracic Society)	✓	✓	25	100%
34	Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	✓	✓	Data collection ongoing will complete October 2013	Data collection ongoing will complete October 2013
35	Diabetes (Paediatric) (NPDA)	✓	✓		Data unavailable at time of printing
36	National Review of Asthma Deaths (NRAD)	✓	✓	1	100%
37	Pain database	✓	✓		100%
38	Fractured neck of femur	✓	✓	50	100%
39	Elective surgery (National PROMs Programme)	✓	✓	n/a	67.7%
41	Epilepsy 12 audit (Childhood Epilepsy)	✓	✓	39	100%
42	"Maternal, infant and newborn programme (MBRRACE-UK)* (Also known as Maternal, Newborn and Infant Clinical Outcome Review Programme) *This programme was previously also listed as Perinatal Mortality (in 2010/11, 2011/12 quality accounts)"	This has only just gone live and previous years data is being inputted.			
43	Paediatric asthma (British Thoracic Society)	✓	✘		
44	Paediatric fever (College of Emergency Medicine)	✓	✓	50	100%
45	Paediatric intensive care (PICANet)	✓	✘	Did not participate 2012/13	
46	Paediatric pneumonia (British Thoracic Society)	✓	✓	10	100%

Table 4					
List of National Confidential Enquires that Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2012/13.					
Number	National Confidential Enquiries	Column A Eligible to Participate In	Column B Participated In	Column C Number of cases submitted	Column D Number of cases submitted as a percentage of the number of registered cases required
1	Alcohol Related Liver Disease Study	Yes	Yes	3	100%
2	Sub Arachnoid Haemorrhage Study	Yes	Yes	4	100%
3	Bariatric Surgery	No	No	N/A	N/A
4	Tracheostomy Care	Yes	Yes	ongoing	ongoing
Data source: Clinical Audit Programme and final reports. This data is governed by standard national definitions					

The reports of 3 National Confidential Enquiries were reviewed by the provider in 2012/13 and along with ongoing work from previous reports Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of health care provided as shown in Table 5.

Table 5	
National Clinical Audits (Confidential Enquiries) presented for assurance to the Board of Directors	Details of actions taken or being taken to improve the quality of local services and the outcomes of care.
Elective and Emergency Surgery in the Elderly – An Age Old Problem	• Leads from each Division are currently completing a gap analysis • Fractured Neck of Femur pathway being developed • Appointed Orthogeriatric Middle grade
A Mixed Bag	• Cross divisional work ongoing with a gap analysis completed and action plan developed to improve services • Total Parenteral Nutrition (TPN) proforma developed and implemented • Business case for Nutrition team developed and awaiting presentation at time of printing • A presentation on TPN will be presented to the June Clinical Policy Forum • Linking in with Neonates and pharmacy and Regional Network • Biochemistry flag abnormalities
Adding Insult to Injury – A review of the care of patients who died in hospital with a primary diagnosis of acute kidney injury (acute renal failure)	• A review of all fluid balance charts used throughout the Trust and introduction of a new fluid balance charts throughout the Trust • Review of intravenous fluid administration equipment available throughout the Trust to ensure accurate timing and administration of fluid infusions • Education programme to recognise the acutely ill patient and recognising renal impairment • Regular audits around compliance of Eealy Warning Score / Recognise and Act / Fluid balance • Biochemistry flagging patients with a raised creatinine • Risk assessment for kidney injury developed • AKI Policy being finalised and will be presented to the Clinical Policy Forum May 2013. • Variance of creatinine flagged as trigger in Glucose Tolerance Test audit monthly • Risk assessment for kidney injury trialed. • Adding insult integrated renal assessment into admission document. • Adult Medical Unit consultants increased from 2 to 5 full time posts, one with specialist cardiology input. • Accident and Emergency consultants increased from 4 to 6 full time posts. • Care of the Elderly consultants increased from 4 to 6 (includes stroke) plus locums to cover escalation wards as required
Knowing the Risk – A Review of the peri-operative Care of Surgical Patients	• Report presented and disseminated throughout organisation by NCEPOD Ambassador and Reporter • Report reviewed and GAP analysis being undertaken by clinical leads • Trust data benchmarked and compared to National position • Benchmark data presented in summer 12 to Clinical Policy Forum and Clinical Improvement Committee

Table 5 continued	
National Clinical Audits (Confidential Enquiries) presented for assurance to the Board of Directors	Details of actions taken or being taken to improve the quality of local services and the outcomes of care.
Knowing the Risk – A Review of the peri-operative Care of Surgical Patients	• Report presented and disseminated throughout organisation by National Confidential Enquiries Perinatal Outcomes and Deaths (NCEPOD) Ambassador and Reporter • Report reviewed and GAP analysis being undertaken by clinical leads • Trust data benchmarked and compared to National position • Benchmark data presented in summer 12 to Clinical Policy Forum and Clinical Improvement Committee
Surgery in Children – Are We There Yet?	• Report presented and disseminated throughout organisation by NCEPOD Ambassador and Reporter. Gap analysis undertaken • Complete information leaflets and guidelines produced
Data source: Clinical Audit Programme and final reports. This data is governed by standard national definitions	

Local clinical audit is important in measuring and benchmarking clinical practice against agreed markers of good professional practice, stimulating changes to improve practice and re-measuring to determine any service improvements.

During 2012/13, 91% (283) of audits were completed or are running according to schedule for completion. Data collection & analysis, presentation and formulation of an agreed action plan have all been completed for 66% of audits (204) within year. Agreed action plans have been fully implemented in 53% (160) of all registered audits.

The reports of 204 local clinical audits have been reviewed by the provider in 2012/13. A sample of improvements made to the quality of healthcare provided as a result of audit findings are detailed in Table 6 below. Additional information can be found in the Annual Clinical Audit Report 2012/13 which is published on the Trusts website and is available via the following link: http://www.bfwh.nhs.uk/about/performance/. A copy of the Annual Clinical Audit report of is available on request.

Table 6	
Local Clinical Audits presented for assurance to the Board of Directors	Details of actions taken to improve the quality of local services and the outcomes of care.
Review of safe site surgery within surgery (WHO)	GS1103R Safeguarding Invasive procedure provided to all Heads of Department for cascading at ward/department meetings. All theatre staff participating in surgical safety checklist. Annual training given as mandatory. Elective procedures not listed without surgical listing form. Patients not to leave ward unless surgically marked (where appropriate) and consent completed. Brief and de-briefs undertaken daily.
Perioperative temperature monitoring	AN1021 Staff educated regarding the need for patients to arrive at theatre fully covered. All fluids above 500ml to be warmed. Warming all inadvertent hypothermia patients.
Intraoperative Patient Warming	AN1105 Use a warm air blower if operation lasts longer than 30 minutes. Warm fluids.
Analgesia following LSCS	AN1012 Education of staff that pain relief to be prescribed as per patient requirements.
Monitoring and regional analgesia	AN1004 Anaesthetic training after every induction day. Midwife education annually.
Audit of Documenting Anaesthetic Machine Checks	AN1003 Anaesthetic machine check record to be placed with all machines.
Advancing Quality CABG Audit	CAR1105 The introduction of a new prescription sheet within Cardiac ITU with the facility to prescribe antibiotics for a 48 hour period only will assist with the compliance of antibiotic stop times which ensures that clinicians review each patient and only continue with antibiotics based on individual clinical need if they are re-prescribed.
Implantable loop recorder insertion in tertiary care - an audit of patient selection	CAR1003 Suggested referral from Blackout clinic. Staff education to ensure the patient has Tilt/ambulatory ECG/Echocardiogram.

Table 6 continued	
Local Clinical Audits presented for assurance to the Board of Directors	**Details of actions taken to improve the quality of local services and the outcomes of care.**
Assessment of compliance with NICE CG50 in Acutely ill patients in hospital	AN1017 Education of staff re clearer documentation of specific observations frequency for individual patients on the Physiological Observation Track & Trigger System (POTTs) chart. Responsibility to alter the observation charts identified and cascaded. Increased education opportunities for staff to access POTTS training. Trust observation procedure has been reviewed.
Pre-audit of airway incidents in the intensive care unit	CC1104 Changed supplier of ET tubes. Airway incidents investigated in more detail. Review incidents quarterly.
National Care of the Dying Audit	CG1027 Training to support the wards to fax the Liverpool Care Pathway audit form to the GP's and health informatics commenced. End Of Life link staff meetings arranged.
National audit of dementia care	GM0918 Development of ward based dementia guidelines/care plan. Development of dementia questionnaire for Multi Disciplinary Team completion. Basic awareness training. Consideration of environmental issues e.g. Signage, large clocks etc. Development of communication aids/comfort boxes. Review of requirements for end of life care for dementia. Review of pain assessment tools for dementia patients. Integration of nutritional requirements for dementia patients into Nutrition Mission. Improved medication prescribing for dementia patients. Improved assessment identification and management of delirium.
National Audit of Urinary incontinence	CG0916 Review of continence assessment document for nursing assessments undertaken and incorporated into new admission document.
National Audit for falls and bone health	CG0917 Development of Falls Prevention Steering Group. Trial of footwear to improve falls due to ill fitting footwear. Falls prevention programme. Introduction of falls sensors. Introduction of spot audits to monitor compliance with falls risk assessment. Low beds introduced. Introduction of Skin and Safety Walk Around Record (Intentional Rounding).
Re-audit of the usage of Group O Rhesus D Negative Blood	PA1003 Use of O Rhesus D negative red cells for emergency regularly reviewed and incidents investigated where its use was considered inappropriate. Group specific red cells provided rapidly to avoid unnecessary use of emergency group O Rhesus D negative red cells. Education of staff to ensure group O Rhesus D positive recipients with all antibodies that all efforts must be made to identify phenotypically matched group specific blood.
Health Promoting Hospitals Local Audit	CG1030 Work continues to promote stop smoking in secondary care programme. Work with VISION team to incorporate Public Health work ongoing. GAP analysis completed for alcohol IBA training requirements. Care pathway in development and training programme for obesity and physical activity. Communications sub group PH-SIG has been established.
National Diabetes Inpatient Audit	GM1020 Improvement of foot review for in patients with diabetes; improved insulin safety.
Audit of Patient information	CG1119 CORP/PROC/102 has been amended to include the 'Process for documenting the discussion and provision of information to patients. This procedure is to be further amended in relation to the inclusion of Community Services and therefore had not been ratified.
Management of patients admitted to SAU with Head injury	GS1205 Improved documentation. All patients to be reviewed by GP 1 week post head injury. Head Injury advice for all patients and same documented in notes. Use of otoscope to improve diagnosis of basal skull fracture. Criteria for observation in Observation ward or admission to SAU agreed with A&E consultants.
Timing of echocardiography following admission via Primary PCI care-pathway	CAR1202 Integrated care pathway implemented.
Management of pre-existing diabetes during pregnancy	OB1202 - Diabetes pregnancy card completed and offered to all pregnant women with pre-existing diabetes. Education sessions set up for April & Sept 2013 re women with type 1 diabetes and risks, and recognition of DKA in pregnancy.

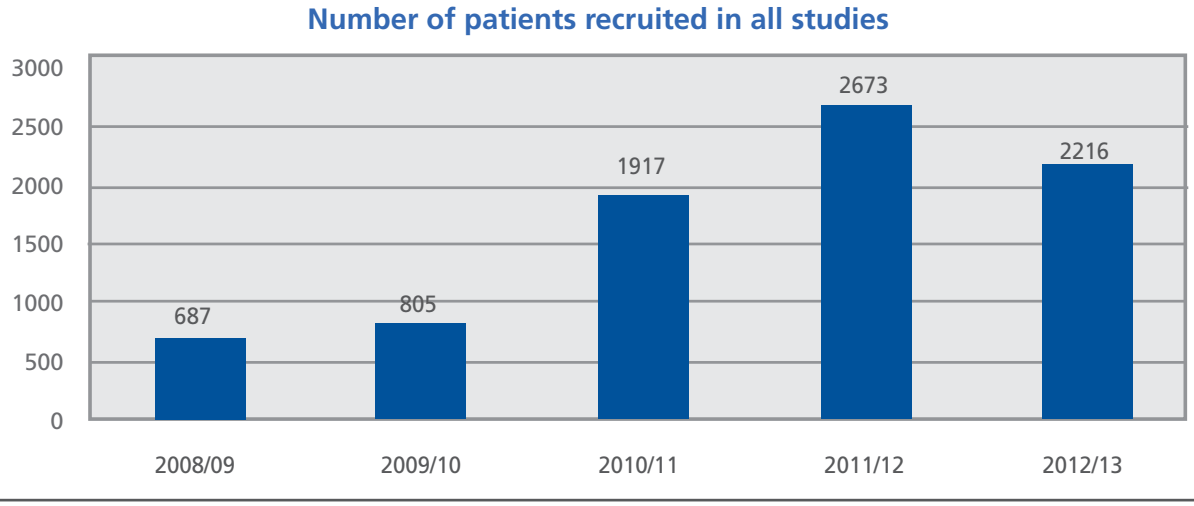
Table 6 continued	
Local Clinical Audits presented for assurance to the Board of Directors	**Details of actions taken to improve the quality of local services and the outcomes of care.**
Audit of Liverpool Care Pathway anticipatory medicine prescribing at a large teaching	PH1142 Training of pharmacy awareness of anticipatory medicines for patients on the LCP. Additional training for junior Dr's.
NHSLA Audit of blood and blood competent transfusions including patient identification	PA1204 Amended Transfusion Care pathway to include recording Alert Verbal Pain Unresponsive (AVPU) scores. Raised awareness of the audit findings.
Complaints Process Audit	CG1117 An email has been sent to all divisions to inform them that they must ensure that a fully completed summary form including lessons learnt be returned to the Complaints Department following an investigation.
Royal College of Physicians National audit to assess and improve service for people with inflammatory bowel disease	GM1013 Bone protection prescribed to all patients receiving corticosteroids; Participation in ongoing UK IBD Biologics Audit; Encourage patients with Crohns to stop smoking; Collection of stool samples on patient's admission; Administration of prophylactic heparin to all appropriate patients.
Re-audit DNAR - Do Not Attempt Resuscitation	CG1029 Safety alert has been developed and issued to address procedural, documentation and process issues where standards not met. Education at all inductions to communicate the need for all medical staff in completing the DNAR form. Risk assessment developed at organisational level.
Management of obesity in pregnancy	OB1108 In house training by consultants to include: Document action plan (i.e. place & mode of delivery) in notes. Improve documentation of thrombo-prophylaxis in management plan. Improve ultrasound request at 36 weeks for patients with BMI >40
2011 National Comparative Audit of bedside transfusion practice	PA1013 Disseminate audit results at Trust Transfusion Committee. Amend Care Pathway to include recording of respiratory rate.
North West Regional Urology Audit	GS1014 Regular TRUS biopsy sessions with extra sessions to accommodate peaks in demand. Listing for TRUS biopsies on receipt of referral letters. New standard letter detailing steps of procedure. Fast track for proctatic biopsies. A further consultant has been appointed. All consultants have clinic slots reserved for giving positive results to cancer patients. Standardised procedure op note that specifically requires the number of cores to be documented. Patients suitable for trials discussed at MDT and discussion documented.
National Paediatric Diabetes Audit	CH1105 - Annual review document developed and incorporated. Investigation results documented in the annual review document.
Follow up of children with Down's Syndrome in Blackpool	CH091 - Original action plan to design proforma for notes has been cancelled due to the introduction of 'Vision'. Instead, a pathway has been commenced and is under development.
Audit of needle stick injury policy	GM1108 Staff education of needle stick policy and dangers of sharps. Review of cannulae and needles in use to ensure retractable and covered. Review and amend needle stick policy to reflect improved use of documentation.
Safeguarding - Audit of child protection procedures and training	CH1011 Improved staff education programme re safeguarding in child protection and related issues. Circulation to all areas of contact details for members of the safeguarding team and child protection supervisors. Specific training to be delivered to A&E staff in child protection. Improved education re level of training required, access and frequency. Recording of safeguarding training provided to be recorded on OLM system.
Clostridium Difficile Infection	PA1010 Continuing antimicrobial stewardship via ward rounds and visits recently expanded with visits occurring regularly to all critical care areas, surgical wards, AMU, cardiac unit, care of the elderly and stroke ward. Reiteration to nursing staff via matrons of the need to get a stool sample as soon as possible from a diarrhoeal patient. Doctors educated on induction regarding pre-emptive treatment.
Data source: Ward-based audit of clinical records. This data may be governed by standard national definitions depending on the audit.	

2.3.3 Participation in Clinical Research in 2012/13

The number of patients receiving NHS services provided or sub-contracted by Blackpool Teaching Hospitals NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee was 2,216*, identified in Graph 1, of which the number of patients recruited to National Institute of Health Research (NIHR) Portfolio Studies is 2,051*. This figure was less than the number recruited in 2011/12 due to a number of high recruiting studies closing during 2012/13.

* It should be noted that 2012/13 NIHR Portfolio Study data is not signed off nationally until 30th June 2013. We therefore estimate the total patient recruitment total to be higher than currently reported (as at 7th June 2013).

Graph 1: Participation in Clinical Research



Data source: NIHR Portfolio Database of studies. This data is governed by standard national definitions.

The National Institute of Health Research Portfolio studies are high quality research that has had rigorous peer review conducted in the NHS. These studies form part of the NIHR Portfolio Database which is a national data resource of studies that meet specific eligibility criteria. In England, studies included in the NIHR Portfolio have access to infrastructure support via the NIHR Comprehensive Clinical Research Network. This support covers study promotion, set up, recruitment and follow up by network staff.

Participation in clinical research demonstrates Blackpool Teaching Hospitals NHS Foundation Trust's provider's commitment to improving the quality of care offered and to making our contribution to wider health improvement. Our clinical staff maintain abreast of the latest possible treatment possibilities, and active participation in research leads to successful patient outcomes.

Blackpool Teaching Hospitals NHS Foundation Trust was involved in conducting 114 clinical research studies during 2012/13. There was over 80 clinical staff participating in research approved by a research ethics committee at Blackpool Teaching Hospitals NHS Foundation Trust during 2012/13. These staff participated in research covering 19 medical specialties as outlined in Table 7 below. Please note the data on the Table 7 is provided by the NIHR whose figures are not finalised until 30th June 2013.

Table 7: Number of patients recruited to National Institute of Health Research Portfolio studies				
Specialty	No. of Patients Recruited 2009/10	No. of Patients Recruited 2010/11	No. of Patients Recruited 2011/12	No. of patients recruited 2012/13
Anaesthetics and Pain	3	24	6	36
Cancer	111	140	419	306
Cardio-Vascular	209	268	449	549
Critical Care	25	977	359	8
DeNDRoN	5	11	6	0
Dermatology	0	21	10	9
Diabetes	0	6	150	460
Gastro Intestinal	67	106	238	229
Medicines for Children	30	43	48	68
Musculo-Skeletal	57	26	1	9
Other	0	1	4	101
Paediatrics	10	30	231	173
Palliative Care	0	0	0	0
Primary Care	0	0	132	0
Public Health	2	7	1	4
Renal	114	90	0	0
Reproductive Health & Childbirth	88	54	41	35
Respiratory	13	19	22	20
Stroke	71	94	116	44
Total	**805**	**1917**	**2233**	**2051**

In addition, over the last two years, 145 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. The improvement in patient health outcomes in Blackpool Teaching Hospitals NHS Foundation Trust demonstrates that a commitment to clinical research leads to better treatment for patients.

2.3.4 Information on the Use of the Commissioning for Quality and Innovation Framework

The Commissioning for Quality and Innovation (CQUIN) payment framework aims to support the cultural shift towards making quality the organising principle of NHS services. In particular, it aims to ensure that local quality improvement priorities are discussed and agreed at board level within and between organisations. The CQUIN payment framework is intended to embed quality at the heart of commissioner-provider discussions by making a small proportion of provider payment conditional on locally agreed goals around quality improvement and innovation.

A proportion of Blackpool Teaching Hospitals NHS Foundation Trust's income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between Blackpool Teaching Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at:
http://www.bfwh.nhs.uk/about/performance/

The payment mechanism in 2012/13 was that Contracted Commissioners paid 50% of the CQUIN value through block contracts followed by the remaining 50% upon the Trust successfully achieving the agreed goals. The total planned monetary value of CQUIN in 2012/13 conditional upon achieving quality improvement and innovation goals is £6,270,679; however, it is estimated that the Trust will achieve a total monetary value of £5,031,578 in 2012/13; and a monetary total for the associated payment in 2011/12 is £2,900,864.

The main areas of risk are the Dementia, Patient Experience and Chronic Obstructive Pulmonary Disease (COPD) CQUIN themes; however performance against these measures will not be confirmed until August 2013.

2.3.5 Registration with the Care Quality Commission and Periodic/Special Reviews

Statements from the Care Quality Commission

Blackpool Teaching Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is compliant with no conditions.

The (CQC) has not taken enforcement action against Blackpool Teaching Hospitals NHS Foundation Trust during 2012/13.

Special Reviews/Investigations

Blackpool Teaching Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following programmes during 2012/13. The Care Quality Commission has undertaken two visits during 2012/13 in relation to a national programme of dignity and nutrition for older people review at Blackpool Victoria Hospital and a review at Ashton Road Community Dental Clinic in which the details are provided below. Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to address the recommendations or requirements reported by the Care Quality Commission as detailed below. Blackpool Teaching Hospitals NHS Foundation Trust has made the following progress by 31st March 2013 in taking such action in which the details are provided below.

Unannounced visit regarding a dignity and nutrition for older people review

In August 2012, Blackpool Victoria Hospital was inspected as part of the Care Quality Commission's national programme of dignity and nutrition for older people inspections. The CQC visited the Stroke Ward and Ward 25 Care of the Elderly and they focused on five outcomes, in particular whether patients were treated with dignity and respect and whether their nutritional needs were met. The CQC also reviewed the outcomes in relation to safeguarding, staffing levels and records.

The CQC's final report overall provided positive feedback. The Trust received compliance for three essential standards of quality and safety in relation to:

- Outcome 01: Respecting and involving people who use services
- Outcome 07: Safeguarding people who use services from abuse
- Outcome 13: Staffing

The Trust also received two minor improvement actions as two standards had been identified as not being met. This was in relation to:

- Outcome 05: Meeting nutritional needs. We have judged that this has a minor impact on people who use the service. **How the regulation is not being met:** Patients were not always protected from the risks of inadequate hydration and clinical nutrition
- Outcome 21: Records. We have judged that this has a minor impact on people who use the service. **How the regulation is not being met:** By omitting information on some patients records, had the potential to put patients at risk

Based on the final report the Trust developed an action plan and commenced implementation of the recommendations to address the two areas for improvement detailed above. The Trust has demonstrated compliance with Outcome 05 and Outcome 21. This has been achieved by the following:

- The Stroke Unit has introduced a standard to ensure that Nurses who take charge of the ward have received dysphasia training to prevent a delay for patients requiring a swallow assessment
- To improve communication with regards to handover of patient care. A column has been added on the 'Patients at a glance board' which now incorporates "Nutrition". Walk Round handovers are carried out daily for all shifts for all patients who are in the Acute stage and Rehabilitation stage.
- To ensure an individual patients plan of care is reviewed on a daily basis Ward Rounds are carried out daily by the Team to ensure a clear direction is given to nursing staff with regards to the patient's nutrition/hydration.
- As part of the Ward handover communication a section is included in the Ward handover documentation to review individual patient's nutritional status.
- The use of red lids are now used to symbolise patients require assistance and the need for monitoring oral fluids.
- Revised Stroke pathway documents were ratified by the Health Records Committee on the 26th September 2012. The pathway has been professionally printed and introduced into the Stroke Unit on the 19th October 2012. The stroke pathway test of change has shown an improvement in clinical documentation to date.

