Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Chairman's Office
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PLEASE NOTE THE LATER START TIME OF 10.30 AM

15th May 2014

Dear Colleague

Blackpool Teaching Hospitals NHS Foundation Trust – Board of Directors Meeting

A meeting of the Board of Directors of the Blackpool Teaching Hospitals NHS Foundation Trust will be held in public on Wednesday 21st May 2014 at **10.30 am** in the Board Room, Trust Headquarters (second floor main entrance), Blackpool Victoria Hospital.

Members of the public and media are welcome to attend the meeting but they are advised that this is a meeting held in public, not a public meeting.

Any questions relating to the agenda or reports should be submitted in writing to the Chairman at the above address at least 24 hours in advance of the meeting being held. The Board may limit the public input on any item based on the number of people requesting to speak and the business of the Board. Enquiries should be made to the Foundation Trust Secretary on 01253 306856 or judith.oates@bfwhospitals.nhs.uk.

Yours sincerely

J A Oates (Miss)
Foundation Trust Secretary

A G E N D A

Agenda Item Number	Agenda Item	Duration
1	Chairman's Welcome and Introductions – Mr Johnson to report. (Verbal Report).	10.30 am
2	Declaration of Board Members' Interests Concerning Agenda Items – Mr Johnson to report. (Verbal Report).	10.35 am
3	Patient Story – **Mrs Mary Whyham, Patient Carer and Chairman at North West Ambulance Service, to attend for this item.**	10.36 am

4	Apologies for Absence – Mr Johnson to report. (Verbal Report).	10.56 am
5	Minutes of the Previous Board of Directors' Meeting held in Public on 30th April 2014 – Mr Johnson to report. (Enclosed).	10.57 am
6	Matters Arising:- a) Action List from the Previous Board of Directors' Meeting held in Public on 30th April 2014 – Mr Johnson to report. (Enclosed).	11.02 am
7	Overview of Challenges and Debates Outside Formal Board Meetings from Non-Executive Directors and Executive Directors - Board Members to report. (Verbal Report).	11.12 am
8	Chief Executive's Report:- a) Annual Report & Accounts and Quality Report – Mr Bennett/ Mrs Thompson to report. (Enclosed). b) Governance Review: Terms of Reference/KPMG Report – Mr Roff to report. (Enclosed). c) Assurance Report from the Chief Executive and Board Statutory Committees/Board Sub-Committees/Reporting Committees. (Enclosed):- • **Quality** • **Risk** • **Workforce** • **Audit** • **Finance** • **Strategy** d) Chief Executive's Update. (Enclosed).	11.17 am
9	Chairman's Report:- a) Chairman's Update. (Enclosed). b) Annual Declarations of Interests. (Enclosed).	12.17 pm
10	Attendance Monitoring – Mr Johnson to report. (Enclosed).	12.22 pm
11	Any other Business – Mr Johnson to report. (Verbal Report).	12.23 pm
12	Items Recommended for Decision or Discussion by Board Sub-Committees. (Verbal Report).	12.24 pm
13	Questions from the Public – Mr Johnson to report. (Verbal Report).	12.25 pm
14	Date of Next Meeting – Mr Johnson to report. (Verbal Report).	12.35 pm
15	Resolution to Exclude Members of the Media and Public The Board of Directors to resolve "That representatives of the media and other members of the public be excluded from Part Two of the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest." in accordance with Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960) and the Public Bodies (Admissions to Meetings) (NHS Trusts) Order 1997.	12.36 pm
		Total Duration – 2 hours, 7 minutes

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Minutes of the Blackpool Teaching Hospitals NHS Foundation Trust
Board of Directors Meeting Held in Public
on Wednesday 30th April 2014 at 9.30 am
in the Board Room, Trust Headquarters, Blackpool Victoria Hospital

Present: Mr Ian Johnson – Chairman

Non-Executive Directors

Mr Jim Edney
Mr Doug Garrett
Mr Alan Roff
Mr Tony Shaw

Executive Directors

Mr Gary Doherty – Chief Executive
Mr Tim Bennett – Director of Finance
Mrs Nicky Ingham – Director of HR & OD
Dr Mark O'Donnell – Medical Director
Mrs Pat Oliver – Director of Operations
Mrs Marie Thompson – Director of Nursing and Quality
Mrs Wendy Swift – Director of Strategy/Deputy Chief Executive *

In Attendance: Mr David Holden – Interim Deputy Director of Clinical Affairs & Governance
Miss Judith Oates – Foundation Trust Secretary

Governors

- Mrs Sheila Jefferson – Public Governor (Fylde Constituency)
- Mr Cliff Chivers – Public Governor (Blackpool Constituency)
- Mr Clive Barley – Public Governor (Fylde Constituency)
- Mrs Gillian Wood – Public Governor (Fylde Constituency)
- Mr Ramesh Gandhi – Public Governor (Wyre Constituency)

Members of Public - 5

30/14 Chairman's Welcome and Introductions

The Chairman welcomed attendees to the Board meeting in public which was taking place in the new Board Room and asked that it be brought to his attention if the proceedings were not visible and audible.

The Chairman outlined the house-keeping rules in respect of fire alarms and mobile phones and advised that there would be a break at some point during the meeting.

It was noted that the Chairman had not received any questions from members of the public in advance of the meeting, however, he stated that he would, if time permitted, take two or three questions from members of the public at an appropriate point during the meeting.

* Non-Voting Executive Director

The Chairman advised members of the public that one of the key issues for the Board was to assure itself of the safety and quality of the services provided by the Trust, both in hospital and in the community. The Chairman further advised that the Board was also focusing on strategy, involving not only this Trust but neighbouring Trusts, Commissioners, etc, and that the Council of Governors would be involved in discussions around strategy.

The Chairman stated that if Governors/members of the public had any comments regarding the content of the meeting to write to him following the meeting.

31/14 Declarations of Interests

The Chairman reminded Board members of the requirement to declare any interests in relation to the items on the agenda.

It was noted that there were no declarations of interests in relation to the items on the agenda.

32/14 Patient Story DVD

The Chairman explained that patient story DVDs were shown at Board meetings to give the Board and members of the public the opportunity to hear about some of the positive and negative issues experienced by patients and their relatives.

Dr O'Donnell advised the Board that this was a negative story from a patient's relative who had expressed his annoyance at the inconvenience and service his wife and he received when she was required to attend a clinic for an intravenous anti-biotic over a bank holiday weekend.

Following the DVD Dr O'Donnell pointed out that the positive aspect to this story was that the recently introduced scheme had resulted in patients not having to be admitted to hospital for treatment.

Dr O'Donnell stated that it was not acceptable that the patient could not gain access to the building and that the attitude from staff was less than helpful; it being noted that this had resulted in a formal complaint which was currently being investigated.

Mrs Thompson stated that the HPAT service had a particularly good reputation, however, consideration needed to be given to patient referrals, particularly out of hours.

It was noted that the relative had met twice with the Patient Relations Team and discussions had revealed a poor communication process and lack of processes in place for out of hours treatment. With regard to access to the building, it was reported that part of the improvement work was to introduce a "meet and greet" arrangement. It was further noted that the relative had met with the Team Leader who had conveyed feedback to staff and the relative had subsequently received a formal apology. In addition, the relative had worked with the team to share his story and had found that to be helpful.

In summary, it was noted that this had been a negative experience but there had been some lessons learned in terms of out of hours treatment and understanding links with the HPAT team.

The Chairman reiterated Dr O'Donnell's comments about the positive aspect of the service and the fact that treatment was being provided on a Bank Holiday.

Mr Doherty acknowledged that the basic issues around access to the building and staff attitude were not acceptable and pointed out that there were lessons to be learned regarding service planning and communicating with patients.

33/14 Apologies for Absence

Apologies for absence were received from Mrs Karen Crowshaw and Mrs Michele Ibbs.

34/14 Minutes of the Previous Board of Directors Meeting Held in Public

RESOLVED: That the minutes of the previous Board of Directors Meeting held in public on the 26th February 2014 be approved and signed by the Chairman, subject to the following amendment:-

Page 6 – Item 22/14 (a) – CEO Assurance Report – A & E Waiting Times – Seventh Bullet Point to read: "there were lessons to be learned in terms of the reporting mechanisms for *mixed sex* breaches.

35/14 Matters Arising:-

a) Action List from the Board of Directors Meeting held on 26th February 2014

It was noted that all actions had been completed.

b) Action Tracking Document

It was noted that there was one outstanding item on the action tracking document which was expected to be actioned by the timescale of 21st May 2014.

36/14 Overview of Challenges and Debates Outside Formal Board Meetings from Non-Executive Directors and Executive Directors

Mr Garrett reported that he had observed the Blackpool CCG Board Meeting on the 1st April 2014 and provided feedback as follows:-

- The majority of the discussion was around end of year issues.
- There was some debate about failure of the A & E targets and the CCG's decision to impose a penalty of £24,000; it being noted that there had been acknowledgement that there were pressures from elsewhere other than A & E but not from outside the hospital.
- The work being undertaken by Oliver Wyman was widely supported by the CCG but not by the Council.