The completed action plan and progress report detailed above has been submitted to the Care Quality Commission in February 2013 following approval by the Board. A follow up review undertaken by the Care Quality Commission on the 19th March 2013 confirmed compliance with the above standards on 10th May 2013.

Planned review at Ashton Road Community Dental Clinic

The Care Quality Commission (CQC) carried out a visit on the 5th July 2012 at Ashton Road Community Dental Clinic as part of a planned routine schedule in order to review the Trust's compliance with the essential standards of quality and safety. The CQC provided positive feedback with no recommendations identified and confirmed that Ashton Road was meeting the essential standards of quality and safety reviewed as listed below.

- Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it
- Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights
- Outcome 16: People should be cared for in a clean environment and protected from the risk of infection
- Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills
- Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

The Care Quality Commission regulates and inspects health and social care organisations.

If it is satisfied that the organisation provides care which meets essential standards of quality and safety it will register the organisation to provide services "without conditions"

2.3.6 Information on the Quality of Data

Good quality information and data is essential for:

- The delivery of safe, effective, relevant and timely patient care, thereby minimising clinical risk
- Providing patients with the highest level of clinical and administrative information
- Providing efficient administrative and clinical processes such as communication with patients, families and other carers involved in patient treatment
- Adhering to clinical governance standards which rely on accurate patient data to identify areas for improving clinical care
- Providing a measure of our own activity and performance to allow for appropriate allocation of resources and manpower
- External recipients to have confidence in our quality data, for example, services agreements for healthcare provisions
- Improving data quality, such as ethnicity data, which will thus improve patient care and improve value for money.

NHS Number and General Medical Practice Code Validity

Blackpool Teaching Hospitals NHS Foundation Trust submitted records during 2012/13 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was:
- 99.0% for Admitted Patient Care;
- 99.7% for Outpatient Care; and
- 98.1% for Accident and Emergency Care.

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

Information Governance Assessment Report 2012/13

Blackpool Teaching Hospitals NHS Foundation Trust's Information Governance Toolkit Assessment Report overall score for 2012/13 was 84% and was graded Satisfactory.

For 2012/13 the grading system is based on:
- **Satisfactory:** level 2 or above achieved in all requirements
- **Not Satisfactory:** minimum level 2 not achieved in all requirements

This rating links directly to the NHS Operating Framework (Informatics Planning 2010/11) which requires organisations to achieve Level 2 or above in all requirements. A list of the types of organisations included along with compliance data is available on the Connecting for Health website (www.igt.connectingforhealth.nhs.uk).

Blackpool Teaching Hospitals NHS Foundation Trust will continue to work towards maintaining and improving compliance standards during 2013/14 monitored by the Health Informatics Committee.

The Data Quality and Records Management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation.

Payment by Results (PBR) Clinical Coding Audit

Blackpool Teaching Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period (February 2013) by the Audit Commission and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were 5.9%.

The results are detailed in Table 8 and demonstrate better than national average performance:

Table 8: Data Published by the Audit Commission	
Clinical Coding	Percentages
Primary Diagnoses Incorrect	9.0%
Secondary Diagnoses Incorrect	6.0%
Primary Procedures Incorrect	7.5%
Secondary Procedures Incorrect	2.6%
Data source: External audit carried out by an approved auditor through the Audit Commission. This data is governed by standard national definitions	

These percentages show the percentages of errors made in each of the categories detailed and have improved from previous years and show the Trust achieving above the national average. The following actions were identified to improve the quality of coding in the latest audit and are detailed below:

- Provide feedback and training to the coders on the issues highlighted in this report including:
  - o Establish a method of capturing pressure ulcers information
  - o Remove the facility from the system to add and remove codes from any staff other than coding staff and other essential users

Please see explanatory note for clinical coding:

- The results should not be extrapolated further than the actual sample audited.
- The following services were reviewed within the sample as shown in Table 9

Table 9: Data Sampled		
Area Audited	Specialty/ Sub-chapter/ Healthcare Resource Group	Sample size
Theme	Trauma and Orthopaedic	100
Speciality	Random Sampling	100

Statements or Relevance of Data Quality and Actions to Improve Data Quality

Blackpool Teaching Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- Data quality indicators on NHS number coverage, GP of patient, Ethnicity, Gender, national secondary users service (SUS) quality markers will continue to be monitored on a daily, weekly and monthly basis from the Trust's dedicated data quality team all the way through to the Board.
- Areas of improvement have been identified and actioned to maintain the Trust's high quality standards.

"We recognise that good data quality information underpins the effective delivery of patient care"

2.3.7 Core Quality Indicators

From 2012/13 all Trusts are required to report against a core set of Quality indicators, for at least the last 2 reporting periods, using the standardised statement set out in the NHS (Quality Accounts) Amendment Regulations 2012.

Set out in Table 10 are the care quality indicators that Trusts are required to report in their Quality Accounts. Additionally, where the necessary data is made available to the Trust by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the Trust (as applicable) are included for each of those listed in Table 10 with:

a) the national average for the same; and

b) with those NHS Trusts and NHS Foundation Trusts with the highest and lowest of the same, for the reporting period.

Table 10: Core Quality Indicators

The data made available to the Trust by the Information Centre is with regard to –

(a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period; and
(b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.

	SHMI				Palliative Care Coding			
Period	Trust	England Average	England Highest	England Lowest	Trust	England Average	England Highest	England Lowest
October 2011 to September 2012	1.21	1	1.21	0.685	13.40%	18.90%	43.30%	0.20%
July 2011 to June 2012	1.26	1	1.26	0.711	14.50%	18.40%	46.30%	0.30%

**Internally calculated data suggests the Trust's SHMI score on next release will be 1.19

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has embarked on an intensive plan for reducing mortality both in hospital and within 30 days of discharge.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate/number, and so the quality of its services, by undertaking the following actions:

- The Trust has shown a significant and sustained improvement in not only Risk Adjusted Mortality Index (RAMI) over the last three years but has also since July 2012 shown marked improvements in HSMR and SHMI mortality measures that have historically portrayed the Trust in a poor light.

See section 3.4.1- For further information to Reduce the Trust's Hospital Mortality Rate / Summary Hospital Mortality Indicators (SHMI) and any actions taken to improve performance.

The data made available to the Trust by the Information Centre with regard to the Trust's patient reported outcome measures scores for-
(i) groin hernia surgery,
(ii) varicose vein surgery,
(iii) hip replacement surgery, and
(iv) knee replacement surgery,
during the reporting period.

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
Groin Hernia	2010/11	369	0.052	0.085	0.156	-0.02
	2009/10	360	0.06	0.082	0.136	0.011

**Provisional scores for 2011/12 show Trust position as 0.089

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
Varicose Vein	2010/11	377	0.005	0.091	0.155	-0.007
	2009/10	341	0.058	0.094	0.15	-0.002

**Provisional scores for 2011/12 show Trust position as 0.097

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
Hip Replacement	2010/11	238	0.267	0.405	0.503	0.264
	2009/10	236	0.353	0.411	0.514	0.287

**Provisional scores for 2011/12 show Trust position as 0.366

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
Knee Replacement	2010/11	323	0.231	0.298	0.407	0.176
	2009/10	251	0.279	0.294	0.386	0.172

**Provisional scores for 2011/12 show Trust position as 0.297

Table 10: Core Quality Indicators continued

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The comparison data for internal PROMS between Blackpool Teaching Hospitals Provisional PROMs Data 2010 -11 (April 2010 - March 2011) and Provisional PROMs Data 2011-2012 (April 2011 - March 2012) shows an improvement against the national scores, but reviewing the negative scores, the Trust has improved on previous data. In regard to varicose vein PROMS the Trust scores against national scores appear to have slightly decreased, but in reviewing the scores comparing full year 2010/11 data to part year April to December 2011 data all scores have seen an increase in value.

The Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by the following actions:

- We continue to work with CAPITA our new survey provider to get accurate detail relating to participation rates and also patient level detail at consultant level, once this work is complete the Scheduled Care Division will be asked to be greater involved in developing improvement actions relating to direct surgeon feedback.

See section 3.4.1 – For further information regarding improving outcomes from planned procedures - Patient Reported Outcome Measures (PROMS) and any actions taken to improve performance.

The data made available to the Trust by the Information Centre with regard to the percentage of patients aged -
(i) 0 to 15; and
(ii) 16 or over,
readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

Age Group	2010/11	2009/10	2010/11 England Average	2009/10 England Average	2010/11 England Highest	2009/10 England Highest	2010/11 England Lowest	2009/10 England Lowest
16+ Years	12.04	12.09	11.42	11.16	22.93	22.09	0	0
<16 Years	10.73	10.79	10.15	10.18	25.8	31.4	0	0

**Latest readmission percentages for 2011/12 show the Trust rate as 6.9% overall

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason

- The data shows that the work being undertaken across the health economy has started to impact on the percentage of readmissions seen at the Trust.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services:

- A clinically led review of readmissions to identify implement actions required to reduce the number of avoidable admissions
- Joint work with Clinical Commissioning Groups to identify and implement health economy wide readmission avoidance schemes, including single point of access services to ensure patients access the most appropriate care, improvements to discharge and on-going care planning

See section 3.4.1 - For further information regarding Reduce Emergency Readmissions to Hospital within 28 days of Discharge and any actions taken to improve performance.

The data made available to the Trust by the Information Centre with regard to the Trust's responsiveness to the personal needs of its patients during the reporting period.

Year	Trust	England Average	England Highest	England Lowest
2011/12	67	67.4	85	56.5
2010/11	68.3	67.3	82.6	56.7
2009/10	66.1	66.7	81.9	58.3

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: in that the Trust considers patients feedback to be pivotal in ensuring our services continue to develop in order for the Trust to meet individual patient needs.

The Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by enhancing the standard of communication and information given to our patients.

See section 3.4.2 - For further information regarding Priority 3: Quality of the Patient Experience and any actions taken to improve performance.

Table 10: Core Quality Indicators continued

The data made available to the Trust by the Information Centre with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

Year	Trust	England Average	England Highest	England Lowest
2012	89%	87%	98%	68%
2011	87%	88%	98%	70%

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- We continue to focus energy and efforts on improvements to patient outcomes, quality care and patient experience
- The Trust is part way through a training programme to help staff to be at their best more of their time when delivering care to patients
- The Trust is highlighting the friends and family test data and is investing in a team to work with this in real time
- Additional monies have been identified to support increased nurse recruitment to enhance patient care but this is still ongoing

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services:

- By continuing to roll out the patient experience training to clinical staff and complete the actions as described above.

See section 3.4.2 - For further information regarding the percentage of staff who would recommend their friends or family needing care and any actions taken to improve performance.

The data made available to the Trust by the Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thrombo-embolism during the reporting period.

Quarter	Trust	England Average	England Highest	England Lowest
Q3 2012/13	99.40%	94.10%	100.00%	84.60%
Q3 2011/12	97.50%	90.70%	100.00%	32.40%

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has aimed to implement current best practice guidelines in order to ensure that all adult inpatients receive a Venous Thrombo-Embolism Risk Assessment on their admission to the hospital, and that the most suitable prophylaxis is instituted. The Trust has embedded and improved the implementation of VTE guidelines within the Trust and has demonstrated this by achieving above the 90% compliance indicator. From 1st April 2011 to 31st August 2011 the Trust did not achieve the VTE target, however from 1st September 2011 - 31st March 2013 the Trust achieved above 90% compliance due to the hard work, commitment and the actions taken by staff. Since then we have been able to sustain this improvement as shown by latest figures from March 2012 to 31st March 2013 in 17.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this 90 percentage compliance indicator and so the quality of its services, by undertaking the following actions:

- The Trust has established a Thrombosis Committee to implement and achieve compliance with the National Institute for Health and Clinical Excellence Venous Thrombo-Embolism guideline (CG 92). These guidelines have been incorporated into easy to follow risk assessment forms across various specialties and are an integral part of clerking documents. This will not only ensure that VTE risk assessments are undertaken and embedded permanently in the admission pathway but also facilitates its documentation for subsequent analysis. The Thrombosis Committee monitors performance of individual clinical areas. Although there has been some delay, we are making fresh efforts to roll out an electronic assessment tool to give "live" information about compliance. This will help us to give feedback to individual areas and address poor performance pro- actively.

See section 3.4.3 - For further information to Improve the percentage of admitted patients risk assessed for Venous Thrombo-Embolism (VTE) and any actions taken to improve performance.

Table 10: Core Quality Indicators continued

The data made available to the Trust by the Information Centre with regard to the rate per 100,000 bed days of cases of Clostridium Difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.

Year	Trust	England Average	England Highest	England Lowest
2011/12	20.4	21.8	51.6	0
2010/11	38.9	29.6	71.8	0

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Following the significant reductions in Clostridium Difficile Infection (91.33% for the last six years for the Acute Trust from 2007/2008) the Trust has continued to embed measures to reduce levels further within the organisation.

- There have been 28 cases of Clostridium Difficile Infection (CDI) attributed to the Acute Trust between April 2012 and March 2013, in comparison to 53 for the period April 2011 to March 2012, demonstrating a reduction of 47.17% The Trust was required to achieve a trajectory of 51, a reduction of 3.77% on Clostridium Difficile rates from the 2011-12 level, by March 2013. Information on how the criterion for this indicator has been calculated is detailed in the Glossary of Terms.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this trajectory of 51 cases, and so the quality of its services, by undertaking the following actions:

- To mitigate the risk of breaching the Trust's infection prevention target, we continued to deliver a wide ranging programme of work which emphasises to all staff that remaining compliant with the requirements of the Code of Practice for Healthcare Associated Infections is everyone's responsibility.

See section 3.4.3 - For further information to Reduce Clostridium Difficile Infection Rates as Reflected by National Targets and any actions taken to improve performance.

The data made available to the Trust by the Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Period	Incidents				Resulting in Severe Harm or Death			
	Trust Rate per 100	England Rate per 100 (Average)	England Rate per 100 (Highest)	England Rate per 100 (Lowest)	Percentage of Total (Trust)	Percentage of Total (England)	Percentage of Total (Highest)	Percentage of Total (Lowest)
01/04/2012 to 30/09/2012	8.3	6.7	13.61	1.99	0.1	0.7	2.5	0
01/04/2011 to 30/09/2011	5.92	5.99	10.08	2.75	0.2	0.8	2.9	0.1

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- There has been a steady increase in the number of untoward incidents reported over the past 4 financial years Patient Safety Incidents account for approximately 76% of all reported untoward incidents.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this 25 percent of patient safety incidents resulting in harm, and so the quality of its services, by undertaking the following actions:

- It is essential that lessons are learned from SUI's in order to mitigate the risk of reoccurrence, these lessons are fed back to staff within the Divisions through training, ward meetings and the Trust wide monthly "lessons learned" newsletter.
- Engagement of the patient and their relatives is very important not only to the Trust with an open and honest culture, but as a healing tool. Patients and relatives are informed when an incident has occurred and that an investigation is to be undertaken.

See section 3.4.3 For further information to monitor the rate of patient safety incidents and reduce the percentage resulting in severe harm or death and any actions taken to improve performance.

Part 3: Other Information - Review of Quality Performance

The Quality Account has provided an overview of the Quality Improvement work which has taken place across the organisation. There are a number of projects which we will be taking forward into the coming year and focusing our attentions upon. We would however, like to highlight the following projects as key priorities for 2012/13:

3.1 An Overview of the Quality of Care Based on Performance in 2012/13 with an Explanation of the Underlying Reason(s) for Selection of Additional Priorities

Table 1 in Part 2 sets out the priorities for improvement which were identified in the 2011/12 report and none of these priorities changed in 2012/13 because they were all considered to be of importance by the Board of Directors. Additional information regarding the rationale for the priority selection is detailed in 2.2.2 and 2.2.3 We also identified one additional priority for quality improvement for monitoring in 2012/13 in relation to improving communications with our service users. The additional priority has been identified and included and monitored during the reporting period 2012/13 for the following reasons detailed below:

Improving Communications With Our Service Users

Many complaints and negative feedback comments are related to poor communication or lack of information. The Foundation Trust is constantly seeking to establish the most effective way of communicating with patients and exploring new ways to address communication barriers faced by patients using our services. The following developments highlight our commitment to improving communication with all our service users:

- Updated patient information folders at the bed side
- 'I don't want to complain but...' posters in all areas, these posters highlight the name of the Clinical Matron and Ward Manager and also the uniforms and role of staff that patients may meet in the ward areas.
- Following receipt of a complaint the complainant is offered a face to face meeting so their views can be aired and discussed openly with the key members of staff, in which we have seen an increased uptake of meetings for this nature
- Training is delivered to staff on documentation and record management, enhanced communication skills and 'ten steps to discharge planning' to help staff improve communication with our service users.

3.2 Performance Against Key National Priority Indicators And Thresholds

The NHS Outcomes Framework for 2012/13 sets out high level national outcomes which the NHS should be aiming to improve. The Board of Directors monitors performance compliance against the relevant key national priority indicators and performance thresholds as set out in the NHS Outcomes Framework 2012/13. This includes performance against the relevant indicators and performance thresholds set out in Appendix B of the Compliance Framework 2012/13. Please note: there will be some overlap with indicators set out in part 2 which are now mandated by the Quality Accounts Regulations. Only the additional indicators which have not already been reported in part 2 will be reported here to avoid duplication of reporting.

Performance against the key national priorities is detailed on the Business Monitoring Report to the Board each month and is based on national definitions and reflects data submitted to the Department of Health via Unify and other national databases. For 2012/13 the relevant key national priorities for the NHS Outcomes Framework were:

- Improving cleanliness and improving healthcare associated infections
- Improving access
- Keeping adults and children well, improving health and reducing health inequalities
- Improving patient experience, staff satisfaction and engagement
- Preparing to respond in a state of emergency, such as an outbreak of a new pandemic

Table 11 shows the results from the Trust's self assessment of performance against the relevant key national priority indicators and thresholds over the past 4 years.

Table 11: Performance against Relevant Key National Priority Indicators and Thresholds				
Quality Standard	Trust Self Assessment 2009/10	Trust Self Assessment 2010/11	Trust Self Assessment 2011/12	Trust Self Assessment 2012/13
All Cancers: one month diagnosis to treatment:				
First Treatment (target >= 96%)	Achieved	Achieved	Achieved Q1 99.5% Q2 99.6% Q3 99% Q4 99.8%	Achieved Q1 99.3%, Q2 99.4%, Q3 98.5%, Q4 98.9%
Subsequent Treatment – Drugs (Target >=98%)	Achieved	Achieved	Achieved Q1 100% Q2 100% Q3 99.3% Q4 99.3%	Achieved Q1 100%, Q2 100%, Q3 99.2%, Q4 98.6%
Subsequent Treatment – Surgery (Target >=94%)	Achieved	Achieved 100% for all 4 quarters	Achieved Q1 100% Q2 100% Q3 100% Q4 100%	Achieved Q1 100%, Q2 95.8%, Q3 96.7%, Q4 100%
Subsequent treatment – Radiotherapy (Target >=94%)	Not applicable	Not applicable	Not applicable	Not applicable
All Cancers: two month GP urgent referral to treatment:				
62 day general (target >=85%)	Achieved	Achieved	Achieved Q190.8% Q2 87.2% Q3 92.3% Q4 87%	Achieved Q1 85.1%, Q2 89.5%, Q3 85.5%, Q4 83%
62 day screening (target >=90%)	Under-achieved	Achieved	Achieved Q1 90.5% Q2 93.7% Q3 86.8% Q4 96.7%	Achieved Q1 94%, Q2 91.3%, Q3 98%, Q4 96.6%
62 day upgrade (Target TBC)		Achieved greater than 95% in all 4 quarters	Achieved greater than 94% in all 4 quarters	Achieved Q1 91.4%, Q2 90.9%, Q3 92.2%, Q4 95.6%
All Cancers: two week wait (Target 93%)	Achieved	Achieved Q1, 95.4%; Q2, 95.1%; Q3, 95.4%; Q4, 95.8%	Achieved Q1 94.4% Q2 95% Q3 94.4% Q4 94.2%	Achieved Q1 93.2%, Q2 94.4%, Q3 95.5%, Q4 96.9%
Breast Symptoms – 2wk wait (Target 93%)	Achieved	Achieved Q1, 93.7%; Q2, 95.7%; Q3, 94.9%; Q4, 96.2%	Achieved Q1 94.1% Q2 94.7% Q3 93.2% Q4 96.4%	Achieved Q1 93.8%, Q2 96.5%, Q3 97.2%, Q4 93.4%
Reperfusion (Thrombolysis waiting times).	Not applicable	Achieved	Achieved	Achieved
Delayed Transfers of Care (target <3.5%)	1.42%	Achieved	Achieved	Achieved
Percentage of Operations Cancelled (target 0.8%)	0.53%	Achieved 0.6%	Achieved 0.56%	Achieved 0.45%
Percentage of Operations not treated within 28 days (target 0%)	0%	Achieved 0%	Achieved 0%	Achieved 0%
Patient Experience Survey	Achieved	Achieved	Under-achieved	Under-achieved
Quality of Stroke Care		Achieved	No longer measured	No longer measured
Ethnic Coding Data quality	Achieved	Achieved	Achieved	Achieved
Maternity Data Quality	Achieved	Achieved	Achieved	Achieved
Staff Satisfaction	Achieved	Achieved	Achieved	Achieved
18 week Referral to Treatment (Admitted Pathway) (target >=90%)	95.48%	Achieved 94.08%	Achieved 91.89%	Achieved

Table 11: Performance against Relevant Key National Priority Indicators and Thresholds continued				
Quality Standard	Trust Self Assessment 2009/10	Trust Self Assessment 2010/11	Trust Self Assessment 2011/12	Trust Self Assessment 2012/13
18 week Referral to Treatment (Admitted Pathway) (target >=90%)	95.48%	Achieved 94.08%	Achieved 91.89%	Achieved 94.66%
18 week referral to treatment Open Pathways (Target >+92%)	Not Applicable	Not Applicable	Not Applicable	Achieved 94.37%
18 week Referral to Treatment (Non-Admitted Pathways [including Audiology]) (Target >=95%)	97.43%	Achieved 96.46%	Achieved 95.76%	Achieved 97.51%
18 week Referral to Treatment (non admitted pathways) 95th percentile (target 18.3 weeks)	Not Applicable	Not Applicable	Achieved	No longer measured
18 week Referral to Treatment (admitted pathways) 95th percentile (target 23 weeks)	Not Applicable	Not Applicable	Achieved	No longer measured
Incidence of MRSA	8 (target <=12)	4 (target <=3)	2 (target <=3)	3 (target <=3)
Incidence of Clostridium Difficile	134 (target <=185)	101 (target <=152)	53 (target <=86)	28 (target <=51)
Mixed Sex Accommodation (Target 0)	Not Applicable	2 breaches	5 breaches	12 breaches
Total time in A&E (target 95% of patients to be admitted, transferred or discharged within 4hrs)	98.93%	Achieved 97.69%	Achieved 95.93%	Achieved 96.61%
Total time in A&E (95th percentile) (Target 240 minutes)	Not applicable	Not applicable	Under-achieved	Under-achieved
Total time to initial assessment (95th percentile) (Target 15 minutes)	Not applicable	Not applicable	Under-achieved	Under-achieved
Time to treatment decision (median) (Target 60 minutes)	Not applicable	Not applicable	Under-achieved	Achieved
Unplanned re-attendance (Target 5%)	Not applicable	Not applicable	Achieved	Achieved
Left without being seen (Target 5%)	Not applicable	Not applicable	Achieved	Achieved
Ambulance Quality (Category A response times)	Not applicable	Not applicable	Not applicable	Not applicable
Waiting times for Rapid Access Chest Pain Clinic	100%	100%	100%	100%
Access to healthcare for people with a learning disability	Achieved	Achieved	Achieved	Achieved
Participation in heart disease audits	Achieved	Achieved	Achieved	Achieved
Smoking during pregnancy	26.05%	Under-achieved 26.99%	24.59%	24.56%
Breast-feeding initiation rates target	66.94%	Under-achieved 63.14%	60.47%	56.35%
Emergency Preparedness	**	**	**	**
Where needed the criteria for the above indicators has been included in the Glossary of Terms				

** The Pandemic Influenza Plan (Version 7) was reviewed in September 2012 and ratified by the Board of Directors. This document defines the key pandemic influenza management systems and responsibilities of staff**.

The Major Incident Plan (Version 5) and Decontamination Plan (Version 4) were reviewed in December 2012 and ratified by the Board of Directors. These documents define the key roles and responsibilities of staff during those incidents and the management systems. Decontamination training is undertaken every 6 weeks with the responding departments. A major incident exercise with the Paediatrics Department is planned for March 2013.

To support these arrangements the Trust has a Trust wide Business Continuity Plan (Version 3) which was reviewed and ratified by the Board of Directors in February 2013. Beneath the Trust Business Continuity Plan are forty Directorate Business Continuity Plans with operational information on alternative options to deliver their services.

The Emergency Planning Officer and Local Security Management Specialist continue to undertake group training sessions for the ninety on call or duty staff, this includes Duty Directors, Duty Managers (Acute and Community Health Services), members of the Acute Response Team, Associate Directors of Nursing, Senior Nurses covering bleep 002, On Call Consultant Haematologists and Loggists.

Readmissions within 30 days

The Trust has been working with its health economy partners to implement strategies to reduce readmissions. Overall the percentage of all readmissions 2012/13 was equal to peer average; however for readmissions following non-elective admissions the Trust was above peer average and showing a comparative improvement to last year as shown in Table 12. Work continues to improve the performance of patients readmitted following an elective procedure.

Table 12: Readmissions within 30 days

Indicator	Trust 2011/12	Peer 2011/12	Trust 2012/13	Peer 2012/13
All Admissions	6.9%	7.0%	6.8%	6.8%
Non-elective	11.9%	10.9%	11.7%	10.5%
Elective	3.0%	3.5%	3.3%	3.4%

Data source: CHKS Quality and Patient Safety Tool. This data is governed by standard national definitions

3.3 Additional Other Information in Relation to the Quality of NHS Services

Accident and Emergency

The Trust has achieved the national 4 hour standard in every quarter of the financial year, whereby 95% of patients are to be treated, admitted discharged within 4 hours of arrival to the Accident & Emergency Department

The Trust is monitoring performance against the new clinical quality standards with two of the national standards consistently being delivered. The Trust has implemented several changes to improve compliance with all of the clinical quality indicators and following work to improve the patient environment and flow around the department expects to report significant performance improvements in 2013/14.

18 Weeks Referral to Treatment Targets

The Trust has delivered the 18 week referral to treatment performance target consistently since December 2007. The Trust continues to monitor and redesign pathways to ensure the delivery of timely and efficient patient care across all specialties. During 2012/13 Trust performance remained well above the standard, with 94.66% of patients for admitted care and 97.51% of patients for non admitted care being treated within 18 weeks of referral. The Trust has reviewed and improved pathways to ensure that greater than 92% of patients on open pathways had waited less than 18 weeks.

62 day Cancer Waiting Time Standard

Delivery of the 62 day Waiting Time standards for both GP urgent and screening programme referrals continued to require significant work and pathway development across the Trust, the local health economy and wider Cancer Network during 2012/13 and the year end figure was 85.77%. A significant amount of work was undertaken to understand and address the issues within pathways and across organisations for the benefit of patients. Information on the criteria for this indicator is detailed in the Glossary of Terms.

Learning from Patients

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

During the financial year 1st April 2012 to 31st March 2013 we received 3372 thank you letters and tokens of appreciation from patients and their families.

The number of formal complaints received by the Trust during the same period was 456 this includes 375 written complaints registered via the Trust and 81 Community formal complaints. There were also 31 verbal complaints made. The overall numbers of formal complaints show a decrease of eight for the Trust figures, however, including the Community figures show an overall increase of 20 compared to the previous year as shown in the Table below.

Date - Financial Year	Complaints
2012/2013	**457 Total** (376 Trust + 81 Community)
2011/2012	**483 Total** (399 Trust + 84 Community)
2010/2011	**347** (Trust only)

The main categories of complaints are related to:

- Clinical Care 203
- Communication 44
- Staff Attitude 59
- Waiting Times 35
- Essential Nursing Care 15

Once the complaint has been acknowledged by the Trust, it is sent to the appropriate Division for local investigation. Once this investigation has been completed, their response is compiled and, following quality assurance checks, the response is signed by an Executive Director and posted to the complainant. Divisions are actively encouraged to arrange face to face meetings with complainants and during 2012/13, 64 meetings were held in order to resolve a complaint in a more timely manner (13 after a final response and 51 before a final response), an decrease of four from the previous year.

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

Once local resolution has been exhausted the complainant has the right to contact the Health Service Ombudsman for a review of the complaint. During 2012/13, nine complaints were considered by the Ombudsman. Of these, there are five cases where the Ombudsman has assessed the issues and arrangements made for the Trust to resolve the issues at local resolution, 3 cases reported no further action to be taken and one case that has been referred to the second stage.

Informal Complaints

The aim of the Patient Relations Team, previously known as Patient and Liaison Service (PALS) is to be available for on-the-spot enquiries or concerns from NHS service users and to respond to those enquiries in an efficient and timely manner.

The table below shows the number of issues dealt with by the by PALS team over the last three years.

Date - Financial Year	Number of Cases	Number of Issues
2012/21013	2,496	2,702
2011/2012	3,124	3,508
2010/2011	2,609	2,887

The number of cases handled by the Patient Experience Team this year has decreased by 628 cases in comparison to the previous year. The main themes that have emerged from the cases recorded are:

- Administration (402 issues)
- Staff Attitude (133 issues)
- Treatment Issues (431 issues)
- Waiting Times (397 issues)
- Communication (165 issues

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

3.4 Detailed Description of Performance on Quality in 2012/13 against Priorities in 2011/12 Quality Accounts

This section provides a detailed description regarding the quality initiatives that have been progressed by the Trust including both hospital and community services information based on performance in 2012/13 against the 2011/12 indicators for the following priorities:

- Priority 1: Clinical Effectiveness of Care;
- Priority 2: Quality of the Patient Experience and;
- Priority 3: Patient Safety.

3.4.1 Priority 1: Clinical Effectiveness of Care

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

Reduce the Trust's Hospital Mortality Rate / Summary Hospital Mortality Indicators (SHMI)

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The Trust has embarked on an intensive plan for reducing mortality both in hospital and within 30 days of discharge. Since July 2012, a series of distinct work streams have been developed to ensure that national mortality ratio measures accurately reflect the Trust's position as well as ensuring safe, appropriate, harm free care is being delivered, these include but are not limited to:

- Improving the process of consultant sign-off for coding of deaths. The purpose of this is to ensure that all diagnoses attributed to a patient accurately reflects the prevalent condition. This allows us to identify areas of high mortality and plan appropriate action.

- Improved documentation processes to ensure safer handover of clinical care and ensure information is available to attribute accurate clinical codes

- Engagement with Northwest area AQUA team to develop a definitive action plan for mortality improvement

- Development of enhanced informatics tools for early identification of mortality issues

- Initiated a review of the compliance with agreed care pathways and care bundles within clinical areas

- Detailed review of all mortality indicators with Chief Executive involvement

At the same time we have maintained our focus on harm reduction strategies such as reducing medical outliers (medical patients receiving treatment on non-medical wards), hospital acquired infections and medication errors. Progress on all these objectives has been reported to the Board on a regular basis. The emphasis has been on improving processes so that the improvements are local, measurable and immediate and are owned by the team providing the care.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate/number and so the quality of its services, by undertaking the following actions:

The Trust has shown a significant and sustained improvement in not only Risk Adjusted Mortality Index (RAMI) over the last three years but has also since July 2012 shown marked improvements in HSMR and SHMI mortality measures that have historically portrayed the Trust in a poor light.

The Trust continues to be part of a North West Collaborative Programme for mortality reduction and has implemented programmes specifically around the care of patients with pneumonia and patients with severe sepsis. In addition to this work hospital mortality has been improved by the implementation of harm reduction strategies including reduction in hospital acquired infections, progress on reducing Venous Thrombo-Embolism (VTE), strict adherence to quality measures as part of the North West Advancing Quality initiative and improving the management of deteriorating patients and increased nurse to patient staffing levels.

In addition, on 6th February 2013, the Prime Minister announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided by those NHS trusts and NHS foundation trusts that are persistent outliers on mortality indicators. A total of 14 hospital trusts are being investigated as part of this review.

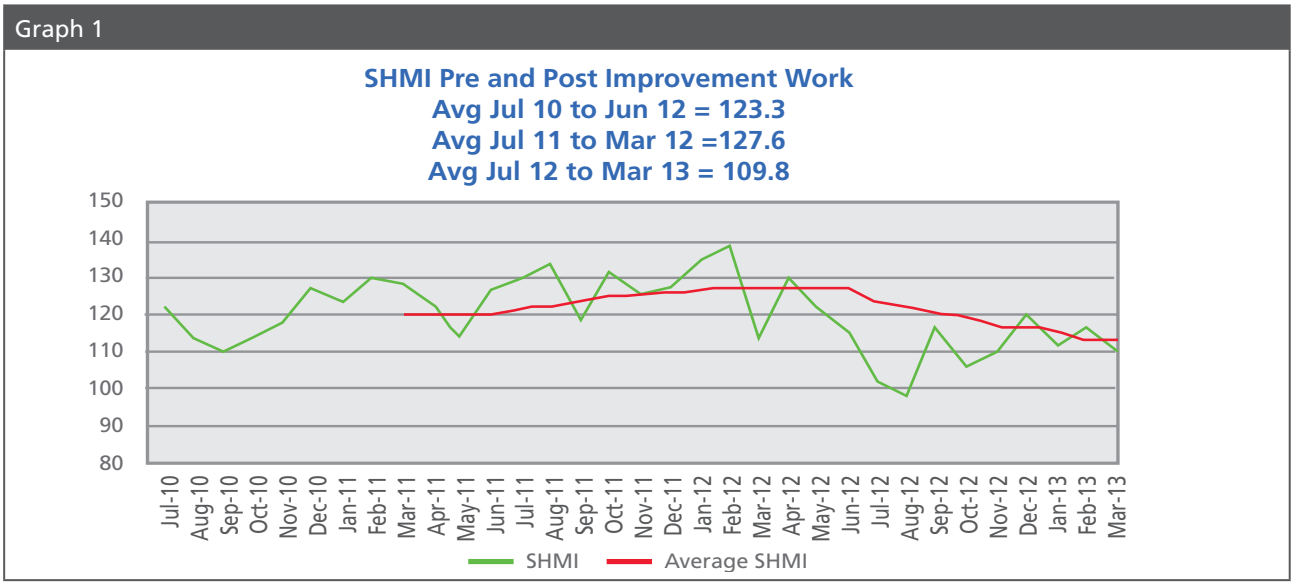
The review will be guided by the NHS values set out in the NHS Constitution and underpinned by the following key principles:

- Patient and public participation
- Listening to the views of staff
- Openness and transparency
- Co-operation between organisations

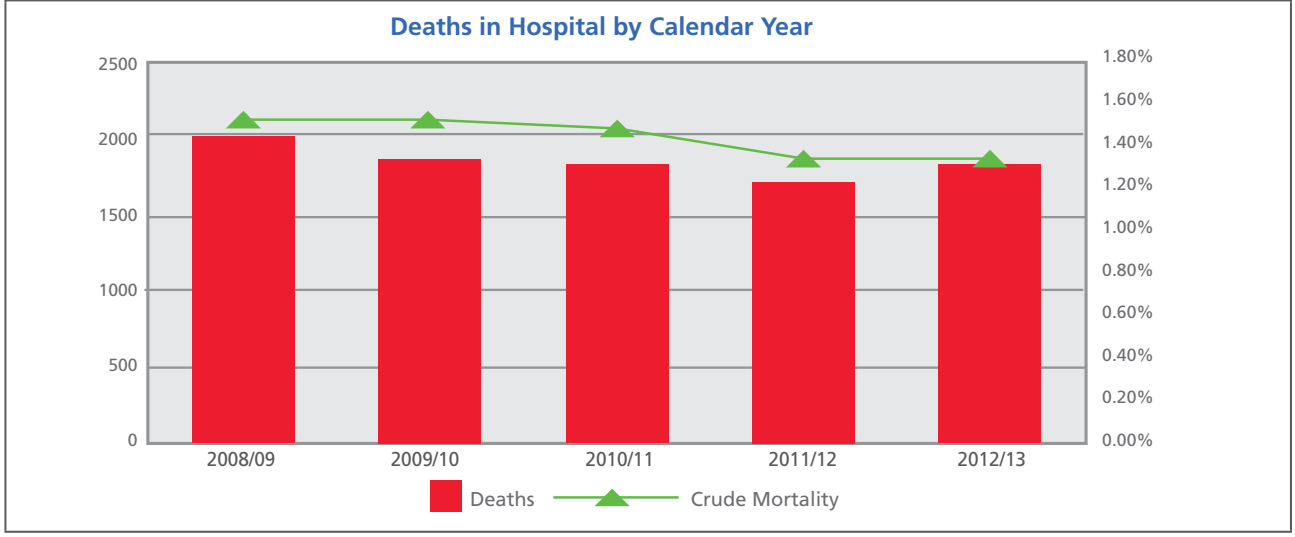
Blackpool Teaching Hospitals is one of the 14 Trusts identified for review as a persisting outlier on the national SHMI measure based on data from pre March 2012. The Trust welcomes this review and believes it will provide an opportunity to demonstrate to patients and relatives the high standards of patient care provided by the hospital and show the improvements that have been made in measures against national mortality ratios since July 2012.

Since commencement of work in July 2012 the Average Summary Hospital Mortality Indicator (SHMI) as produced by the Healthcare Evaluation Data Tool (HED) and internal calculations has fallen by 14 points compared to the period from June 2010 to commencement of work and by 18 compared to the same period in the previous year.

Graph 1



Graph 2



The graph above demonstrates that not only have improvements been made in Risk Adjusted Mortality Indicators but also the Trust has managed a reduction in the overall number of deaths year on year for four years prior to 2012/13 and more significantly a reduction in the crude mortality rate (the percentage of patients that died in hospital compared to the total number of discharges from hospital).

North West Advancing Quality Initiative

The Trust participates in the NHS North West (Strategic Health Authority) Advancing Quality Programme, which focuses on the delivery of a range of interventions for each of the following conditions listed in Table 13. Examples of the interventions can be found in the following information and Tables below:

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

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

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

Table 13

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

Scheme	Threshold	Collection Period
Acute Myocardinal Infection (Heart Attack)	95%	Discharges which occur between 1st April 2012 and 31st March 2013
Hip and Knee Replacement Surgery	95%	
Coronary Artery By-pass Graft (CABG)	95%	
Heart Failure	75.08%	
Community Acquired Pneumonia	84.81%	
Stroke	90%	
Patient Experience Measures (PEMs)	25%	

Data source: NHS North West Advancing Quality Programme. This data is governed by standard national definitions.

Comparison of Data

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

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

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

Please note: The 2012/13 data cannot be published publicly until Grant Thornton have completed their audit to validate the data, which is anticipated to be September/October 2013.

Acute Myocardial Infarction (Heart Attack)

The Trust has always performed well against the advancing quality measure for Acute Myocardial Infarction (Heart Attack). A number of measures have been introduced to ensure compliance with all performance measures. The Trust achieved the Composite Quality Score (CQS) of 98.17% as shown in Table 14.

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

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

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

Table 14				
Acute Myocardial Infarction (Heart Attack)	Trust Performance			
Measure	Year 1 Oct 08 – Sept 09	Year 2 Oct 09 – Mar 10	Year 3 Apr 10 – Mar 11	Year 4 Apr 11 – Mar 12
Aspirin at arrival	100.00%	100.00%	100.00%	99.78%
Aspirin prescribed at discharge	99.40%	100.00%	100.00%	100.00%
ACEI or ARB for LVSD	100.00%	100.00%	100.00%	100.00%
Adult smoking cessation advice/counselling	92.86%	96.00%	96.61%	95.12%
Beta Blocker prescribed at discharge	98.03%	100.00%	98.79%	99.54%
Beta Blocker at arrival	99.07%			
Fibrinolytic therapy received within 30 minutes of hospital arrival	100.00%			
Primary Coronary Intervention (PCI) received within 90 minutes of hospital arrival	100.00%	100.00%	95.12%	91.50%
Survival Index	96.76%	99.00%	90.80%	96.52%
Acute Myocardial Infarction (AMI) Composite Quality Score (CQS)	**98.55%**	**99.62%**	**97.98%**	**98.17%**
Top 25% CQS Threshold	97.02%	99.04%		
Top 50% CQS Threshold	94.40%	98.00%		
CQUIN Threshold		87.35%	95.00%	95.00%
Year 1 – Trusts had to achieve over the Top 25% (green) or Top 50% (amber) to receive an incentive payment (red = no payment received).				
Year 2 – Trusts had to achieve the Attainment Threshold to receive the incentive. If they achieved the Attainment Threshold then they could also be eligible for the Top 25% (green) or Top 50% (amber) incentive.				
Year 3 –The Trust had to achieve the CQUIN Threshold of 95%. The Trust met the CQUIN Threshold – we scored 97.98%.				
Year 4 – The Trust met the CQUIN Threshold – target 95% and we scored 98.17%.				

Hip and Knee Replacement Surgery

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. With regard to antibiotic prophylaxis we have developed a system, involving both Flucloxacillin and Gentamicin antibiotics as a first line for patients without Penicillin/ Cephalosporin antibiotic allergy, and compliance in this area is 100%. The Trust achieved the Composite Quality Score (CQS) of 96.25% as shown in Table 15.

Table 15

Hip and Knee Replacement Surgery	Trust Performance			
Measure	Year 1 Oct 08 – Sept 09	Year 2 Oct 09 – Mar 10	Year 3 Apr 10 – Mar 11	Year 4 Apr 11 – Mar 12
Prophylactic antibiotic received within 1 hour prior to surgical incision	99.53%	88.14%	97.96%	94.97%
Prophylactic antibiotic selection for surgical patients	98.88%	97.36%	99.59%	97.18%
Prophylactic antibiotic discontinued within 24 hours after surgery end time	95.33%	98.31%	96.64%	95.63%
Recommended Venous Thromboembolism prophylaxis ordered	100.00%	99.66%	100.00%	99.11%
Received appropriate Venous Thromboembolism (VTE) prophylaxis w/I 24 hrs prior to surgery to 24 hrs after surgery	99.84%	99.66%	100.00%	98.96%
Readmission (28 Day) avoidance index	90.31%	94.02%	92.50%	91.98%
Hip and Knee Composite Quality Score (CQS)	**94.52%**	**96.19%**	**97.78%**	**96.25%**
Top 25% CQS Threshold	94.52%	96.89%		
Top 50% CQS Threshold	92.04%	94.27%		
CQUIN Threshold		75.67%	95.00%	95.00%

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

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

Year 3 – The Trust had to achieve the CQUIN Threshold of 95%. The Trust met the CQUIN Threshold – we scored 97.78% (green).

Year 4 - The Trust met the CQUIN Threshold – target 95% and we scored 96.25%.

Coronary Artery Bypass Graft (CABG) Surgery

There are four Trusts undertaking Coronary Artery Bypass Graft Surgery within the North West, all of which have scored highly for Year 1, Year 2, Year 3 and Year 4. It is very competitive due to the low number of Trusts involved in this initiative.

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

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

All data is shared with the Consultant Team and Health Professionals at the monthly Directorate meeting and in the Divisional Governance meeting. The Trust achieved the Composite Quality Score (CQS) of 97.23% as shown in Table 16.

Table 16				
Coronary Artery Bypass Graft Surgery	Trust Performance			
Measure	Year 1 Oct 08 – Sept 09	Year 2 Oct 09 – Mar 10	Year 3 Apr 10 – Mar 11	Year 4 Apr 11 – Mar 12
Aspirin prescribed at discharge	99.53%	98.54%	98.68%	99.30%
Prophylactic antibiotic received within 1 hr prior to surgical incision	94.71%	87.89%	95.59%	99.68%
Prophylactic antibiotic selection for surgical patients	98.14%	94.88%	98.30%	99.68%
Prophylactic antibiotic discontinued within 24 hrs after surgery end time	82.15%	89.82%	93.62%	90.42%
Coronary Artery Bypass Graft Composite Quality Score (CQS)	**93.77%**	**92.73%**	**96.54%**	**97.23%**
Top 25% CQS Threshold	98.71%	97.75%		
Top 50% CQS Threshold	95.01%	97.73%		
CQUIN Threshold		95.00%	95.00%	95.00%
Year 1 – Trusts had to achieve over the Top 25% (green) or Top 50% (amber) to receive an incentive payment (red = no payment received).				
Year 2 – Trusts had to achieve the Attainment Threshold to receive the incentive. If they achieved the Attainment Threshold then they could also be eligible for the Top 25% (green) or Top 50% (amber) incentive payment (red = no payment received).				
Year 3 - The Trust had to achieve the CQUIN Threshold of 95%. The Trust met the CQUIN Threshold – we scored 96.54% (green).				
Year 4 - The Trust met the CQUIN Threshold – target 95% and we scored 97.23%.				

Heart Failure

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

All data is shared with the Consultant Team and Health Professionals at the monthly Directorate meeting and in the Divisional Governance meeting. The Trust achieved the Composite Quality Score (CQS) of 88.37% as shown in Table 17.

Community Acquired Pneumonia

The figures in Year 3/4 clearly show that the Trust has continued to make significant progress compared to year one. A number of measures have been implemented during the year including the introduction of Advancing Quality Pneumonia Quality Cards, which is a credit card sized reminder for all medical staff of what is required in terms of ensuring high quality patient care for patients suspected of having Community Acquired Pneumonia. An e-learning tool is being launched for all medical staff to complete ensuring that they are fully aware of the need to deliver Advancing Quality measures for pneumonia.

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

Performance of Blackpool Teaching Hospitals NHS Foundation Trust based on data for Year 4 shows the Composite Quality Score (CQS) to be 85.74% as shown in Table 18.

Table 17				
Heart Failure	Trust Performance			
Measure	Year 1 Oct 08 – Sept 09	Year 2 Oct 09 – Mar 10	Year 3 Apr 10 – Mar 11	Year 4 Apr 11 – Mar 12
Discharge instructions	7.33%	18.42%	34.43%	76.79%
Evaluation of LVS function	70.20%	84.62%	87.70%	96.40%
ACEI or ARB for LVSD	76.06%	81.37%	84.84%	92.88%
Adult smoking cessation advice / counselling	27.78%	53.85%	28.13%	76.79%
Heart Failure Composite Quality Score (CQS)	**42.40%**	**59.10%**	**65.94%**	**88.37%**
Top 25% CQS Threshold	74.65%	77.60%		
Top 50% CQS Threshold	59.60%	72.19%		
CQUIN Threshold		65.34%	65.34%	75.08%
Year 1 – Trusts had to achieve over the Top 25% (green) or Top 50% (amber) to receive an incentive payment (red = no payment received).				
Year 2 – Trusts had to achieve the Attainment Threshold to receive the incentive. If they achieved the Attainment Threshold then they could also be eligible for the Top 25% (green) or Top 50% (amber) incentive payment (red = no payment received).				
Year 3 - The Trust had to achieve the CQUIN Threshold of 65.34%. The Trust met the CQUIN Threshold – we scored 65.94% (green).				
Year 4 - The Trust met the CQUIN Threshold – target 75.08% and we scored 88.37%.				