Mr Garrett stated that he had provided feedback directly to Mr Doherty immediately following the meeting. Mr Doherty acknowledged that the CCG needed to respond regarding the Trust's failure to meet the A & E target but advised that there was a formal mechanism in place for imposing penalties.

Mr Roff reported that he had observed the Fylde & Wyre CCG meeting on the 25th March 2014 and that their discussions had included performance around A & E targets for both Blackpool and Preston; it being noted that their view was that it was a hospital issue.

Mr Edney welcomed the report from Mr Garrett and Mr Roff which highlighted important issues and he pointed out the need to obtain a holistic view of the cause of the problems in A & E and to continue to engage with the CCGs regarding their involvement. The Chairman pointed out the need for internal communication to ensure that staff were aware of the problems.

With regard to the contractual element, Mr Bennett reported that formal contract meetings took place with both local CCGs on a monthly basis and he reiterated Mr Doherty's comment about the processes in place for imposing penalties.

It was noted that Mrs Oliver was leading a review team which had been tasked with investigating the reasons for under-achievement in A & E and recommending improvements, following which a decision would be made regarding contractual remedies.

Mrs Shaw suggested that the problems in A & E were being created by increased attendances due, in some part, to the public not being able to book appointments with GPs within short timescale.

Mrs Swift emphasised the importance of resolving this issue and engaging public health in strategic work.

The Chairman commented that it was really helpful to have a NED representative at the CCG meetings, even in an observer capacity.

At this juncture, the Chairman commented that this was the first Board meeting since the results of the CQC visit had been published and confirmed that all issues would be addressed by the Executive Team.

37/14 a) Assurance Report from the Chief Executive and Board Committees/ Reporting Committees:-

Introduction

The Chief Executive reported on the year end position as follows:-

Quality

The message for 2013/14 was that high assurance could be given to the Board that there had been significant improvements in quality within the organisation and that plans had been delivered, however, there was a balance between areas where the Trust had performed well and areas where the Trust could, and should, have performed better.

Mr Doherty highlighted areas where there had been positive improvements in quality, some of which had been discussed by the Quality Committee:-

- In-Patient Survey
- Friends and Family Test
- SHMI
- Pressure Ulcers
- Falls Prevention
- VTE
- Nursing Care Indicators

Mr Doherty highlighted the areas of limited assurance, in particular A & E.

It was noted that A & E performance had improved during April, with the targets being achieved for three consecutive weeks and delivery being expected for the current week and thereafter, however, assurance remained limited and further improvements were needed, together with an understanding of how to predict and manage performance.

RESOLVED: **That Mrs Oliver would establish an Assurance Group, with appropriate Non-Executive Director and clinical involvement, to provide assurance to the Board regarding plans to improve waiting times in the A & E Department.**

Mr Doherty referred to other key issues, namely stroke, dementia and never events; it being noted that a number of actions were referred to in the report.

Mr Roff challenged the performance relating to stroke and Dr O'Donnell explained that there were significant delays in transferring patients from A & E to the stroke team and that plans were in place to address this. Mr Doherty stated that investment had been made in nurse staffing on the Stroke Ward and additional consultants in A & E.

Mr Garrett pointed out that, due to the nature of Blackpool, there was a variety of people who would influence the flow of patients to A & E and he asked for an insight into any discussions that had taken place. Mrs Oliver reminded the Board of the extremely busy period during the heatwave in July last year and advised that a task and finish group had been established to discuss the summer plan and produce a heatwave plan. It was noted that one of the challenges was persuading Blackpool Council to invest money in healthcare. Mr Garrett commented that the Blackpool Town Centre Management Team would be a good contact for the Trust. It was noted that the facilities at Whitegate Health Centre would be publicised and that there would be a survey of patients who had attended A & E and a communications campaign led by Commissioners.

The Chairman commented that he was pleased to hear about the focus and pace on dementia and stroke.

Action Taken Following The Meeting
The Assurance Group is in the process of being arranged.

Finance

Mr Doherty provided a brief description of the year end position confirming that, subject to audit, the Trust would deliver a surplus of £3.2 million and a CoSR rating of 3.

With regard to 2014/15 and 2015/16, Mr Doherty reported that there would be major challenges for the Trust, specifically to reduce costs by £20 million each year; it being noted that there was likely to be a small deficit of £1.3 million in 2014/15 and small surplus of £2.3 million in 2015/16.

Reference was made to the draft income and expenditure plan which included a possible CoSR of 2 for both 2014/15 and 2015/16.

Reference was also made to the plans to deliver the cost reduction plan which totalled £20 million, £9 million of which related to high risk items.