Table 18				
Community Acquired Pneumonia	Trust Performance			
Measure	Year 1 Oct 08 – Sept 09	Year 2 Oct 09 – Mar 10	Year 3 Apr 10 – Mar 11	Year 4 Apr 11 – Mar 12
Oxygenation assessment	96.89%	100.00%	99.81%	100.00%
Blood Cultures performed in A&E prior to initial antibiotics received in hospital	17.09%	41.60%	80.35%	77.82%
Adult smoking cessation advice / counselling	10.20%	39.62%	39.26%	50.00%
Initial antibiotic received within 6 hrs of hospital arrival	54.21%	64.94%	79.24%	83.60%
Initial antibiotic selection for Community Acquired Pneumonia in immune-competent patients	67.13%	97.32%	99.68%	100.00%
CURB-65 score				75.63%
Community Acquired Pneumonia Composite Quality Score (CQS)	**62.08%**	**76.28%**	**86.29%**	**85.74%**
Top 25% CQS Threshold	82.11%	84.03%		
Top 50% CQS Threshold	74.77%	82.24%		
CQUIN Threshold		78.41%	78.41%	84.81%
Year 1 – Trusts had to achieve over the Top 25% (green) or Top 50% (amber) to receive an incentive payment (red = no payment received).				
Year 2 – Trusts had to achieve the Attainment Threshold to receive the incentive. If they achieved the Attainment Threshold then they could also be eligible for the Top 25% (green) or Top 50% (amber) incentive payment (red = no payment received).				
Year 3 - The Trust had to achieve the CQUIN Threshold of 78.41%. The Trust met the CQUIN Threshold – we scored 86.29% (green).				
Year 4 - The Trust met the CQUIN Threshold – target 84.81% and we scored 85.74%.				

Stroke

Following a significant improvement against the Advancing Quality programme for Stroke in 2011/12, sustaining this performance proved challenging during the beginning of 2012/13. Performance was primarily compromised because we did not admit all patients within 4 hours. Following the implementation of a thorough action plan, which featured a re-launch of educational initiatives to ensure all departments and individuals involved in the stroke pathway were fully aware of the direct admissions pathway, performance improved significantly in August 2012. This improved performance, which has seen both the Composite Quality Score (CQS) and Appropriate Care Score (ACS) thresholds met, is being sustained and achievement of both thresholds by year end is fully anticipated as shown in Table 19.

Table 19

Stroke (New Target Introduced October 2010)	Trust Performance	
Measure	Year 1 (1.10.2010 – 31.3.2011)	Year 2 (Apr 11 – Mar 12)
Stroke Unit Admission	41.92%	74.19%
Swallowing Screening	97.77%	97.96%
Brain Scan	68.15%	84.41%
Received Aspirin	90.71%	99.09%
Physiotherapy Assessment	98.48%	96.69%
Occupational Assessment	97.01%	95.47%
Weighed	98.15%	98.49%
Stroke Composite Quality Score (CQS)	**83.65%**	**92.07%**
Stroke Appropriate Care Score (ACS)	**34.27%**	**68.11%**
CQS - CQUIN Threshold	90%	90%
ACS - CQUIN Threshold	50%	50%
Year 1 – The Trust had to achieve two CQUIN Thresholds – CQS target of 90% and ACS target of 50% The Trust did not achieve the CQUIN Threshold – we scored 83.65% (CQS) and 34.27% (ACS) (red = no payment received). This was due to patient's not being admitted to the Stroke Unit within 24 hours of suffering a TIA and not having a brain scan within the appropriate timescale.		
Year 2 – The Trust met the CQUIN Threshold – target 90% / 50% and we scored 92.07% / 68.11%.		

Patient Experience Measures

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

The 8 questions were as follows:

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

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

For Year 2 there is just one question but the response rate target increased to 25%. The Trust failed the target in Year 2 but is currently well on track to achieve the target in Year 3 as shown in Table 20.

Table 20

Patient Experience Measures (PEMs) (New Target Introduced April 2011)	Trust Performance	
Measure	Year 1 (April 10 – Dec 10)	Year 2 (April 11 – Mar 12)
Advancing Quality Threshold	10%	25%
Trust Response Rate	6.69%	22%
Year 1 – Advancing Quality Threshold missed – We scored 6.69% (red – no payment received)		
Year 2 - Advancing Quality Threshold target of 25% missed – We scored 22% (red – no payment received)		

Implementing 100,000 Lives and Saving Lives Programme - Reduce the Incidence of Surgical Site Infections

Mandatory surveillance is completed for hip replacement surgery (Graph 4) and repair of fractured neck of femur surgery (Graph 5) during April to June each year. This data is required by, and is submitted to the Health Protection Agency.

Mandatory Orthopaedic Surveillance

Overall, for the mandatory surveillance, the number of infections has increased from 1.72% in 2011 to 4.06% in 2012.

Surveillance identified a number of key areas for further improvement.

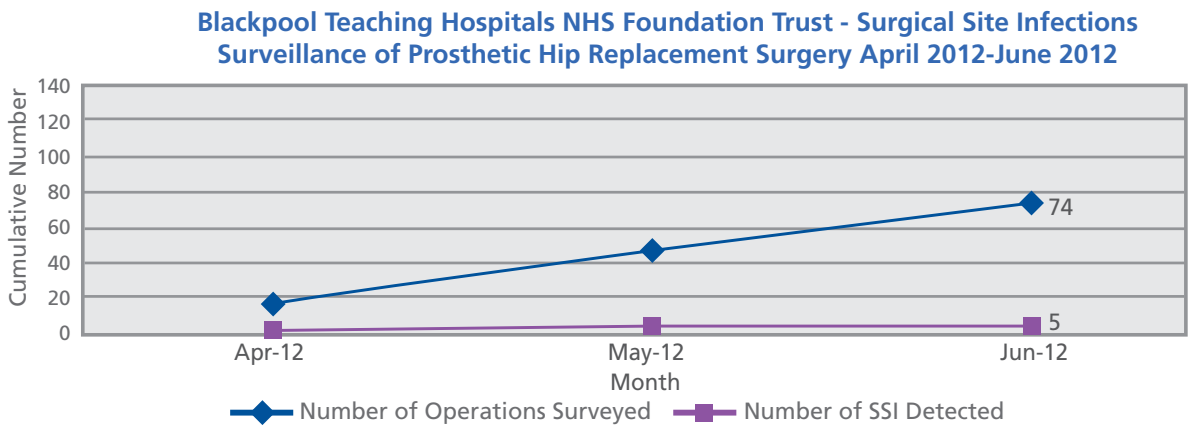
Given the increase in infections, a lead consultant for infection prevention in orthopaedics has been appointed to look at ways of reducing this number for the next surveillance period.

A three month rolling programme of surveillance is also completed for other specialities which include:

- Non mandatory hip replacement surgery (Graph 6)
- Knee replacement surgery (Graph 7)
- Cardiac Surgery (where a sternal wound is a result of the procedure) (Graph 8)
- Caesarean Section Surgery (Graph 9)

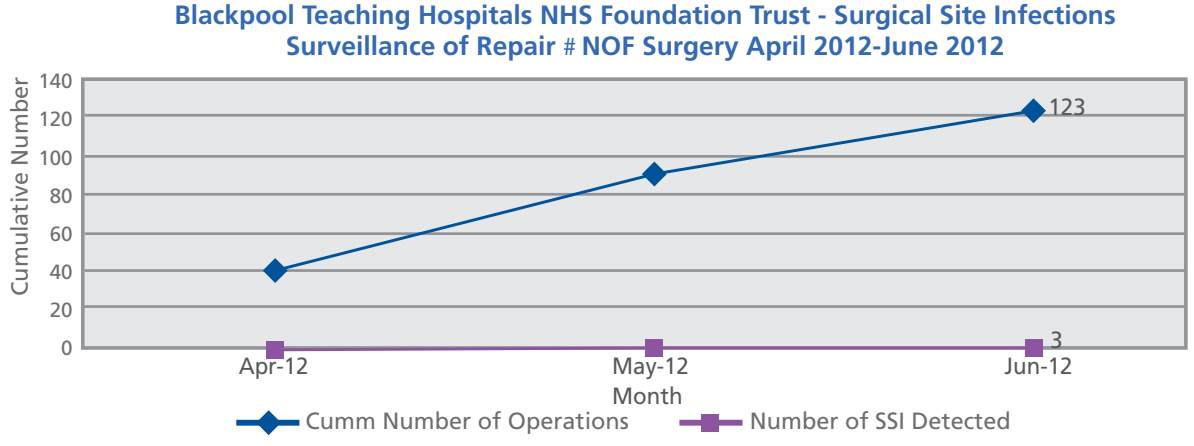
Once completed, the report for each speciality is presented and then sent to the Divisional Director and Associate Director of Nursing for the appropriate Division for their action.

Graph 4 Hip Replacement Surgery



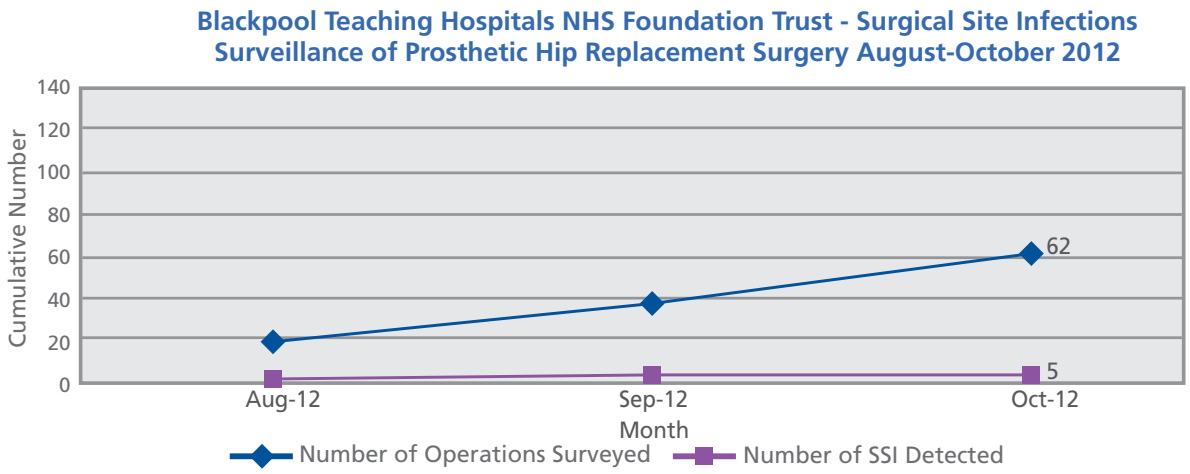
Data source: Health Protection Agency. This data is governed by standard national definitions.

Graph 5 Repair of Fractured Neck of Femur Surgery



Data source: Health Protection Agency. This data is governed by standard national definitions.

Graph 6 Non mandatory Hip Replacement Surgery



Data source: Internal data system. This data is not governed by standard national definitions.

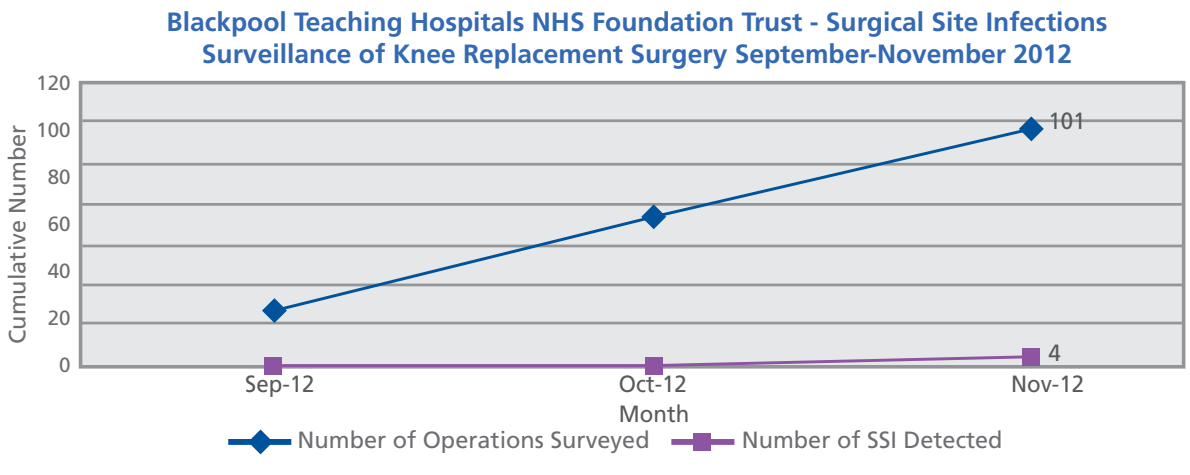
The number of infections has increased from 6.75% in the mandatory period (April to June 2012) to 8.06% (August to October 2012).

As above, a number of key areas for further improvement have been identified and a lead consultant for infection prevention in orthopaedics has been appointed to look at ways of reducing the number of infections.

The number of infections has decreased from 4.39% in 2010 to 3.96% during this surveillance period.

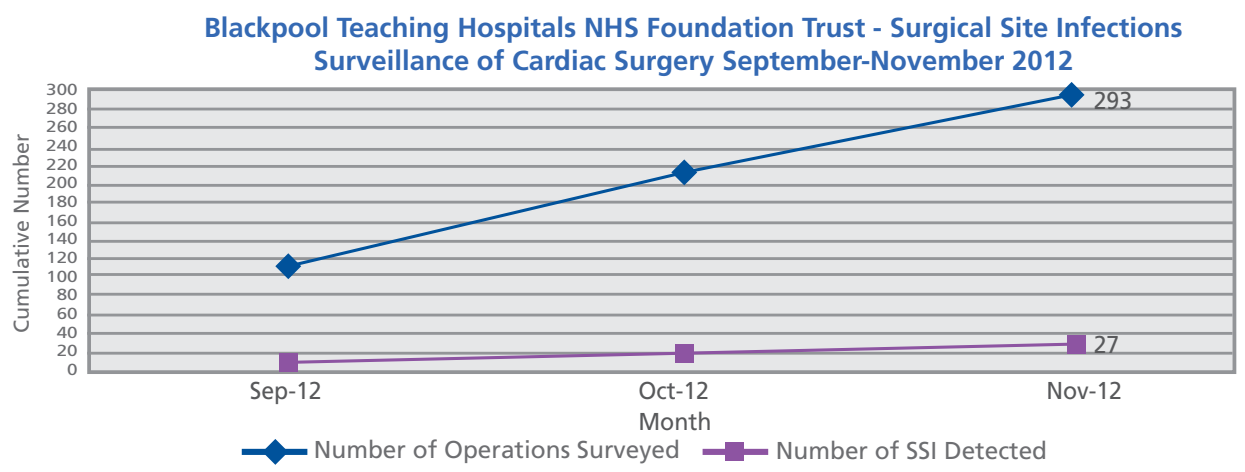
As above a number of key areas for further improvement have been identified and a lead consultant for infection prevention in orthopaedics has been appointed to look at ways of reducing the number of infections.

Graph 7 Knee Replacement Surgery



Data source: Internal data system. This data is not governed by standard national definitions.

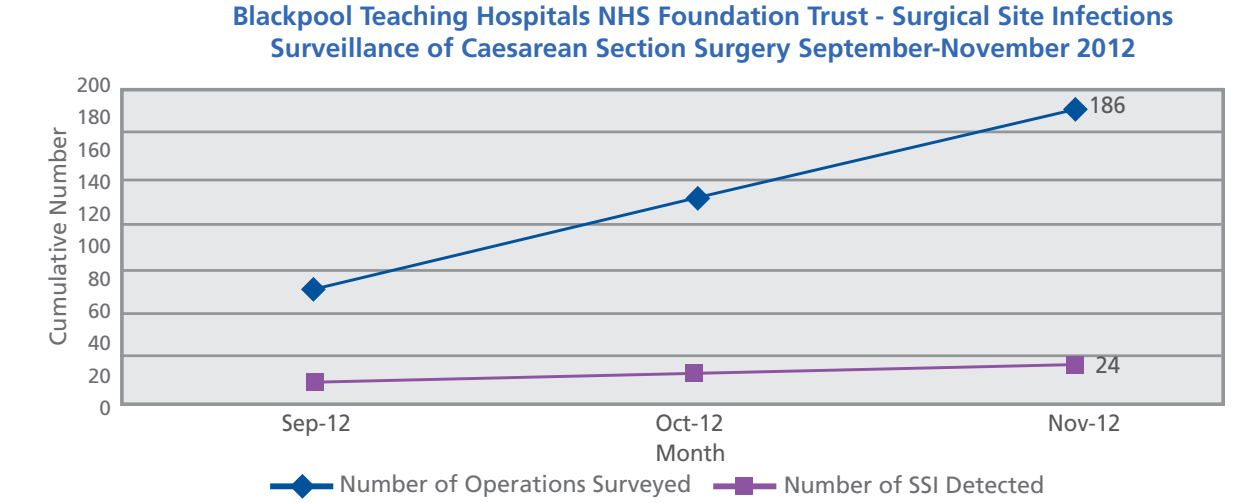
Graph 8 Cardiac Surgery (where a sternal wound is a result of the procedure)



The number of infections has slightly increased during this period but there were (14.9%) more patients involved in the surveillance. The number of deep infections has decreased (33.3%) since the last period in 2011.

A number of key areas for further improvement have been identified which are under discussion with the Division.

Graph 9 Caesarean Section Surgery



Data source: Internal data system. This data is not governed by standard national definitions.

The number of infections has decreased from 23% in 2011 to 13% during this surveillance period.

A number of key areas for further improvement have been identified which are under discussion with the Division.

Enhancing quality of life for people with dementia - Improve the outcome for older people with dementia by ensuring 90% of patients aged 75 and over are screened on admission

After engagement with clinical staff and working with the NHS Institute, a Care Bundle Approach, which is a process where printed checklist paper forms of accepted clinical guidelines are introduced to relevant wards and made conveniently available to all clinicians, was agreed as the best way for doctors to screen patients for dementia and ensure that a proper assessment and appropriate referral took place.

The Initial Dementia Assessment Tool, which consisted of a medical notes component, a flag to mark the patients involved, and a tracer backing form, was introduced into every inpatient hospital ward on the 29th October 2012.

The goal of the Dementia Care Bundle is to improve the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions and to prompt appropriate referral and follow up after they leave hospital. The bundle is part of the national CQUIN for improving dementia screening in an acute hospital.

Despite the introduction of the Dementia Care Bundle and a mechanism to audit, the Trust was unable to meet the 90% national target but achieved 75% target with ongoing improvements as shown in Table 21. The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Despite the bundle leading to an increased awareness of dementia and cognitive conditions amongst medical staff, with a huge increase in usage of the Dementia Assessment tool, it was identified that further education was required to raise awareness of the importance in completing the assessments.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by the following actions:

- A senior nurse has been seconded to provide education at ward level and to ensure doctors complete the dementia assessment during the admission process. A weekly performance report is now available that breaks down ward compliance and identifies which consultants were in charge at the time.
- A daily alert email is sent to Ward Managers and Ward Clerks that alerts them to patients that need to have their assessment completed within 24 hours in order to meet the 72 hour criteria.
- A weekly performance report is now available that breaks down ward compliance and identifies which consultants were in charge at the time. This is published monthly so that wards can check their performance and make appropriate measures if required.
- The bundle had also been incorporated into the Trust's new Standard Admission Document to ensure that doctors are prompted to complete the assessment on admission.
- Practice Development Sisters will be offering additional training on dementia for clinical staff that will include content on how to complete the bundle particularly the Dementia Assessment.

Table 21 Monthly Trust-wide performance.

Target 90%	Nov 12	Dec 12	Jan 13	Feb 2013	March 2013
Screening Question	29%	27%	90%	82%	72%
Assessment	39%	67%	42%	28%	75%
Referral	0%	33%	74%	4%	0%

Data source: Internal data system and data submitted to the Department of Health. This data is governed by standard national definitions.

In January 2012 following a multi-disciplinary consultation, a Dementia Project – Large Scale Change led by two Associate Directors of Nursing was introduced within the Trust to implement the Dementia Quality Standard and further raise awareness of dementia. The project is divided into six main work-streams each with a lead person responsible. The work-streams are: 1. CQUIN and pathways; 2. Safety and environment; 3. Pharmacology; 4. Education and training and specialist nurses; 5. Volunteers and Partnership; 6. Leadership.

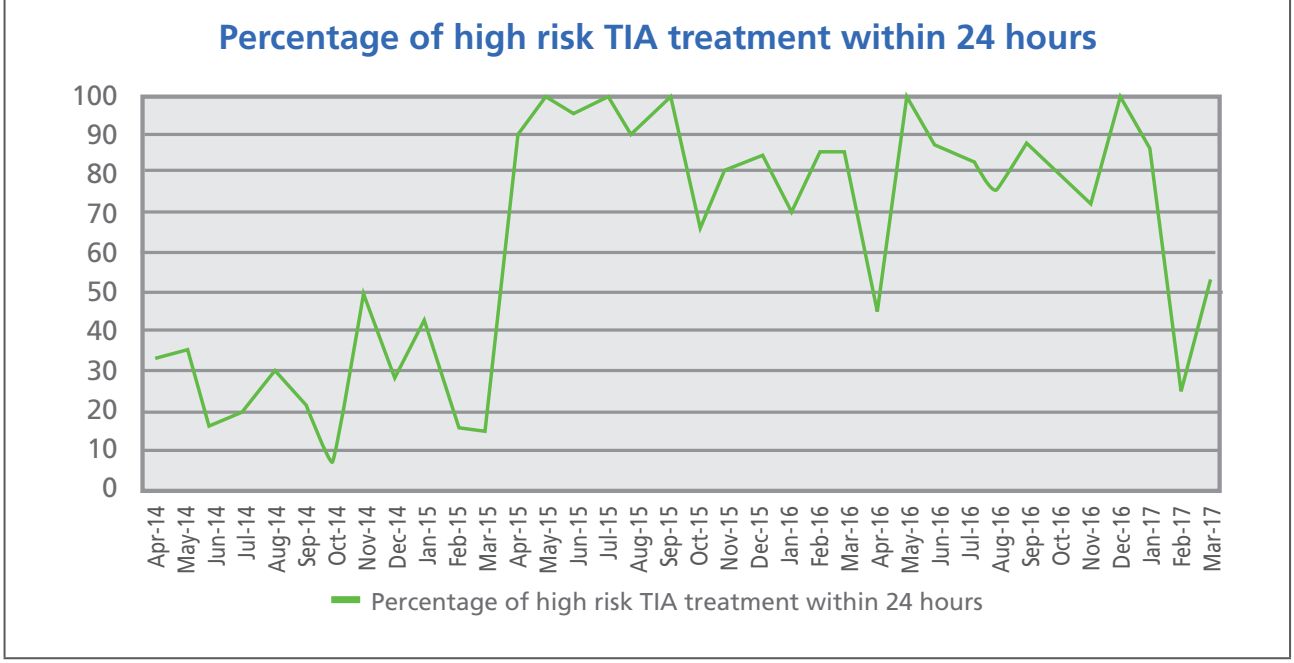
Significant progress has already been made, for example; a Trust wide training and education strategy; audit of antipsychotic prescribing practice and the development of a good practice prescribing guideline; implementation of the key principles of the Kings Fund Enhanced Healing Environment; and participation in the Butterfly Scheme. This is a training and education scheme devised by Barbara Hodkinson, carer to her mother who had Alzheimer's Dementia. It improves well being and safety of patients in hospital by enabling staff to respond appropriately and positively to individuals with cognitive impairment. The Butterfly Scheme was launched in October 2012 with over 600 staff attending from all specialties and professions including Physiotherapists, Occupational Therapists, Porters and Chaplaincy Team. The future goals will be to continue with the implementation of the project, working collaboratively across divisional boundaries within the acute hospital setting and community services.

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

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

Through the circulation of a revised TIA referral form and protocol, GPs now have a direct telephone number through to the Stroke Unit, which they are encouraged to phone whilst the patient is still within the GP practice. An appointment time can then be given to the patient before they leave the GP practice so that the patient is seen in the TIA clinic and receives treatment within 24 hours, in line with recommendations. Clinic slots for high risk patients are flexible and are available on an 'adhoc' basis, and appointments are also integrated into the working schedules of the Stroke Consultants, to enable patients to access the service in the timely manner required. Graph 10 demonstrates from April 2011 the improvement for patients receiving TIA treatment within 24 hours. The graph also highlights a decline in performance from February 2013. This is due to a change in how the performance is reported to ensure it is in line with guidance and reflects the challenges of patient choice and late referrals into the service. A number of actions have and are being taken to improve this, including attendance at GP and internal Trust forums to promote the TIA service and the need for urgent referral into the service to ensure treatment can be given within 24 hours.

Graph 10 Percentage of high risk TIA treatment within 24 hours



Data source: Internal data system and data submitted to the Department of Health. This data is governed by standard national definitions.

Nursing Care Indicators Used To Assess and Measure Standards of Clinical Care and Patient Experience

The Nursing Care Indicators are used as a measure of the quality of nursing care that is provided to patients during their stay in hospital. The framework for the nursing care indicators is designed to support nurses in understanding how they can deliver the most effective patient care, in identifying what elements of nursing practice work well, and in assessing where further improvements are needed. Our overall aim when introducing these measures is to reduce harm and to improve patient outcomes and experiences.

By benchmarking our nursing care across the Trust, we can increase the standard of nursing care that we provide, so that best practice is shared across all wards and departments. The measures are made visible in the ward environment and therefore by using this system we can ensure that accountability is firmly placed on the nurses providing bedside care. We have learned from this process and as a result have made significant reductions in patient harms. Compliance with nursing care indicators such as recording of observations and completion of risk assessments associated with the development of pressure ulcers have ensured that our frontline nurses can see the efforts of their work and make the link between the effective assessment and treatment of patients and improved outcomes. By improving the monitoring of vital signs we have reduced harms from deterioration and failure to rescue rates. By including the care of the dying indicators we have improved our referral times to palliative care services and the way that our staff interacts with relatives at this difficult time.

We have been observing nursing care using the Nursing Care Indicators for the past four years. The process involves a monthly review of documentation, ward environments and the nursing care delivered in each ward. The Associate Directors of Nursing closely analyse each area for trends and non-compliance and, where required, instigate improvement plans that reflect any changes in practise that may be required. The Trust recognises that it has set high standards to be achieved, with a target of 95% for all indicators.

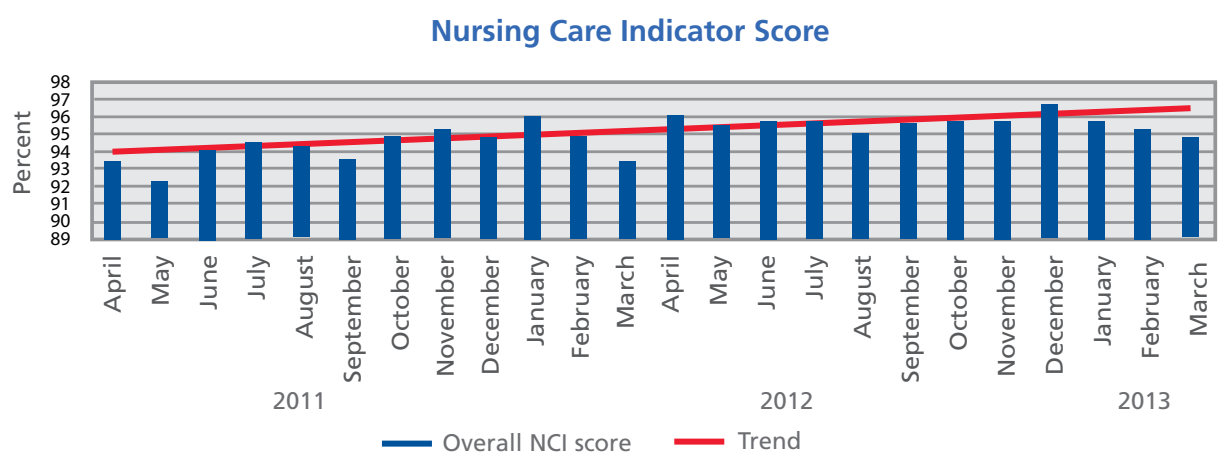
In the development of the Nursing Care Indicators, key themes for measurement were identified from complaints, the patients' survey, the Trust documentation audit, the benchmarks held within the essence of care benchmarking tool, and assessments against Trust nursing practice standards. Measurement of the Nursing Care Indicators is an evolving process and is subject to annual internal review to ensure the indicators reflect current best practice and they are expanded into non ward based areas.

The following themes are measured monthly:

- Patient Observations
- Pain Management
- Falls Assessment
- Tissue Viability
- Nutritional Assessment
- Medication Assessment
- Infection Control
- Privacy & Dignity
- Care of the Dying
- Continence Care

Graph 11 shows the overall Trust performance, expressed as an average percentage of all 10 nursing care indicators, for 2012/13. The variation in scores seen is the type expected in a normal process. The trend clearly shows an overall improvement over the year.

Graph 11



Data source: Ward-based prevalence audit of clinical records. This data is governed by standard national definitions

Implement Nursing and Midwifery High Impact Actions to Improve the Quality and Cost Effectiveness of Care.

The following information provides an overview of performance against the six High Impact Actions, which have been put in place to improve the quality and cost effectiveness of care. These High Impact Actions are in addition to the 10 Nursing Care Indicators.

High Impact Action 1 - Your Skin Matters

The aim of the High Impact Action (HIA) – Your Skin Matters is 'no avoidable pressure ulcer in NHS provided care'.

The Trust is committed to reducing the prevalence of hospital acquired pressure ulcers and embedding cultural change through clinical ownership at ward level. Based on the principles of empowering staff and using change concepts we have implemented a quality improvement initiative programme which has demonstrated a continued and sustained improvement in the prevention of pressure ulcers.
Several initiatives have been undertaken over the last four years, from improved reporting, robust data analysis, introduction of intentional rounding, staff education, set criteria within the nursing care indicators, introduction of intentional meetings with the Director of Nursing and Quality, Associate Directors of Nursing, Ward Managers, Community Team Leaders and Private Care staff to address areas that develop Stage 4 acquired pressure ulcers, which penetrates into the muscle. The purpose of these meetings has been to establish why these pressure ulcers occurred, and identify lessons learned in order to continuously improve patient safety. The integration of the Community Health Services has enabled whole health economy working and the Trust continues to work to provide a seamless service and implement the initiatives identified above. It is also working closely with Residential Care Homes who are caring for patients with pressure ulcers.

In addition to creating significant difficulties for patients, carers and families, pressure ulcers also increase the length of time spent in hospital and therefore cost to the Trust. The Trust is committed to reducing the prevalence of pressure ulcers and embedding cultural change through clinical ownership at ward and community team level. To this end, pressure ulcer prevalence data is collected on a monthly basis and identified as a key performance indicator for each Division on a monthly basis. Incidence reports are generating a root cause analysis to be undertaken on all pressure ulcers. The last 12 months have seen a 35% reduction in the number of hospital acquired pressure ulcers. The number of patients experiencing a pressure ulcer between April 2012 and March 2013 has also reduced by 24.5% compared to the same period last year. The challenge is to achieve zero tolerance of pressure ulcers in all areas, a challenge we will continue to work towards over the coming year.

High Impact Action 2 - Keeping Nourished – Getting Better

The aim of the High Impact Action – Keeping Nourished – Getting Better is 'to ensure all patients receive a nutritionally adequate diet that is fundamental to their wellbeing and delivery of high quality care. The Trust recognises that malnutrition is a major cause and consequence of disease leading to worse health, delayed recovery, increased length of stay and increased financial cost to the NHS. In April 2011 the Trust demonstrated its commitment to improving the nutritional status of patients by launching its 'Nutrition Mission' – a 'rapid spread' campaign which is based on a Department of Health methodology, to provide the best possible nutrition for its patients. This was a multi-disciplinary approach that has resulted in many improvement initiatives being undertaken throughout the Trust through energising and engaging the ward staff and ensuring ownership of the care of their patients through sustained improvements, with the aim of ensuring that all patients are adequately nourished and hydrated. The Trust recognises that well-hydrated and nourished patients get better quicker, have a shorter length of stay and feeling nourished is a key to a positive patient and carer experience.

The Nutrition Mission introduced evidence based care bundles at scale and pace across the whole organisation. Some of the improvements made include every inpatient having access to the correct food at the correct time, help with feeding where necessary, and it is intended that no patient is malnourished whilst staying with us. This project has already seen improved nutritional assessments being carried out for all patients, the Introduction of "hungry to help" volunteers, introduction of alert systems to identify patients requiring assistance, improvements in the quality, range, presentation and availability of food and special diets, food wastage reduced by more than 50% and protected mealtimes have been reinstated with support departments e.g. X-ray adjusting their working patterns to work around patient mealtimes. Some of these initiatives have now been in place since April 2011 and the Trust is delighted to demonstrate sustainability.

The legacy of this project is ward managers who are energised, have the confidence and skills to make changes and improve patient care and dignity. The improvement in patient safety cannot be underestimated either. Staff now realise that mealtimes are as important as medicine rounds, and how important it is to ensure the patients under their care are nourished and hydrated to prevent the associated harms that can occur. As a result of this work the project was featured in the Nursing Times as an example of best practise.

High Impact Action 3 - Staying Safe – Preventing Falls

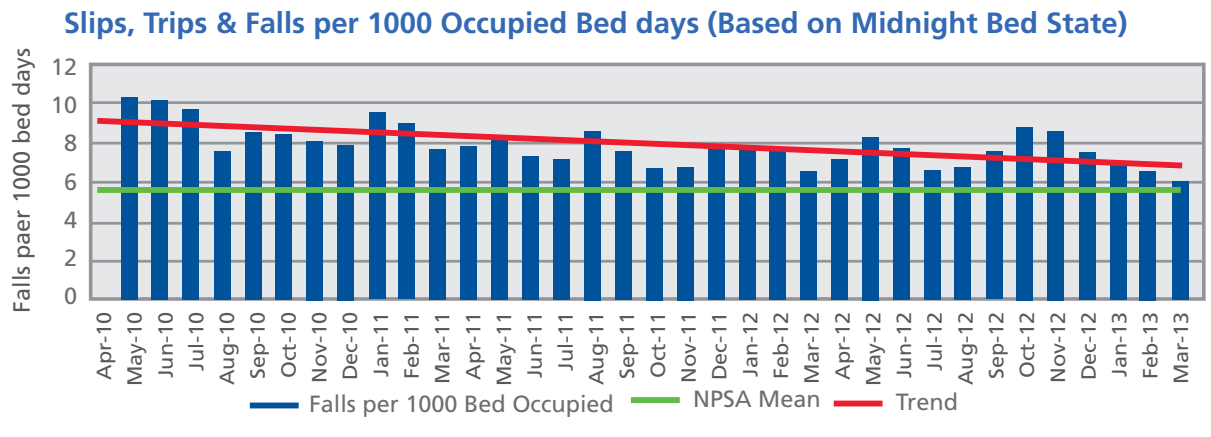
The aim of the High Impact Action Staying Safe – Preventing Falls is to demonstrate a year on year reduction in the number of falls sustained by elderly patients whilst in NHS care. The Trust recognises that even a fall that causes no injury can cause a level of psychological damage to the patient and can result in a loss of confidence and independence which in turn can lead to the need for increased support from the NHS.

The last three years have seen a decrease in the number of patient falls per thousand days from an average of 8.85 in 2010/11, to 7.5 in 2011/12 and then to 7.35 in 2012/13, as shown in Graph 12. This represents a decrease of 17% over the three years. The work of the Falls Prevention Group continues with multi-disciplinary representation across all divisions. The focus remains clearly on preventing harms occurring to patients in order to improve patient safety and the patient experience. A range of initiatives to prevent patient falls continue to be reviewed and implemented and include:

- Falls sensors have been introduced.
- Footwear and low bed trials are underway.
- Documentation has been revamped
- Intentional rounding, in the form of a safety bundle has been introduced into all clinical areas.

Intentional rounding is a checklist approach to check on all patients hourly to ensure they are receiving safe, harm free care. The intentional rounding tool covers all aspects of nursing care and enhances the care given, contributing to the reduction of harm. In particular serious falls have significantly reduced. Graph 12 shows the reduction level of slips, trips and falls. Further information regarding falls prevention can be found in section 3.4.3.

Graph 12



Data source: UNIFY national reporting. This data is governed by standard national definitions.

High Impact Action 4 - Promoting Normal Birth

The promotion of normal birth is a priority for the Maternity Department. The Caesarean section rate has continued to decrease, with a rate of 21.9% against a national average of 33% for 2012. The department has also seen optimum outcomes for both maternal and neonatal health. The introduction of the Vaginal Birth after Caesarean clinic has resulted in a 12% increase in successful vaginal births after a previous Caesarean section. The VBAC clinic has been expanded to incorporate community clinics.

The use of the 2 normal birth rooms on Delivery Suite has been promoted and women are educated and encouraged to deliver normally throughout the antenatal and intrapartum period.

As well as antenatal care and planning the ethos during labour has promoted mobility therefore improving the outcome and the experience. The Maternity Department are engaged in ongoing work to further the promotion of normal birth and these include:

- Use of aromatherapy
- Case review/incidents and good practice
- Staff training
- Family engagement in service changes.

Plans for a Midwifery Led Unit have been developed. This will provide the extended choice for the women and their families. This will also ensure that we are providing care outlined by the Department of Health in Maternity Matters. An application has been placed for Department of Health funding to assist with the implementation of the above plans and the Trust has been successful in the bid application.

High Impact Action 5 - Important Choices – Where to Die when the time comes

Please see section 2.1.3 for further information regarding this improvement initiative.

A Fylde Coast End of Life paper including details of a project to develop an Electronic Palliative Care Coordination Systems (E-PACCS) was approved by Blackpool Clinical Commissioning Group (CCG) on 16th April 2013 with plans for sign off by Blackpool CCG Board in May 2013. The project is being led for Wyre and Fylde by Pippa Hulme and Dr Adam Janjua. A project group is currently being established to enable this work.

High Impact Action 6 - Protection from infection

The Trust is committed to reducing the risk of infections for all patients. Policies and procedures are in place to ensure the risk of infection is minimised. Infection Prevention training and education is provided for all staff through Induction and Mandatory training. All patients admitted to the Trust are screened for Methicillin Resistant Staphylococcus Aureus (MRSA) as per Department of Health guidelines.

High Impact Actions 7 - Fit and Well to Care

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

The department's team undertakes regular work-related health checks, vaccinations and immunisation programmes, and develops and drives programmes to reduce risks in the workplace. They offer advice and support to employees and managers in relation to the rehabilitation of staff returning to work following illness or with a known disability.

As part of our ongoing commitment to assist the Trust in managing stress, the Clinical and Therapy Teams monitor a number of work-related cases within the organisation and ensure support is available for all to access.

A variety of healthy lifestyle initiatives are facilitated by the department namely health weight programmes, yoga, rumba and Calm clinics, which involved the Occupational Health team undertaking healthy lifestyle checks on staff members and empowering health choices.

Discussion is currently taking place to potentially fund a full-time Physiotherapist with an assistant for a year pilot so that staff will be able to directly access the service through Occupational Health whilst they are in or off work. This is a key post to support those staff who are experiencing Musculoskeletal Zone (Msk) problems.

Currently the Occupational Health clinical team have been visiting all areas of the organisation to provide each area with an Occupational Health resource pack, which will give staff and managers more information on the services we provide, advice and guidance so that they are more informed as to when they need to refer and understand their own health needs more.

In addition to the internal services offered, all employees have free access to the Employee Assistance Programme, which offers a confidential telephone helpline and online advice to staff. The flu strategy this year has set a 75% target to reach, so far we have reached 71% (the national target), with the acute site achieving 80% and the community 48%, success has been gained through training many of our Trust clinicians to vaccinate colleagues and strong senior leadership.

Having achieved the accreditation in relation to the Safe Effective Quality Occupational Health Service (SEQOHS) for five years, we will be working to support other Occupational Health colleagues in Cumbria and Lancashire to help them achieve their accreditation also.

Partnership working in Cumbria and Lancashire Occupational Health services continues and we are currently reviewing practices/sharing ideas with view to be more cost effective in relation to sharing services across our geographical footprint also.

We currently manage sickness and absence through a process of wellbeing meetings ensuring that we maintain regular contact with employees in order to facilitate their return to work and support them during extended period of sickness and absence Sickness / absence management practice has been a key project for OH and HR colleagues to establish how Managers actually undertake or record this data, conduct return to work interviews and manage individual cases. Findings so far have resulted in depth training programme for Managers, Leaflets for Employees and Managers that will be circulated shortly to offer advice on guidance in relation to sickness and we are developing electronic recording of all sickness/absence across the organisation to ensure an equitable and consistent approach.

The Nursing and Midwifery sickness and absence data for the period 1st April 2012 – 31st March 2013 is currently demonstrating a year to date figure of 3.85% for the Trust as a whole.

High Impact Action 8 - Ready to go – No delays

To date the number of onsite staff within the Discharge Team has increased from 9 to 14 which results in a larger number of staff available to carry out assessments at ward level. However, the benefits of the additional staffing levels are not being realised due to high levels of sickness amongst the team.

Progress

- Cohort beds are now being utilised – a range of 15 care homes that are accredited by PCTs, Social Services and CQC. The contract will cease at the end of April this year with an intention to re-open in the winter months (September onwards). Discussions are taking place on whether we can 'reserve' a couple of beds during the summer months that could be utilised on an individual needs basis.
- An external company is carrying a review of the discharge team with an intention to streamline the PCTs and Social Services policies and procedures to improve overall services.

Improving outcomes from planned procedures - Patient Reported Outcome Measures (PROMS)

Improve the scores for the following elective procedure

i) Groin hernia surgery
ii) Varicose veins surgery
iii) Hip replacement surgery
iv) Knee replacement surgery

Patient Reported Outcome Measures (PROMs) measure quality from the patient perspective, it is a national programme organised by the Department of Health. Initially covering four clinical procedures, PROMs calculate the health gain after surgical treatment using pre and post operative surveys. The Trust Participation rates are as shown in Table 22.

Table 22: Participation Rates

Date	Participation rate (full year)
2011/2012	66.1%
2012/2013 to November 2012	67.7%

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The comparison data for PROMS between Blackpool Teaching Hospitals Provisional PROMs Data 2010 -11 (April 2010 - March 2011) and Provisional PROMs Data 2011-2012 (April 2011 - March 2012) is shown in Table 23. The data shows an improvement against the national scores, the positive scores are **highlighted in green** but reviewing the negative scores, the Trust has improved on previous data. In regard to varicose vein PROMS the Trust scores against national scores appear to have slightly decreased, but in reviewing the scores comparing full year 2010/11 data to part year April to December 2011 data all scores have seen an increase in value. The Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by the following actions:

We continue to work with CAPITA our new survey provider to get accurate detail relating to participation rates and also patient level detail at consultant level, once this work is complete the Scheduled Care Division will be asked to be greater involved in developing improvement actions relating to direct surgeon feedback.

Table 23:

Comparison between Blackpool Teaching Hospitals NHS Foundation Trust Provisional PROMs Data 2010-11 (April 2010 - March 2011) and Provisional PROMs Data 2011-2012 (April 2011 - March 2012)

	Measure								
Percentage Improving	EQ-5D Index 2010-11	EQ-5D Index 2011-12	Variance	EQ-VAS 2010-11	EQ-VAS 2011-12	Variance	Condition Specific 2010-11	Condition Specific 2011-12	Variance
Groin Hernia	50.5%	49.1%	-1.4%	39.1%	41.6%	2.5%	N/A	N/A	N/A
Hip Replacement	86.7%	88.4%	1.7%	61.4%	61.4%	0.0%	95.8%	96.70%	0.9%
Knee Replacement	77.9%	80.7%	2.8%	50.8%	60.6%	9.8%	91.4%	94.70%	3.3%
Varicose Vein	51.6%	55.3%	3.7%	39.8%	48.7%	8.9%	82.5%	80.20%	-2.3%

Comparison between Blackpool Teaching Hospitals NHS Foundation Trust Provisional PROMs Data 2010-11 (April 2010 - March 2011) and Provisional PROMs Data 2011-12 (April 2011 - March 2012)

	Measure								
Percentage Getting Worse	EQ-5D Index 2010-11	EQ-5D Index 2011-12	Variance	EQ-VAS 2010-11	EQ-VAS 2011-12	Variance	Condition Specific 2010-11	Condition Specific 2011-12	Variance
Groin Hernia	17.9%	13.6%	-4.3%	41.7%	35.3%	-6.4%	N/A	N/A	N/A
Hip Replacement	6.7%	7.2%	0.5%	27.4%	28.8%	1.4%	3.6%	2.70%	-0.9 %
Knee Replacement	11.1%	6.8%	-4.3%	36.5%	31.0%	-5.5%	7.1%	4.10%	-3.0%
Varicose Vein	15.7%	14.5%	-1.2%	40.1%	40.3%	0.2%	17.5%	19.80%	2.3%

Reduce Emergency Readmissions to Hospital (for the same condition) within 28 days of Discharge

The Trust has been working with its health economy partners to implement strategies to reduce readmissions. Overall the percentage 28 day readmissions in 2012/13 was below peer average as shown in Table 24.

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason in that it shows that the work being undertaken across the health economy has started to impact on the percentage of readmissions seen at the Trust as shown in Graph 13.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services:

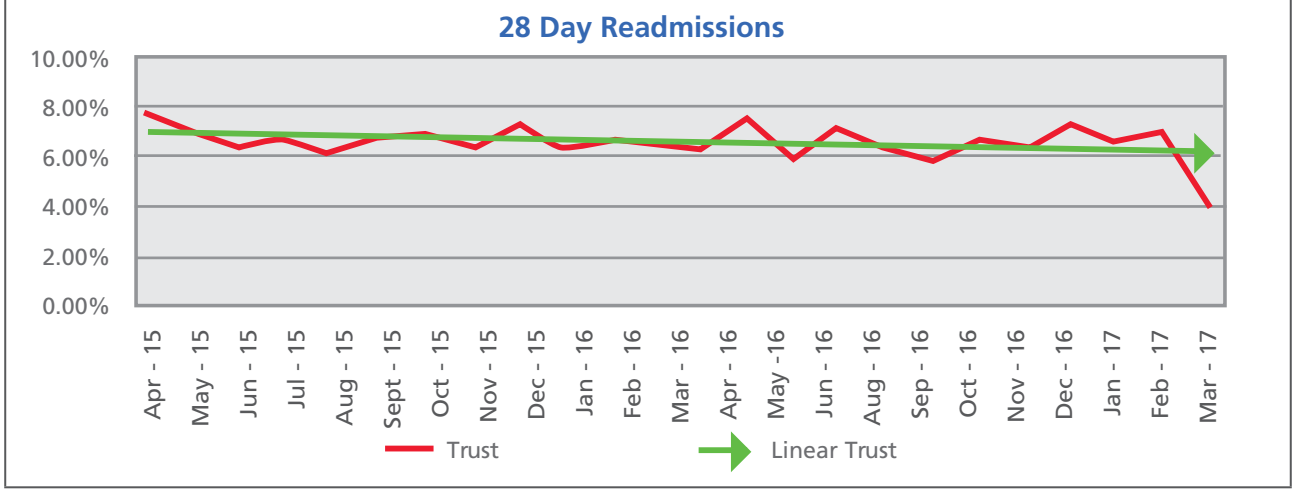
- A clinically led review of readmissions to identify implement actions required to reduce the number of avoidable admissions .
- Joint work with Clinical Commissioning Groups to identify and implement health economy wide readmission avoidance schemes, including single point of access services to ensure patients access the most appropriate care, improvements to discharge and on-going care planning.