The Chairman pointed out the need to improve quality at a reduced cost which would be a significant challenge for the Trust.

At this juncture the Chairman provided feedback from the Finance Committee meeting held on 28th April and confirmed that the Committee was able to give full assurance regarding the achievement of last year's financial plan.

The Committee had emphasised the importance of financial forecasting and had noted the measures being taken to improve this and the need to improve performance management not just in relation to finance but also quality and HR. It was noted that further feedback was to be provided at the next Finance Committee meeting.

The Committee had also discussed capital expenditure and had emphasised the need to have a strategic plan and the need to ensure that any essential capital expenditure was safeguarded within the strategic plan.

Mr Shaw referred to the CIP and expressed concern about the high risk category and the fact that there would be no evidence of savings until at least Month 8 and he challenged whether the finance team would have evidence of savings in the early stages. Mr Edney asked about the timescale for schemes transferring from red to amber/green. Mr Bennett advised that there was a trajectory for schemes transferring from red to amber and from amber to green. Mr Bennett stated that it was a significant challenge and that colleagues were right to point out their concerns, however, there was a plan in place to monitor the schemes.

Mr Bennett reported that a CIP Board had been established whose remit was to ensure that improvements were made; it being noted that the first meeting had taken place the previous week when detailed discussion had taken place regarding a number of the identified schemes. It was noted that the CIP Board was also reviewing the "going concern" concept and various scenarios had been modelled and contingencies and mitigations identified which would be discussed by the Finance Committee.

Mr Bennett also reported that he had recently received a telephone call from the Trust's Relationship Manager at Monitor advising that, because the Trust had submitted a plan with a CoSR of 2, the Trust was now on routine monthly monitoring, therefore additional work would be required to support this process.

The Chairman reported that the regular conference calls with Monitor were continuing, initially around performance in Quarter 1 but now in relation to finance, therefore it was no surprise that the Trust was now on monthly monitoring.

Mr Doherty reported that the CIP Board had discussed in detail three schemes, namely, Out-Patients, Theatres and Better Care Now and that attendees had been asked to take the scheme to the next level for discussion at the next meeting. Mr Doherty reported that a further three areas had been identified for discussion at the next CIP meeting, namely, Procurement, Agency Spend and Corporate.

Mr Roff appreciated all the work undertaken by the Director of Finance and colleagues regarding the end of year rating and the Chairman endorsed Mr Roff's comments.

The Chairman suggested that arrangements be made to visit Monitor to report on the Trust's plans and Mr Bennett agreed that it would be proactive to present a clear financial plan and evidence for the two year programme resulting in a balanced position by end of 2015/16.

Audit

Mr Edney reported that a meeting of the Audit Committee had taken place the previous day and that the assurance report was currently being drafted and feedback would be provided to the Board at the next meeting.

At this juncture, the Chairman gave members of the public an opportunity to ask questions.

Sheila Jefferson – Public Governor (Fylde Constituency)
Mrs Jefferson asked whether the Trust tendered for regular medical supplies or office supplies in order to be able to compare costs.

Mr Bennett confirmed that the Trust did tender for supplies but that the process varied and some products were procured through collaborative arrangements.

Workforce

Mrs Ingham gave a presentation highlighting workforce issues (key highlights of performance, strategy and information) and the staff survey (results and improvement actions).

With regard to sickness absence, it was noted that the target of 3.5% had not been achieved, however, Mrs Ingham advised that there would be one attendance management policy for the whole organisation by May 2014.

Mrs Ingham explained that she had been working on the workforce strategy since she came into post and that there had been some emerging themes from a number of focus groups held with staff from across the Trust.

With regard to the staff survey, Mrs Ingham stated that the Trust should be proud of the results, however, the Board should not be complacent as there were areas for improvement.

Board members were advised that the national quarterly "Staff Friends and Family Test" would be introduced from June 2014 which would be a key indicator of staff engagement.

With regard to medical vacancies, it was noted that the consultant recruitment process was currently being reviewed; it being acknowledged that the process needed a complete overhaul.

Mr Roff welcomed the information and the Chairman thanked Mrs Ingham for her informative presentation.

At this juncture the Chairman referred to the Major Incident Plan and Pandemic Flu Plan detailed in the Chief Executive's Assurance Report and advised that the updated documents, which had been approved by the Emergency Planning Steering Committee, needed to be ratified by the Board.

RESOLVED: That the Major Incident Plan and /Pandemic Flu Plan be ratified by the Board.

Strategy

Mr Doherty drew attention to the "plan on a page" which identified three workstreams, namely, community-centred care, in-hospital care and Lancashire partnerships, all of which had an element of significant challenge going forward and would require working differently.