Table 24: 28 Day Readmissions				
Indicator	Trust 2011/12	Peer 2011/12	Trust 2012/13	Peer 2012/13
All Admissions	6.9%	6.9%	6.4%	6.8%
Non-elective	11.5%	10.8%	10.8%	10.7%
Elective	2.9%	3.2%	3.3%	3.1%

Data source: CHKS Quality and Patient Safety Tool. This data is not governed by standard national definitions

NB: No exclusions are made from the CHKS data and therefore includes (day cases, obstetrics, cancer patients, etc). The Trust is unable to replicate the national methodology in full. The Trust has reviewed its raw data (not standardised as in national data) and non elective readmissions for the Trust equates to 16.77% for 2012/13.

Graph 13: 28 Day Readmissions



3.4.2 Priority 2: Quality of the Patient Experience

The Trust will only be able to improve and maintain high quality services if we listen to the people who use our services and their carers. They are the experts in the care we provide and the Trust continually tries to learn from the experience of individuals to ensure we get it right first time, every time.

Improve Hospitals' Responsiveness to Inpatients' Personal Needs by Improving the CQC National Inpatient Survey Results in the Following Areas: -

The Care Quality Commission National Inpatient Survey is undertaken on an annual basis by the Picker Institute, an independent organisation. Between the period October 2012 and January 2013 a questionnaire was sent to 850 recent inpatients. 410 patients responded. Table 25 shows a comparison of data for six indicators from 2008 to 2011 and progress remains consistent.

These indicators were chosen to be monitored since they relate to key issues that are of great importance to the Board and/or have been identified by our patients as of most importance to them.

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: in that the Trust considers patients feedback to be pivotal in ensuring our services continue to develop in order for the Trust to meet individual patient needs.

The Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by enhancing the standard of communication and information given to our patients.

The Trust are in the process of improving the score in relation to the question 'Did a member of staff tell you about medication side effects to watch for when you went home' The clinical divisions are currently reviewing these results and are looking at what actions are needed to ensure information relating to medication side effects is discussed with the patients on discharge. The pharmacy team are developing information to enable patient to be aware of the use of community pharmacists in medication reviews or any issues relating to medications.

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

Improve Staff Survey Results in the Following Area - Percentage of Staff Who Would Recommend Their Friends or Family Needing Care

The National Staff Survey is undertaken on an annual basis by the Picker Institute, an independent organisation. Between the period October 2011 and January 2012 a questionnaire was sent to 2000 staff. 981 staff responded. Table 26 shows the result for the indicator.

This indicator was chosen to be monitored since this relates to a key issue that is of great importance to the Board and/or have been identified by our patients as of most importance to them.

Table 25: Care Quality Commission National Inpatient Survey

Indicator	2011/12 Results	Comparison to last year's results	2012/13 Result
Were you involved as much as you wanted to be in decisions about your care and treatment?	87.3% said yes often or yes sometimes	↓	82.6% said yes often or yes sometimes
Did you find someone on the hospital staff to talk to about your worries and fears?	52.2% said yes definitely or yes to some extent	↑	75.4% said yes definitely or yes to some extent
Were you given enough privacy when discussing your condition or treatment?	89.2% were always or sometimes	↑	91.3% were always or sometimes
Did a member of staff tell you about medication side effects to watch for when you went home?	55.7% said yes completely or yes to some extent	↓	51.5% said yes completely or yes to some extent
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	67.3% said yes	↓	66.7% said yes

Data source: Patient Perception Survey carried out by Picker Institute Europe an independent organisation. This data is governed by standard national definitions.

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- We continue to focus energy and efforts on improvements to patient outcomes, quality care and patient experience
- The Trust is part way through a training programme to help staff to be at their best more of their time when delivering care to patients
- The Trust is highlighting the friends and family test data and is investing in a team to work with this in real time
- Additional monies have been identified to support increased nurse recruitment to enhance patient care but this is still ongoing

Table 26	
National Staff Survey	
Indicator	2012 Result
Percentage of staff who would recommend their friends or family needing care	89% of staff would be happy to recommend their friends or family needing care

Data source: Staff Perception Survey carried out by Picker Institute Europe, an independent organisation. This data is governed by standard national definitions.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continuing to roll out the patient experience training to clinical staff and complete the actions as described above. In addition the Trust has updated its Strategic Aims and is consulting on new values and behaviours to ensure we each provide a consistent level of care to all our patients and service users and their families. We continue to invest in development of staff at the front line and to review performance. The Trust has updated its Whistle blowing Policy which is currently being consulted on in order that it can be launched by the Chief Executive. The Trust will also implement a range of recommendations from the Francis report as it deems required.

Improvements to the indicator will be monitored on an ongoing monthly basis through the Patient Experience Revolution engagement questionnaire and this information will be presented to the Board of Directors on a quarterly basis to monitor improvements made.

Further findings from the Staff Survey are reported separately in the Annual Report on page 26 and can be accessed via the following link http://www.bfwh.nhs.uk/departments/comms/publications.asp#ann

Improving the Experience of Care for People at the End of Their Lives
- Seeking Patients and Carers Views to Improve End of Life Care

The Trust Cancer End of Life Teams are working closely with Trinity Hospice and representatives from community groups to promote end of life care. A conference was held on Wednesday 15th May 2013 to promote 'Dying Matters' week and to raise awareness of the care that is available across the health economy. The targeted audience included community leaders from all agencies to build a network that can support, inform and inspire others.

The Cancer Network and Macmillan Cancer Support have supported a project to provide comprehensive bereavement information packs for all bereaved families across Lancashire and South Cumbria. These packs will be offered at the time of registration of death.

- Ensure that Patients Who Are Known to be at the End of Their Lives are able to Spend Their Last Days in their Preferred Place Across All Services

The End of Life Team continues to promote the tools available to facilitate the preferred place of care for patients at the end of life. A local family have worked with the team to share their experience of choice and preference at end of life. Their daughter participated in a poster campaign, which received television and radio coverage. These posters were launched throughout the Trust in May 2013 and again supported with media coverage.

Transformation of end of life care in acute hospitals: This is a national project which is being piloted within the Trust to enhance communication, documentation, training, patient choice to improve the overall journey and experience. There will be extra funding available to provide further education to clinical staff to ensure expert end of life care is provided.

Patient Environment Action Team (PEAT) Survey
- To Improve PEAT Survey Results/Standards

Our aim is to deliver the best environment for our patients to ensure that the patient experience exceeds the standards set by the National Patient Safety Agency. Providing a clean and safe environment for our patients is extremely important to the Trust. We monitor this through the Patient Environment Action Team (PEAT) annual audits across all hospital sites.

The teams comprise a multidisciplinary team, including a patient's representative and an external PEAT assessor who conduct annual audits regarding the quality of standards we provide to our patients. The key areas which are audited are:

- Cleanliness
- Specific bathrooms/toilet cleanliness
- Catering Services
- Environment
- Infection Prevention
- Privacy and Dignity
- Access all external areas

The audit follows guidelines set by the National Patient Safety Agency and the results are publicised nationally on an annual basis. In 2012/13, PEAT audits were extremely encouraging across all hospital sites resulting in excellent standards achieved. The results in Table 27 demonstrate the commitment and dedication of all staff within the Trust who strive to ensure that the patient experience is met or exceeded during their stay in our hospitals.

The 2013 assessments will be renamed 'Patient-Led Assessments of the Care Environment' (PLACE), which will commence on the 2nd April 2013. This programme replaces the former Patient Environment Action Team (PEAT) programme. In accordance with the Prime Minister's commitment to give patients a real voice in assessing the quality of healthcare, including the environment for care, at least 50% of those involved in undertaking assessments will be patient representatives. The new audit follows guidelines set by the Health & Social Care Information Centre from April 2013.

3.4.3 Priority 3: Patient Safety

We know that our service must not only be of high quality and effective, but that they must always be safe. We have a range of processes and procedures to ensure that safety always remains a top priority.

Reduce the Incidence of Avoidable Harm to our Patients through the following strands of work: - Safety Thermometer to be used as a Measure to Prevent Harm

The Safety Thermometer is a tool to be used as a measure to prevent harm. It enables the calculation of the proportion of patients who received harm free care. Since April 2012 the Trust has completed this monthly audit across all areas of the hospital and community setting.

The four harms that are the most prevalent are identified below.

- A pressure ulcer of category 2, 3 or 4, acquired anywhere
- A fall which resulted in any degree of harm within the previous 72 hours (3 days) in a care setting
- A new VTE of any type acquired whilst under our care
- Treatment for a UTI in patients with an indwelling urethral urinary catheter

Patients who have one or more of the harms listed above will not be classified as harm free.

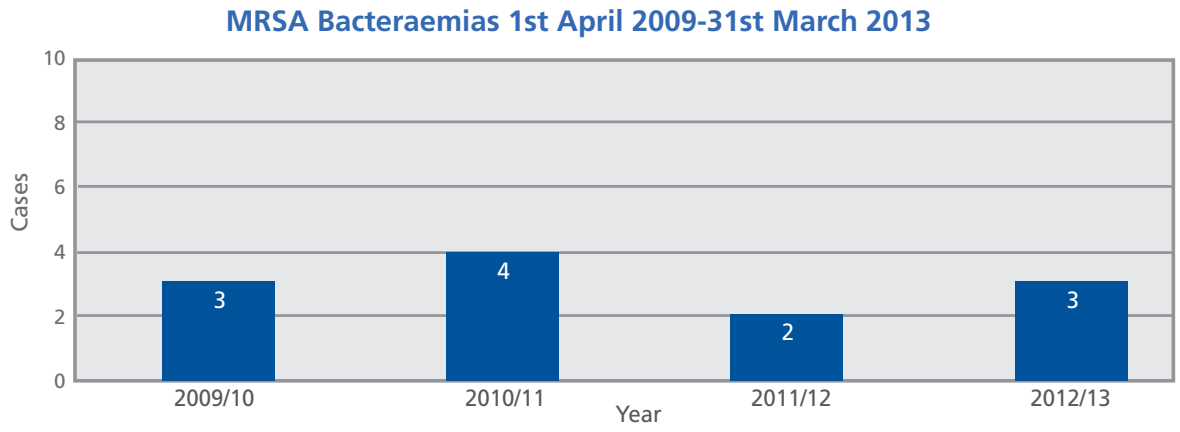
Table 27

Patient Environment Action Team (PEAT) Survey Results

Site	Overall Rating 2010/2011	Overall Rating 2011/2012	Overall Rating 2012/2013
Victoria Hospital	Good	Excellent	Excellent
Clifton Hospital	Excellent	Excellent	Excellent
Wesham Rehabilitation Unit	N/A	N/A	N/A
Rossall Rehabilitation Unit	Excellent	Excellent	Excellent

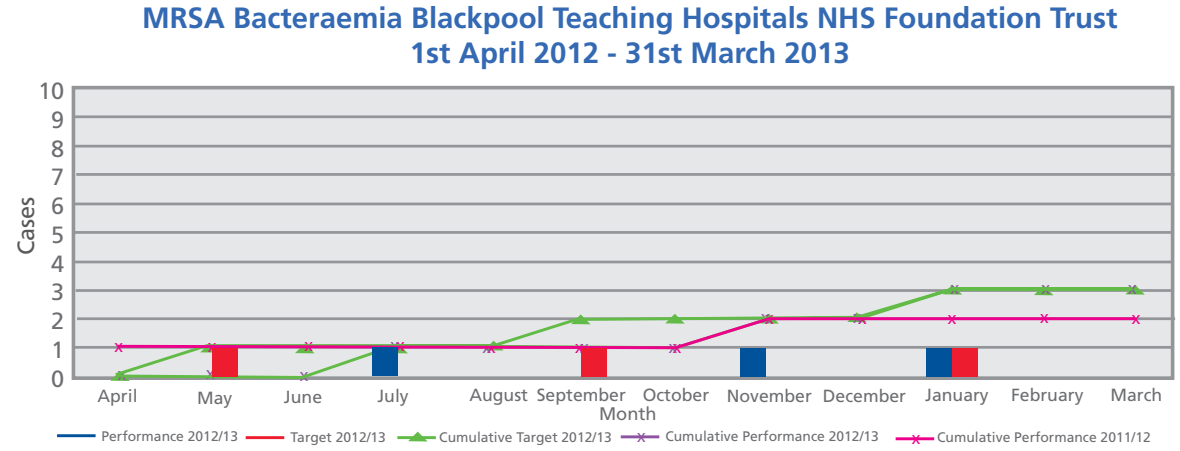
Data source: Local data from the Patient Environment Action Team Survey. This data is governed by standard national definitions.

Graph 14



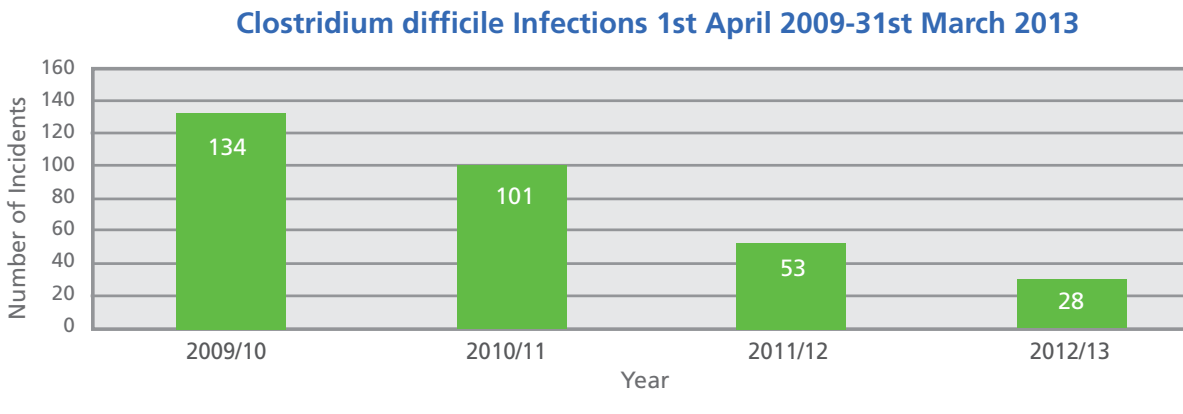
Data source: Health and Social Care Information Centre – NHS Outcomes Framework. This data is governed by standard national definitions.

Graph 15



Data source: Department of Health M.E.S.S. This data is governed by standard national definitions.

Graph 16



Data source: Department of Health M.E.S.S. This data is governed by standard national definitions

The Trust recognises the importance of this measure to identify areas to focus attention and improve the quality of patient care and outcomes. The average percentage of patients receiving harm free care whilst in our care in hospital during 2012/13 is 92.05%. From June 2012 when data collection commenced), in the community setting it is 90%.

Reduce the Incidence of Infections
- Reduce the Incidence of MRSA Infection Rates in the Trust as Reflected by National Targets

Following the significant reductions in Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia by 89% for the Acute Trust when compared to 2007/08, the Trust has continued to make tremendous progress in the last few years and embed Infection Prevention principles across the organisation, ensuring that the risk of acquiring an infection for patients is further reduced as shown in Graph 14 and 15.

The delivery of the MRSA Bacteraemia target remains a clinical risk, in relation to Monitor's Compliance Framework which identifies an MRSA trajectory of 3 cases for the reporting period. The Trust has reported 3 cases for this year, which is on trajectory remaining within Monitor's Compliance Framework target, as detailed in Graph 14 and 15. Information on how the criterion for this indicator has been calculated is detailed in the Glossary of Terms.

- Reduce Clostridium Difficile Infection Rates As Reflected By National Targets

Clostridium Difficile is an organism which may be present in approximately 2% of normal adults. This percentage rises with age and the elderly have colonisation rates of 10-20%, depending on recent antibiotic exposure and time spent in an institution. Symptomatic patients are those whose stools contain both the organism and the toxins which it produces, and have diarrhoea. Those patients who are most at risk of acquiring Clostridium Difficile diarrhoea are the elderly, those on antibiotic therapy and surgical patients. Antibiotic administration is the most important risk factor for Clostridium Difficile diarrhoea, which is also known as Antibiotic Associated Diarrhoea. The clinical features of Clostridium Difficile infection can range from diarrhoea alone, to diarrhoea accompanied by abdominal pain and pyrexia to Pseudo Membranous Colitis (PMC) with toxic megacolon, electrolyte imbalance and perforation.

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- Following the significant reductions in Clostridium Difficile Infection (91.33% for the last six years for the Acute Trust from 2007/2008) the Trust has continued to embed measures to reduce levels further within the organisation.

  There have been 28 cases of Clostridium Difficile Infection (CDI) attributed to the Acute Trust between April 2012 and March 2013, in comparison to 53 for the period April 2011 to March 2012, demonstrating a reduction of 47.17%. The Trust was required to achieve a trajectory of 51, a reduction of 3.77% on Clostridium Difficile rates from the 2011-12 level, by March 2013 as shown in Graph 16. Information on how the criterion for this indicator has been calculated is detailed in the Glossary of Terms.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this trajectory of 51 cases, and so the quality of its services, by undertaking the following actions:

- To mitigate the risk of breaching the Trust's infection prevention target, we continued to deliver a wide ranging programme of work which emphasises to all staff that remaining compliant with the requirements of the Code of Practice for Healthcare Associated Infections is everyone's responsibility. Ongoing actions included:

(i) Continuing to raise awareness and leading by example;
(ii) Ongoing audits of compliance to ensure all infection prevention and control policies and procedures continue to be implemented, including in particular hand hygiene, environmental and decontamination standards; and
(iii) Training on all aspects of infection prevention continues to be delivered;
(iv) Outcomes were assessed by reviewing progress with the Clostridium Difficile target, and auditing compliance with national standards/regulations.

Improve the Percentage of Admitted Patients Risk Assessed for Venous Thromboembolism (VTE)

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has aimed to implement current best practice guidelines in order to ensure that all adult inpatients receive a Venous Thrombo-Embolism Risk Assessment on their admission to the hospital, and that the most suitable prophylaxis is instituted. The Trust has embedded and improved the implementation of VTE guidelines within the Trust and has demonstrated this by achieving above the 90% compliance indicator. From 1st April 2011 to 31st August 2011 the Trust did not achieve the VTE target, however from 1st September 2011 - 31st March 2013 the Trust achieved above 90% compliance due to the hard work, commitment and the actions taken by staff. Since then we have been able to sustain this improvement as shown by latest figures from March 2012 to 31st March 2013 in 17.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this 90 percentage compliance indicator and so the quality of its services, by undertaking the following actions:

- The Trust has established a Thrombosis Committee to implement and achieve compliance with the National Institute for Health and Clinical Excellence Venous Thrombo-Embolism guideline (CG 92). These guidelines have been incorporated into easy to follow risk assessment forms across various specialties and are an integral part of clerking documents. This will not only ensure that VTE risk assessments are undertaken and embedded permanently in the admission pathway but also facilitates its documentation for subsequent analysis. The Thrombosis Committee monitors performance of individual clinical areas. Although there has been some delay, we are making fresh efforts to roll out an electronic assessment tool to give "live" information about compliance. This will help us to give feedback to individual areas and address poor performance pro-actively.

Reduce the Incidence of Inpatient Falls by 30% Resulting in Moderate or Major Harm

Patient falls are one of the most common patient safety incidents reported. The majority of slips, trips and falls result in low or no harm to patients physically. However, any slip, trip or fall can result in the patient losing their confidence. There have been significant improvements within all areas of the Trust in reducing the numbers of falls as shown in Graph 18 and 19 below. There have been a number of initiatives introduced during 2012/13 to promote the reduction in falls resulting in harm.

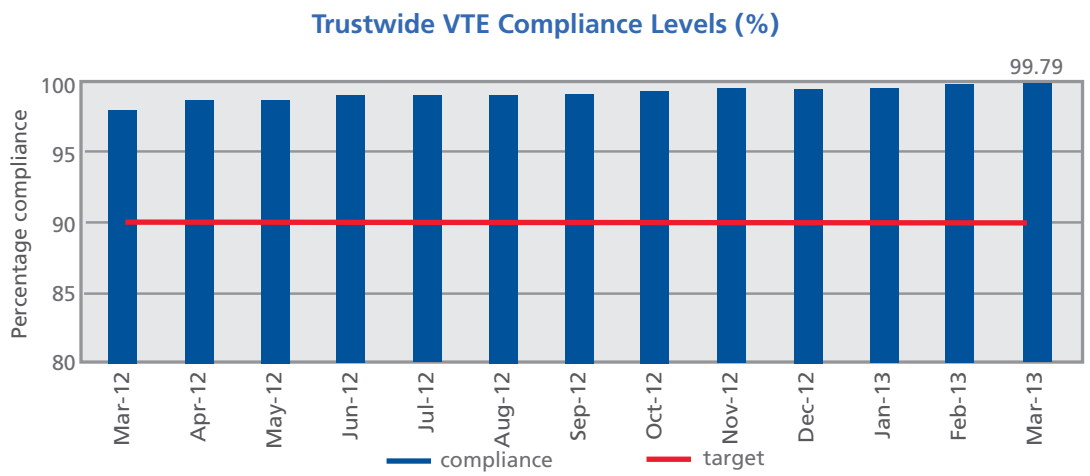
- There has been targeted support and training given to wards within both the Scheduled and Unscheduled Divisions to improve the staffs understanding in relation to bone health and falls risks this included education around the falls risk assessment and the formulation of a care plan for patients at risk of falling.

- Introduction of movement sensors in all the clinical divisions, both on the acute wards and in the community hospitals, for patients who are identified to be at high risk of falling. The sensors are discreet and can be placed either under the mattress of the bed, or on the chair if the patient is sitting out of their bed. The sensors alert the ward nurses via a pager system if a patient attempts to get out of bed or move from the chair unaided. The sensors have already helped prevent potential injury to patients as the nursing staff have been alerted swiftly and assistance given.
- Low beds have been trialed and the trust has introduced these to prevent falls for those patients at higher risk.

- A footwear trial has been completed and we have changed the products used across the Trust
- We have developed a slipper exchange scheme in the care of the older adult wards
- Greater cross boundary working with colleagues working in the community.

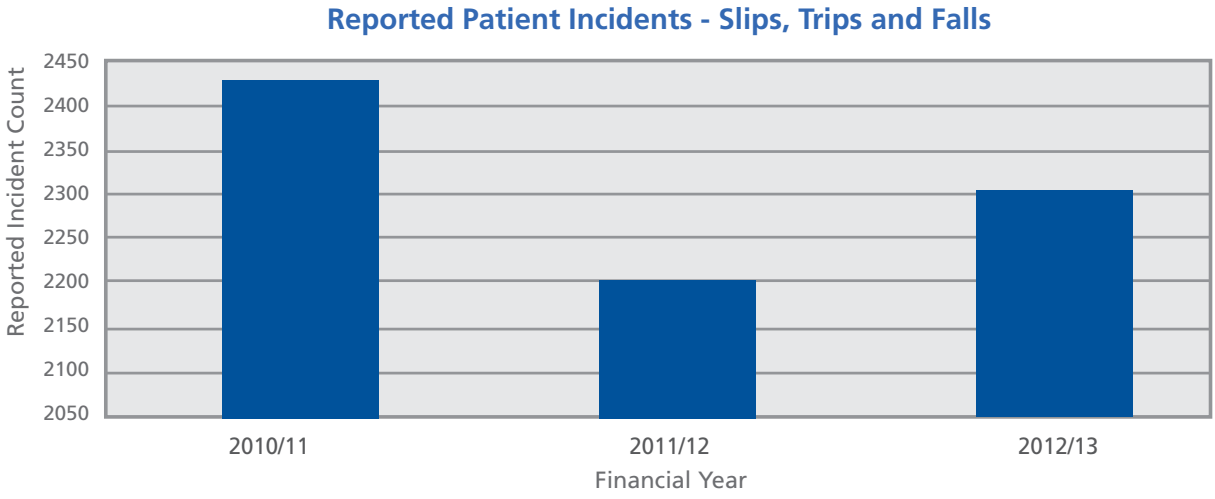
In 2011/12 there were 2205 falls with harm compared with 2301 in 2012/13 as demonstrated in Graph 18. This represents an increase of 4.4%. However, the Trust recognises that there has been improved reporting of falls, which may account for the increase in number of incidents. 2266 falls resulted in low or minor harm being experienced by the patient and there were 35 patients who experienced a fall that resulted in a moderate/serious harm. This is a 15% reduction on the number of patients who experienced the same harm in 2011/12. Measures have been put into place as outlined above and it is anticipated that the Trust will continue to see a downward trend for serious patient falls as demonstrated in Graph 19.

Graph 17



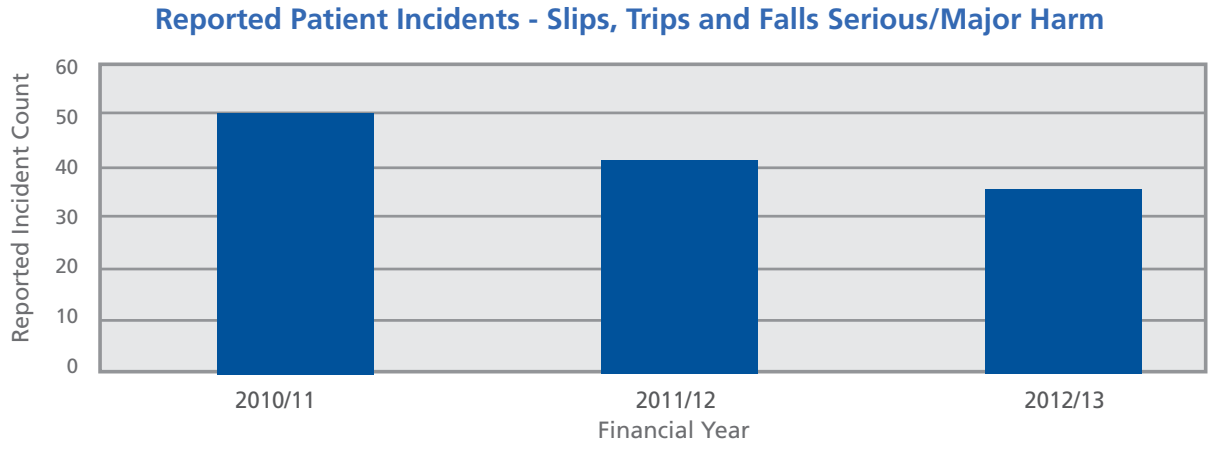
Data source: UNIFY national reporting. This data is governed by standard national definitions.

Graph 18: Patient Slips, Trips and Falls



Data source: Hospital Incident Reporting System (HIRS) provided by the Safeguard Information System. This data is not governed by standard national definitions.

Graph 19: Patient Slips, Trips and Falls



Data source: Hospital Incident Reporting System (HIRS) provided by the Safeguard Information System. This data is not governed by standard national definitions.

Reduce the Incidence of Medication Errors by 50% Resulting in Moderate or Severe Harm

Medicines and medicine safety are an integral part of care provision within the Trust. The Trust continues to engage both staff and patients in the safe usage of prescribed medicines within all Specialities. Medicines are the most frequently and widely used NHS treatment and account for over 12% of NHS expenditure. The Trust maintains current and coherent medicines policies, protocols and guidance that aim to increase patient access to medicines and safety. The Trusts policies on medicines and medicine safety cover every step of the journey from the development of medicines to their use by the patient.

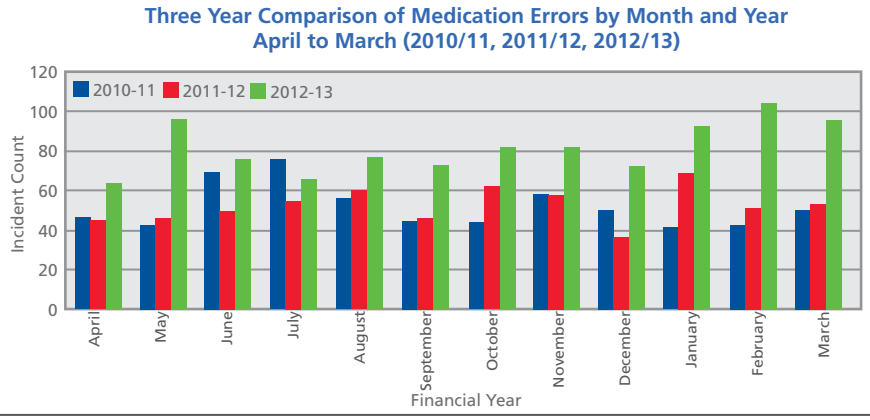
The provision of Medicines Management Mandatory training continues to re-enforce the safe management of medicines within the Trust for all professionals to reduce the risk of medication errors. Medication incidents /errors are reported through the Trust Ulysses system which is fed into the National Reporting and Learning System. Currently medication errors reported by the Trust are identified in Graph 20.

Medication errors can occur anywhere within the care pathway including dispensing, preparing, administering, monitoring, storing or communication. The number of medication process errors are identified in Graph 21. The Medicines Management Team continue to ensure that the principles, safety and recommendations from all the National Patient Safety Agency Alerts are firmly embedded and maintained within all clinical areas. A robust and comprehensive audit process assures the Trust that standards are sustained on an annual basis.

The Medicines Management Committee meets bi-monthly. A report is supplied by the risk department which details all medication errors, drug type, level of harm to the patient, cause group and area. A trend and theme analysis is completed with the aim that target areas can be highlighted and action plans devised to mitigate the risk. Several areas now have dedicated pharmacist cover, this has been found to reduce medication errors in these areas, it is hoped that this service will be extended over the coming year. The Trust has introduced Specialist Nurse Practitioners who are able to prescribe a set group of medications, this has been shown to reduce prescription errors and waiting times for discharge medication. Drug administration has been shown to be consistently the highest cause group as demonstrated in Graph 21, further analysis of the incidences indicated that many of these incidences were as a result of staff being interrupted whilst completing drug rounds, all nurses are now required to wear 'do not disturb' tabards when completing drug rounds.

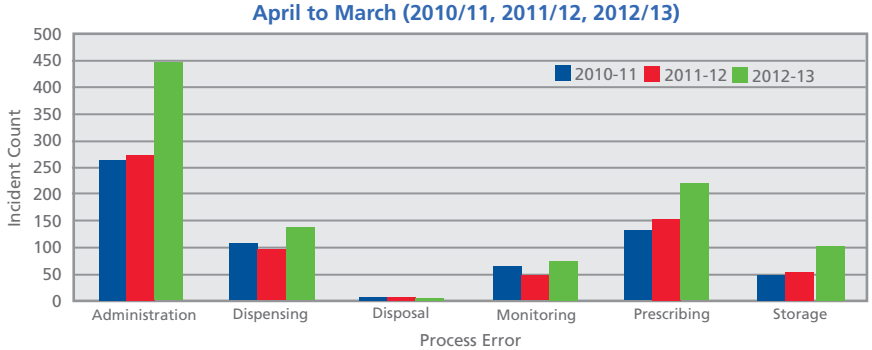
The September 2012 published report from the National Patient Safety Agency (NPSA) highlighted that nationally, but specifically to Large Acute General Hospitals, incidents involving medicines between October 2011 and March 2012 are the third largest group (9.9%) of all incidents reported to the National Reporting and Learning Service (NRLS) after patient accidents (28.4%) and treatment and procedures (11.9%). The Trust is able to report an improvement in the number of incidents reported by staff and a reduction in the level of patient harm. This emphasises the improvement in safety and medication awareness within clinical areas. The Trust Median reporting is 6.3% per 100 admissions compared to the National average of 5.9%.

Graph 20: Medication Errors



Data source: Hospital Incident Reporting System (HIRS) provided by the Safeguard Information System. This data is not governed by standard national definitions.

Graph 21: Medication Errors



Data source: Hospital Incident Reporting System (HIRS) provided by the Safeguard Information System. This data is not governed by standard national definitions.

Reduce the Incidence of Newly Acquired Grade 2, 3 and 4 Pressure Ulcers by 30% in the Trust

The reduction of pressure ulcers has also been identified as a priority indicator to enable the Trust to meet national healthcare directives and current local quality improvement priorities for 2012/13. To improve the quality of care provided, the Trust made a commitment to ensure that all patients who suffered a hospital acquired pressure ulcer stage 2, 3 or 4 would have a root cause analysis undertaken.

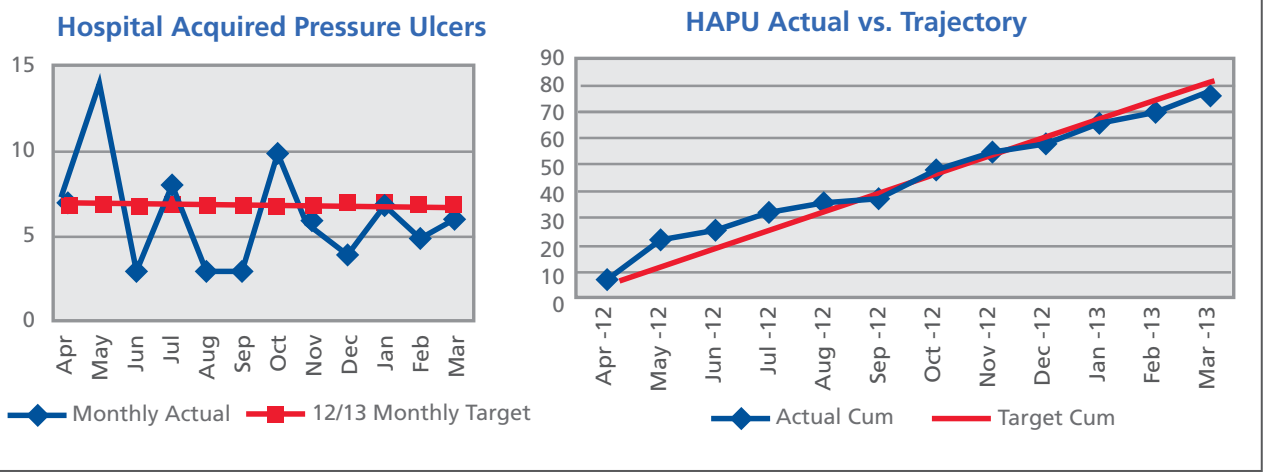
Through the implementation of a quality improvement initiative programme the Trust has demonstrated how pressure ulcers have been reduced and targets met due to the initiative being implemented over the last twelve months as shown in Graph 22.

The above strand of work is being monitored to enable the Trust to measure progress in reducing avoidable patient harms and to improve patient outcomes and experiences.

Work will continue to ensure that changes are embedded into practice and the improvements in performance are sustained. During 2012, the Acute site integrated with Community Health Services. Collaborative working between the staff has seen an improvement in the reporting of pressure ulcer incidents in the community setting and the implementation of improvement processes has commenced.

The Trust is delighted that it continues to see a significant and sustained year on year reduction in the number of hospital acquired pressure ulcers. Since March 2009, hospital acquired pressure ulcers have reduced by 76.7%. The last 12 months since April 2012 have seen a 35% reduction in the number of hospital acquired pressure ulcers, which is better than trajectory by 7.3%. The number of patients experiencing a pressure ulcer between April 2012 and March 2013 has also reduced by 24.5% compared to the same period last year.

Graph 22



Data source: Ward-based prevalence audit. This data is governed by standard national definitions.

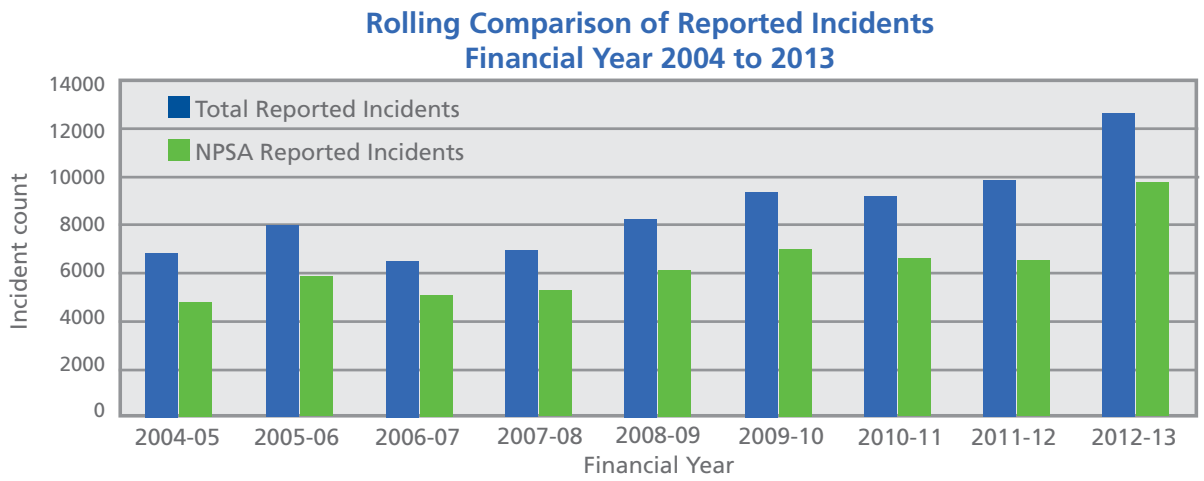
To Monitor the Rate of Patient Safety Incidents and Reduce the Percentage Resulting in Severe Harm or Death

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- There has been a steady increase in the number of untoward incidents reported over the past 4 financial years (Graph 23). Patient Safety Incidents account for approximately 76% of all reported untoward incidents. In the year 2012/2013 there have been 12746 untoward incidents reported and of these 9700 were patient safety incidents and as such were reported to the National Patient Safety Agency. Of these 9700 patient safety incidents, 2529 or 26% resulted in harm to the patient and in comparison to the number of attendances at the Trust (407,378) there is a patient safety incident reported for every 1 in 42 patients.

Since 2010/2011 there has been a reduction in the number of patient safety incidents that have resulted in severe patient harm (Graph 24 and Table 28). This is as a response to analysis of trends and themes, lessons being learned and actions being taken at lower level incidents.

Graph 23



Data source: Hospital Incident Reporting System (HIRS) provided by the Safeguard Information System. This data is not governed by standard national definitions.

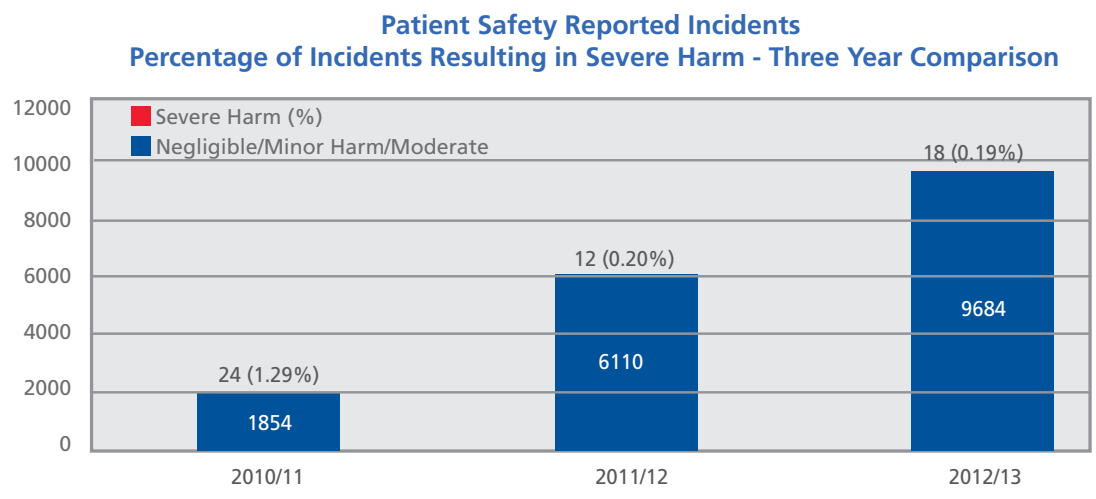
The Trust has a policy of reporting incidents within 24 hours of occurrence, 67% of severe harm or death incidents were reported within 24 hours of occurrence. In order to address this shortfall all induction, clinical mandatory and specific incident reporting and investigation training includes the importance of contemporaneous reporting. The message being communicated is that if an incident has occurred action needs to be taken promptly to prevent a reoccurrence especially if the incident has resulted in severe harm or death.

Table 28: Patient Safety Incidents That Resulted In Severe Patient Harm

Financial Year	Severe/ Major Harm	Disaster/ Death	Total
2004-05	22	5	27
2005-06	6	3	9
2006-07	10	2	12
2007-08	8	1	9
2008-09	7	2	9
2009-10	8	4	12
2010-11	24	0	24
2011-12	12	0	12
2012-13	13	4	17

Data source: Hospital Incident Reporting System (HIRS) provided by the Safeguard Information System. This data is not governed by standard national definitions

Graph 24



Data source: Hospital Incident Reporting System (HIRS) provided by the Safeguard Information System. This data is not governed by standard national definitions.

In 2012/13 there have been four incidents where following a serious untoward investigation it has become evident that the cause of death was as a direct consequence of the incident. There has been no identifiable trend or theme within these investigations and all were tragic circumstances. A description of each of the incidents and the lessons learned are detailed in Table 29.

Table 29: An overview of the incidents that resulted in death of a patient and lessons learned

Description of the Incident	Lessons learned
Unexpected Maternal Death - Accident and Emergency. A female patient was admitted to the Accident and Emergency (A&E) Department with a history of breathlessness and chest pain. The patient was high risk of deep vein thrombosis (DVT) and pulmonary embolism (PE), having had a caesarean section five weeks previously. The patient collapsed and subsequent resuscitation attempts were unsuccessful. Post-mortem examination indicated that the cause of death was pulmonary embolism.	In order to ensure that all pregnant or postnatal women who attend hospital are appropriately reviewed, all patients attending A&E will be reviewed by a senior nurse and a past medical history will be sought. In order to ensure that a postnatal woman who presents to A&E is reviewed by an obstetrician, A&E must inform maternity services of her admission. Staff need to be aware of the increased risk of VTE during pregnancy and the postnatal period.
Unexpected Death - Cardiac Unit. A 57 year old patient with significant aortic stenosis and severe impairment in left ventricular systolic function attended for Dobutamine Echo Stress (DES) test. DES tests are performed when the patient is unable to exercise to stimulate the heart rate so that the heart can be assessed for suspected coronary artery disease. In high risk patients low dose dobutamine is used to assess myocardial viability. In this case high dose dobutamine was administered. The patient sustained a cardiac arrest and resuscitation was unsuccessful.	All referrals for Dobutamine Echo Stress (DES) test must be triaged and allocated to the appropriate clinician. The introduction of a formal sign off process which enables all registrars to have supervised practice prior to a formal sign off, following competency being demonstrated, will facilitate safe practice. The development of a protocol which includes the process to follow if complications occur during a DES will facilitate the safe provision of treatment for the patient. The consent process must include provision of information to the patient which includes all known risks including death.
Suboptimal Care of a Deteriorating Patient. A 45 year old Patient was admitted to the Acute Medical Unit with a suspected urinary tract infection. The patient's clinical observations recorded on the early warning score (EWS) chart indicated that the patient's condition was deteriorating. The Trust 'Graded Response Strategy' identifies the escalation process to be followed in the event of a deteriorating patient. This was not activated. The patient was found to be in cardiac arrest and resuscitation was undertaken, during which the bed space suction apparatus failed to work which necessitated the use of hand held suction. The resuscitation was unsuccessful.	Where an EWS chart indicates that the patient's condition is deteriorating, staff must activate the escalation process in order to ensure that the patient receives relevant and prompt attention. Failure to ensure rigorous maintenance of suction units in ward areas may result in the inability to resuscitate a patient in an emergency situation.
Unexpected Death - Cardiac Unit. A 45 year old patient underwent cardiac surgery. The patient was receiving high levels of ventilator support. The patient required a tracheostomy. There were concerns that the tracheostomy tube was an incorrect fit. An alternative size tracheostomy was sourced but it was deemed a greater risk to change to an alternative size rather than leave the existing one in place. During the process of bringing the patient out of sedation he was noted to become agitated, this increased the risk of the tracheostomy becoming dislodged. The patient suffered a cardiac arrest where initial resuscitation was successful, however subsequent tests showed that the patient had sustained a period of brain hypoxia leading to brain death, the most likely cause being inadequate oxygenation due to a blocked tracheostomy tube.	A range of tracheostomy tubing is to be available within the Cardiac Unit. Patients are to be monitored for carbon dioxide levels whilst ventilated and the staff are to receive heightened awareness sessions on the importance of monitoring carbon dioxide levels. Staff are to receive additional training on the management of tracheostomies where suspicion of occlusion or dislodgement is present. Staff must ensure that advanced life support protocols are adhered to, ensuring that the patency of airways and chest inflation is achieved.

All level 4 and 5 patient safety incidents are investigated within the Serious Untoward Incident (SUI) process. Following completion of the investigation report the recommendations and action plan are monitored. Assurance that actions have been completed and practice changed is gained from evidence collection, audit findings and further monitoring of reported incidents. A requirement for a risk assessment is considered within the SUI process, in relation to the contributory factors which led to the SUI, which will be monitored and reviewed by the Divisions and the Board.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this 25 percent of patient safety incidents resulting in harm, and so the quality of its services, by undertaking the following actions:

- It is essential that lessons are learned from SUI's in order to mitigate the risk of reoccurrence, these lessons are fed back to staff within the Divisions through training, ward meetings and the Trust wide monthly "lessons learned" newsletter. Lessons learned are also discussed at the monthly Learning from Incidents and Risks Committee. All completed SUI reports are published on the Trust intranet so that any member of staff can access and use it as a learning experience. Links with the Learning and Development Team have been adopted so that training and development can be tailored around real life incidents and patient experiences. The Trust's simulation centre has undertaken several sessions where staff who were involved in an incident have the opportunity to re-enact the scenario, reflect on the events and evaluate what went wrong and why. Feedback from staff has been extremely positive especially with those staff who have been involved in an incident where the patient's were severely harmed or died.
- Engagement of the patient and their relatives is very important not only to the Trust with an open and honest culture, but as a healing tool. Patients and relatives are informed when an incident has occurred and that an investigation is to be undertaken. In some cases they are asked for their version of events and this is reflected within the report. Following completion of the investigation report they are given the opportunity to discuss the findings and further action to be taken to prevent further occurrence. Please note: Graph 23 and Graph 24 includes comparison data for the three former organisations (Blackpool Teaching Hospitals, NHS Blackpool and NHS North Lancashire.

3.4 Statements from Local Clinical Commissioning Groups (CCG's), Local Healthwatch Organisations and Overview and Scrutiny Committees (OSCs)

The statements supplied by the above stakeholders in relation to their comments on the information contained within the Quality Account can be found in Annex A. Additional stakeholder feedback from Governors has also been incorporated into the Quality Account. The lead Clinical Commissioning Group has a legal obligation to review and comment on the Quality Account, while Local Healthwatch organisations (previously known as Local Involvement Networks (LINks)) and OSC's have been offered the opportunity to comment on a voluntary basis. Following feedback, wherever possible, the Trust has attempted to address comments to improve the Quality Account whilst at the same time adhering to Monitor's Foundation Trusts Annual Reporting Manual for the production of the Quality Account and additional reporting requirements set by Monitor.

3.5 Quality Account Production

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

The Quality Account 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 Account.

3.6 How to Provide Feedback on the Quality Account

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

Telephone: 01253 655520
Contact us on: www.bfwh.nhs.uk
Email: mary.aubrey@bfwhospitals.nhs.uk

Deputy Director of Corporate Affairs and Governance
Blackpool Teaching Hospitals NHS Foundation Trust
Trust Headquarters
Whinney Heys Road
Blackpool
FY3 8NR

3.7 Quality Account Availability

If you require this Quality Account in Braille, large print, audiotape, CD or translation into a foreign language, please request one of these versions by telephoning 01253 655632.

Additional copies of the Quality Account can also be downloaded from the Trust website: www.bfwhospitals.nhs.uk

3.8 Our Website

The Trust's website gives more information about the Trust and the quality of our services. You can also sign up as a Trust member, read our magazine or view our latest news and performance information.

Annex A: Statements from Local Clinical Commissioning Groups (CCGs), Local Healthwatch Organisations and Overview and Scrutiny Committees (OSCs)

1.1 Statement from Blackpool Clinical Commissioning Group and Fylde and Wyre Clinical Commissioning Group – 22.05.13

Re: Blackpool Teaching Hospitals NHS Foundation Trust Quality Account for 2012/13
We would like to thank you for forwarding a draft copy of the Blackpool Teaching Hospitals NHS Foundation Trust Quality Account and report for 2012/13 in accordance with the requirements of the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010. We are pleased to provide the response from Blackpool CCG as Lead Commissioner together with Fylde and Wyre CCG as co-commissioners with regard to this document.
We recognise the amount of work involved in producing the Quality Account and anticipate that the following provides concise and comprehensive feedback including assessment of the accuracy of the report.

Quality Account 2012-2013 Statement
This statement represents feedback from Blackpool CCG as Lead Commissioner together with Fylde and Wyre CCG as co-commissioner and we welcome the opportunity to appraise the content of the Quality Account for 2012-2013. We are pleased to acknowledge that there is a real focus on the key quality elements and Blackpool Teaching Hospitals NHS Foundation Trust has clearly referenced its organisational objectives, focusing on the three key dimensions of quality as outlined within 'High Quality Care For All' (DH, 2008):

- Patient Safety
- Clinical effectiveness of Care
- Quality of the Patient Experience

Performance against 2011/12 quality priorities
Of the 35 indicators referenced we are pleased to note improvement or maintenance in 21 of these areas. Advancing Quality Hip and knee surgery indicators have moved from green to amber but we note the commitment to improvement for 2012/13 as this is included as a contractual CQUIN indicator for 2013-14.

We commend the Trust for establishing priorities as a result of consultation with patients, relatives and carers.

Blackpool Teaching Hospitals NHS Foundation Trust has been an outlier for hospital mortality. We acknowledge and support the work over the last 18 months on reducing these rates. We are pleased with the improvements taken by the Trust to date and wish to continue to work in partnership throughout 2013/14.

The Trust participated in 100% of National Confidential Enquiries and 86% of National Clinical Audits and this is a clear indication of an organisation with a commitment to delivery of evidence based and safe care however, CCG would like to see an improvement of 100% participation in clinical audit of services provided by the trust for 2013/14.

Blackpool Teaching Hospitals NHS Foundation Trust has met the requirements of the Information Governance Toolkit with no serious breaches in data security and as such patients and the public can be assured that personal data held is stored, used and transferred securely and confidentially.
We note that Blackpool Teaching Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit with the error rate noted to be 5.9% and although this is above the national average we are pleased to see that the Trust is implementing actions to improve percentages for 2013/14.

Research is well supported at Blackpool Teaching Hospitals NHS Foundation Trust and CCG confirm that a research active provider demonstrates a strong commitment to clinical effectiveness in support of improving the quality of care delivered but we would like to see a commitment to working with the newly formed Academic Health Research Networks.

Quality Initiatives to be progressed 2012/13

Quality of Patient Experience
Blackpool Teaching Hospitals NHS Foundation Trust was subject to an unannounced Care Quality Commission visit regarding dignity and nutrition and CCG are pleased to see that in accordance with the NHS Outcomes framework privacy and dignity continues to be a priority area for the Trust and it is pleasing to see compliance with the 3 essential standards. Following receipt of 2 minor improvement requirements the trust produced a robust action plan that has resulted in CQC assigning compliance to these areas. The CCG would like to commend

Blackpool Teaching Hospitals NHS Foundation Trust on the work that has taken place regarding eliminating mixed sex accommodation.

Performance measures
National performance targets are reported to commissioners and we confirm Blackpool Teaching Hospitals NHS Foundation Trust has achieved or is on target for a number of measures but showing under achievement for total time in A&E, total time to initial assessment and time to treatment decision. Blackpool CCG would like to see local improvement and commissioners will continue to monitor progress via an integrated Quality and Safety Dashboard.

Clinical effectiveness measures
Of significant note and commendation is Blackpool Teaching Hospitals NHS Foundation Trust commitment to reducing HealthCare Associated Infection and achieved a significant reduction of 47.17%. The year end trajectory for MRSA was 3 and whilst the Trust is currently within this trajectory they have reported 3 cases for 2012/13. Blackpool CCG acknowledges the challenge in delivery of the dementia care bundle and note that this has been challenging for many Hospitals. The current position for March 2013 shows a significant improvement in assessment although referral data is still awaited.

The Trust set itself ambitious targets for reduction in the incidence of in-patient falls by 30% and whilst not achieving this figure the CCG note and commend achieving 20% reduction and we hope to see a continued target of 30% for 2013/14 to ensure continued focus on this important patient safety initiative. Medication error reduction was set at 50%, but this was not achieved. Incidence is shown to be increasing across all elements but most noticeably in administration which concerns the CCG. For 2013/14 CCG's will review action planning and reporting of medication errors.

As the Quality Account is aimed at patients, public and carers we note the report is not very user friendly or readable for this target audience. This we feel is due to the Blackpool Teaching Hospitals NHS Foundation Trust combining the Quality Account with the Quality Report required by Monitor. As such we recommend that for 2013/14 you give consideration to producing a more public facing document.

Blackpool CCG and Fylde and Wyre CCG confirm the data underpinning the measures of performance and quality reported in the Quality Report, are robust and reliable.

We look forward to continuing to work closely with the Trust in the coming year and to see improvements in the quality of services provided as outlined in the Quality Account. We will support Blackpool Teaching Hospitals NHS Foundation Trust as they strive for excellence to successfully deliver the priorities identified for the forthcoming year. We are happy to discuss any of the above in more detail if required.

1.2 Statement from Governors – 22-05-2013

A group of Governors of this Trust have examined this Quality Account several times. Sometimes a report is questioned and request made to explain something more clearly. The purpose was not only to ensure that the facts were correct but also that they were displayed in a manner that we could all understand. Some sections are still a bit heavy going because the "powers that be" insist upon a prescribed form of words. We hope you will read at least those sections of particular interest to you and then a little further into a record of continuous striving to become one of the leading health Trusts in the country.

1.3 Statement from Local Healthwatch Lancashire - 22-04-2013

Lancashire LINk ceased operations on 31st March 2013. Many of its functions, including responsibility for commenting on health trust's quality accounts, have been transferred to Healthwatch Lancashire.

Healthwatch Lancashire is a very new organisation which is in the process of setting up its structures, including a new board, and is not in a position to undertake any major pieces of work in the immediate future. Therefore it has been decided that this year Healthwatch Lancashire will not provide a formal statement on quality accounts. We will, of course, by next year be fully operational and able to take part in this important work.

1.4 Statement from Lancashire Health Overview and Scrutiny Committee - 20-05-2013

The Lancashire Health Scrutiny Committee has made a commitment to ensure that members are aware of, and take a keen interest in the facilities, services and performance of the Trust. To maintain this they will continue to have an overview of the design and development of quality services provided to the residents of Lancashire. In addition a priority of the Committee is to reassure the public that an honest and transparent relationship is developed with the Trust to enable effective scrutiny to take place.

Annex B: Statement of Directors' Responsibilities in Respect Of the Quality Account

The Board of Directors is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporates the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14:

- The content of Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2012 to June 2013;
  - Papers relating to Quality reported to the Board over the period April 2012 to June 2013;
  - Feedback from the commissioners - Blackpool Clinical Commissioning Group and Fylde and Wyre Clinical Commissioning Group – dated 22/05/2013;
  - Feedback from Governors dated 15/02/2013, 02/05/2013 and 21/05/2013;
  - Feedback from Local Healthwatch organisations (previously LINks) - Local Healthwatch Lancashire dated 22/04/2013;
  - The Trust's Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 11/04/2013;
  - The latest 2012 national patient survey published 01/02/2013;
  - The latest 2012 national staff survey published 28/02/2013;
  - The Head of Internal Audit's annual opinion over the Trust's control environment approved 30/04/2013;
  - Care Quality Commission quality and risk profiles dated 02/04/2012; 31/05/2012; 30/06/2012; 31/07/2012; 30/09/2012; 31/10/2012; 30/11/2012; 31/01/2013; 28/02/2013; 31/03/2013.

- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;

- The performance information reported in the Quality Report is reliable and accurate;

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at http://www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at http://www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By order of the Board:

Date: 23rd May 2013 Chairman:
Ian Johnson

Date: 23rd May 2013 Chief Executive:
Gary Doherty

Annex C: Glossary of Abbreviations and Glossary of Terms

Table 31 Glossary of Abbreviations

Abbreviation	Meaning
AMI	Acute Myocardial Infarction
AQ	Advancing Quality
ACEI	Angiotension Converting Enzyme Inhibitors
ARB	Angiotension Receptor Blocker
BVH	Blackpool Victoria Hospital
CABG	Coronary Artery Bypass Graft
CAP	Community Acquired Pneumonia
CC	Clinical conditions.
CCG	Clinical Commissioning Group
CDI	Clostridium Difficile Infection
CDU	Clinical Decisions Unit
CEMACH	Confidential Enquiry into Maternal and Child Health - This is a national enquiry to improve the health of mothers, babies and children by carrying out confidential enquires on a nationwide basis and by disseminating the findings and recommendations as widely as possible.
CHKS	Name of the Company which is used for benchmarking
CHP	Combined Heat and Power
CRC	Carbon Reduction Commitment
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CQS	Composite Quality Score
CQUIN	Commissioning for Quality and Innovation
DoH	Department of Health
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
ERIC	Estates Returns Information Collections
GHG	Green House Gas
GP	General Practitioners
HCAI	Healthcare Acquired Infection
HES	Hospital Episode Statistics
HPA	Health Protection Agency
HRG	Healthcare Resource Group
HSMR	The Hospital Standardised Mortality Ratio (HSMR)

Table 31: Glossary of Abbreviations	
Abbreviation	Meaning
IRMER	Ionising Radiation Medical Exposure Regulations 2000
LAC	Looked After Children
LSCB	Local Safeguarding Children's Board
LVSD	Left Ventricular Systolic Dysfunction
LVS	Left Ventricular Systolic Function Assessment
Medusa	Electronic version of the Injectable Medicines Guide
MRSA	Methicillin Resistant Staphylococcus Aureus
NCEPOD	National Confidential Enquiries into Perinatal Outcomes of Death
NICE	National Institute for Health and Clinical Excellence
NCI	Nursing Care Indicators
NHSLA	National Health Service Litigation Authority
NIHR	National Institute for Health Research
NHS OF	The NHS Outcomes Framework
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning Service
PbR	Payment by Results
PCI	Primary Coronary Intervention
PCT	Primary Care Trust
PEAT	Patient Environment Action Team
RAMI	Risk Adjusted Mortality Index
SBAR	Situation Background Assessment Recommendations
SHMI	Summary Hospital Level Mortality Indicator
SUS	Secondary Uses System
TIA	Trans Ischemic Attack
VTE	Venous Thromboembolism

Table 32: Glossary of Terms	
Abbreviation	Glossary of meaning
Antibiotic Prophylaxis	Antibiotic Prophylaxis is preventive treatment given to patients in order to protect them from developing an infection.
Cardiac Arrest	Cardiac arrest, (also known as cardiopulmonary arrest or circulatory arrest) is the cessation of normal circulation of the blood due to failure of the heart to contract effectively.
Clinical Commissioning Group	Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in NHS England. CCGs are clinically led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs will operate by commissioning (or buying) healthcare services including: • Elective hospital care • Rehabilitation care • Urgent and emergency care • Most community health services • Mental health and learning disability services
Clinical Conditions	JD042: Minor Skin Disorders category 3 without CC "CC" means clinical conditions. Therefore in this context the patient had no other clinical conditions or co-morbidities.
Clinical Divisions	Unscheduled Care Division comprises of Medicine, Adult Medical Assessment Unit, Intensive Therapy Unit and Accident and Emergency Department and Community Term Adult Long Term Conditions. Scheduled Care comprises of the Cardiac Unit and the Surgical Unit. Women's Health comprises of the Women and Children's unit, Paediatric Unit, Community Midwives, School Nurses and Health Visitors.
Clostridium Difficile	Clostridium Difficile (C. diff) is a bacterium that is present naturally in the gut of around two thirds of children and 3% of adults. C. diff does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C. diff bacteria can multiply and produce toxins (poisons), which cause illness such as diarrhoea and fever. At this point, a person is said to be 'infected' with C. diff.
Endoscopy Accreditation	Accreditation within Endoscopy is enabling the Trust to prove that all processes around the use of endoscopes within Gastroenterology, Cardiac Directorate and ENT are conducted to the highest standard. Systems are now in place to prove that all areas, within the Trust, conform to the same standards and Trust has passed the second stage which shows that we do what we have documented. Extremely good feedback was received during all visits by the inspector.
Evidence Based Practice	Evidence based practice (EBP) is: "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research".
Friends and Family Test	The test will provide us with a simple, easily understandable headline matrix which combined with other information, patient feedback and follow up questions can support the trust in pinpointing areas for improvement, and will inform and empower the ward, and the board, to tackle areas of weak performance and enhance areas of excellent practice. The test will be designed to be a single matrix and we will still need to supplement this with other methods of capturing, responding and understanding the patients experience data. It is not designed to replace more local operational level information, yet will be designed to act as an opener for deeper organisational work across all patients pathways. The test will help us quickly flag issues, which will be easily responded to. Effective, targeted improvements will quickly show up as the score will improve, validating and incentivising further improvements across the Trust. Further information can be located at the following link: http://transparency.dh.gov.uk/2012/11/28/nhs-friends-and-family-test.
Healthcare Resource Groups	Developed by The Case mix Service, Healthcare Resource Groups (HRGs) are standard groupings of clinically similar treatments which use common levels of healthcare resource. Healthcare Resource Groups offer organisations the ability to understand their activity in terms of the types of patients they care for and the treatments they undertake. They enable the comparison of activity within and between different organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time. Healthcare Resource Groups are currently used as a means of determining fair and equitable reimbursement for care services delivered by Health Care Providers. Their use as consistent 'units of currency' supports standardised healthcare commissioning across the NHS. They improve the flow of finances within - and sometimes beyond - the NHS. HRG4 has been in use for Reference Costs since April 2007 (for financial year 2006/7 onwards) and for Payment by Results (PbR) since April 2009 (for financial year 2009 onwards). HRG4 was a major revision that introduced Healthcare Resource Groups to new clinical areas, to support the Department of Health's policy of Payment by Results. It includes a portfolio of new and updated HRG groupings that accurately record patient's treatment to reflect current practice and anticipated trends in healthcare.

Table 32: Glossary of Terms	
Abbreviation	Glossary of meaning
Hospital Standardised Mortality Ratio	The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect. HSMR compares the expected rate of death in a hospital with the actual rate of death. Dr Foster looks at those patients with diagnoses that most commonly result in death for example, heart attacks, strokes or broken hips. For each group of patients we can work out how often, on average, across the whole country, patients survive their stay in hospital, and how often they die.
Investors In People Gold Standards	Investors in People is all about business improvement to help transform the organisation's performance by targeting chosen business priorities
JACIE Accreditation	The Joint Accreditation Committee is a non profit body established in 1998 for the purpose of assessment and accreditation in the field of haematopoietic stem cell (HSC) transplantation. JACIE's primary aim is to promote high quality patient care and laboratory performance in haematopoietic stem cell collection, processing and transplantation centres through an internationally recognised system of accreditation.
Joint Advisory Group (JAG) Accreditation on our Endoscopy Unit	Joint Advisory Group (JAG) Accreditation and Global Rating Score (GRS) The Endoscopy Global Ratings Scale (GRS) is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation. Accreditation definition: Usually a voluntary process by which an independent agency grants recognition to organisations which meet certain standards that require continuous improvement in structures, processes and outcomes. Quality improvement and accreditation offers a risk reduction strategy that an endoscopy service is doing the right things and doing them well; thereby significantly reducing the risk of error in the delivery of services. What is JAG Accreditation intended to accomplish? Stimulate continuous improvement in processes and patient outcomes Strengthen endoscopy services Provide a knowledge base of best practices Increase patient confidence in services Improve the management and efficiency of services Provide education on better/best practices The GRS & accreditation pathway will assist you to both achieve and demonstrate this
Methicillin Resistant Staphylococcus Aureus	MRSA stands for Methicillin-Resistant Staphylococcus Aureus. It is a common skin bacterium that is resistant to some antibiotics. Media reports sometimes refer to MRSA as a superbug. Staphylococcus Aureus (SA) is a type of bacteria. Many people carry SA bacteria without developing an infection. This is known as being colonised by the bacteria rather than infected. About one in three people carry SA bacteria in their nose or on the surface of their skin. MRSA bacteraemia – An MRSA bacteraemia means the bacteria have infected the body through a break in the skin and multiplied, causing symptoms. If SA bacteria.
Microbial Contamination	Inclusion or growth of harmful microorganisms (such as clostridium botulinum) in an item used as food, making it unfit for consumption.
NHS Outcomes Framework	The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on: • Domain 1 Preventing people from dying prematurely • Domain 2 Enhancing quality caring of life for people with long-term conditions • Domain 3 Helping people to recover from episodes of ill health or following injury; • Domain 4 Ensuring that people have a positive experience of care; and • Domain 5 Treating and for people in a safe environment • Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance
Risk Adjusted Mortality Index	Risk Adjusted Mortality Index – is a measure of the outcomes of care for patients. Risk Adjusted Mortality compares us to what is expected from the types of cases we manage and compares us to other similar hospitals in the country.
Summary Hospital Level Mortality Indicator	The Summary Hospital-level Indicator (SHMI) reports mortality at trust level across the NHS in England using standard and transparent methodology. The Summary Hospital Level Mortality Indicator measures whether mortality associated with hospitalisation was in line with expectations. http://www.ic.nhs.uk/CHttpHandler.ashx?id=10664&p=0

Table 32: Glossary of Terms	
Abbreviation	Glossary of meaning
Trans Ischemic Attack	Trans Ischemic Attack – A transient stroke that lasts only a few minutes. It occurs when blood to the brain is briefly interrupted
Venous Thrombo embolism (VTE)	Venous Thromboembolism (VTE) is the collective term for deep vein thrombosis (DVT) and Pulmonary Embolism (PE). A DVT is a blood clot that forms in a deep vein, usually in the leg or the pelvis. Sometimes the clot breaks off and travels to the arteries of the lung where it will cause a pulmonary embolism (PE).We can avoid many VTEs by offering preventative treatment to patients at risk.
VTE Prophylaxis	Venous Thromboembolism (VTE) Prophylaxis is preventive treatment given to patients in order to protect them from developing a blood clot that forms in a deep vein.
62 day cancer screening waiting time standard	Number of patients receiving first definitive treatment for cancer within 62 days referral from the screening programme as a percentage of the total number of patients receiving first definitive treatment for cancer following a referral from the screening programme.
Mortality Rate	Location of the latest published data can be accessed from: http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/summary-hospital--level-mortality-indicator-shmi
Patient Reported Outcome Scores	The patient reported outcome scores are for i) groin hernia surgery, ii) varicose vein surgery, iii) hip replacement surgery, and iv) knee replacement surgery http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/patient-reported-outcome-measures-proms
Emergency readmissions to hospital within 28 days of discharge	Location of the latest published data can be accessed from: http://www.ic.nhs.uk/pubs/hesemergency0910
National Patient Survey Results	The patient survey question to be monitored by the Trust is in relation to 'Responsiveness to inpatients' personal needs' http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_126972
National Staff Survey Results	The staff survey question to be monitored by the Trust is in relation to the 'Percentage of staff who would recommend the provider to friends or family needing care' Location of the latest published data can be accessed from: http://www.nhsstaffsurveys.com/
Percentage of admitted patients risk-assessed for Venous Thrombo-Embolism	Location of the latest published data can be accessed from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_131539
Clostridium. Difficile Target	Number of patients identified with positive culture for C. Difficile
Rate of Clostridium Difficile	Location of the latest published data can be accessed from: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/ClostridiumDifficile/EpidemiologicalData/MandatorySurveillance/cdiffMandatoryReportingScheme/ The following information provides an overview on how the criteria for measuring this indicator has been calculated: • Patients must be in the criteria aged 2 years and above • Patients must have a positive culture laboratory test result for Clostridium Difficile which is recognised as a case • Positive specimen results on the same patient more than 28 days apart are reported as a separate episode • Positive results identified on the fourth day after admission or later of an admission to the Trust is defined as a case and the Trust is deemed responsible
MRSA Target	Number of patients identified with positive culture for MRSA bacteraemia

Table 32: Glossary of Terms	
Abbreviation	Glossary of meaning
Rate of MRSA	The following information provides an overview on how the criteria for measuring this indicator has been calculated: • An MRSA bacteraemia id defined as a positive blood sample test for MRSA on a patient (during the period under review); • Reports of MRSA cases includes all patients who have an MRSA positive blood culture detected in the laboratory; whether clinically significant or not, whether treated or not; • The indicator excludes specimens taken on the day of admission or on the day following the day of admission; • Specimens from admitted patients where an admission date has not been recorded or where it cannot be determined if the patient was admitted, are attributed to the Trust; and • Positive results on the same patient more than 14 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where the specimens were taken.
Maximum 62 days from urgent GP referral to first treatment for all cancers	The following information provides an overview on how the criteria for measuring this indicator has been calculated: • The indicator is expressed as a percentage of patients receiving their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer; • An urgent GP referral is one which has a two week wait from the date that the referral is received to first being seen by a consultation (see http://www.dh.gov.uk/prod-consum-dh/groups/dh-digitalassets/documents/digitalassset/dh-103431.pdf); • The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait); • The clock start date is defined as the date the referral is received by the Trust; and • The clock stop date is defined as the date of first definitive cancer treatment as defined in the NHS Dataset Change Notice (A copy of this can be accessed at: http://www.ish.nhs.u/documents/dscn/dscn2008/dataset/202008.pdf. In summary this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.
Rate of patient safety incidents and percentage resulting in severe harm or death	Location of the latest published data can be accessed from: http://www.nrls.npsa.nhs.uk/resources/?entryid45=132789

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