It was noted that the plan on a page was intended as a form of communication, both internally and with key stakeholders.

Mr Shaw congratulated the team on being able to clearly set out the key fundamental issues on one page.

Dr O'Donnell stated that he was strongly in support of the proposed strategy which provided an excellent sense of direction and which needed endorsement by the Board in order that it could be rolled-out both within and outside the organisation.

The Chairman referred to the Trust's tertiary services which were excellent and an important part of the Trust.

The Chairman expressed thanks to Mrs Swift and her team for the work undertaken to date in respect of the strategy.

RESOLVED: That approval be given to the vision, values, quality goals and strategic objectives.

That approval be given to the strategic outline for the three workstreams.

b) Review of Strategic and Compliance Reporting Measures

Reference was made to the draft report which had only been available to Board members the previous day.

RESOLVED: That Board members would review the content of the report and provide feedback to Mrs Swift.

Action Taken Following The Meeting
Feedback has been provided to Mrs Swift and an updated version of the report will be discussed at the Strategy & Assurance Committee meeting on the 25th June 2014.

c) Quarterly Monitoring Return to Monitor – Quarter 4

The Chairman referred to the quarterly Governance Statement to Monitor which recommended completion of "Not Confirmed" for Finance and "Confirmed" for Governance.

RESOLVED: That the Quarter 4 Monitoring Return be approved for signature by the Chairman and Chief Executive and for submission to Monitor.

d) CQC Hospital Inspection Report

Mrs Thompson gave a presentation regarding the CQC inspection using the slides shared by Sir Mike Richards at the Quality Summit on the 28th March 2014.

It was noted that, although the Trust had been given a rating of "requires improvement", a significant number of areas had been rated "good".

Dr O'Donnell highlighted two areas rated "outstanding" which Sir Mike Richards had commented on, namely, Children's Services and End of Life Care.

Dr O'Donnell referred to one of the issues which had been identified as "must take action to improve" which related to the high levels of post-partum haemorrhage (PPH) and subsequent high rates of hysterectomy. Dr O'Donnell explained in detail the background to this issue and the governance processes already in place prior to publication of the CQC report and the actions being implemented subsequent to publication of the CQC report.

With regard to the previously identified actions, it was noted that the Trust had invited the Royal College of Obstetricians and Gynaecologists to carry out a review of the PPH cases and it was noted that the team were currently on site and would be able to provide initial feedback later in the day followed by a report within a few weeks.

Mr Roff referred to the action relating to medical records and asked about the timescale for improvements. Dr O'Donnell responded that the improvements related to the records of current or new patients and would involve providing a divided record for correspondence and notes.

Mr Roff asked for an update to be provided to the Board regarding EDMS (Electronic Document Management System).

RESOLVED: That an update in respect of EDMS would be provided to the Board in June 2014.

In summary, it was noted that there were areas where improvements were needed and the Executive Team was confident that the necessary improvements would be made.

The Chairman expressed thanks to all those involved in the visit, inspection and follow-up.

Mrs Thompson reported that the Trust was required to submit a high level action plan to the CQC within one week of the Quality Summit and that this had been achieved and had been shared with Monitor. Mrs Thompson further reported that a detailed action plan had been prepared and the most recent update had been circulated to Board members the previous evening and, subject to further updates, would be forwarded to the CQC by the end of the week.

Board members were advised that there were a number of compliance actions within the report which were currently being finalised.

Board members were asked to approve the action plan, subject to including the compliance actions.

RESOLVED: That the CQC action plan be approved.

Action Taken Following The Meeting
An update in respect of EDMS will be provided at the Board Seminar in May 2014.

e) Nursing and Midwifery Staffing Establishment Review and Implementation of National Quality Board Guidance

Mrs Thompson presented the six monthly staffing review which provided details of the current level of nursing and midwifery staffing; it being noted that this information had been submitted to the Quality Committee and also reported to the Finance Committee.

Mrs Thompson outlined the "next steps" and requested approval from the Board.

It was noted that the detail would be reviewed by the Quality Committee with assurance provided to the Board.

It was also noted that a further report would be submitted to the Board in the Autumn to include proposals regarding further investment, if required, in advance of the budget setting process.

Reference was made to section 3 of the report which outlined the Trust's current position in relation to the National Quality Board's ten expectations under six themed headings; it being noted that Mrs Thompson and Mrs Ingham were currently actioning expectation 2 relating to "staffing establishments being achieved on a shift to shift basis" with the aim of providing a report to the Board in June providing a retrospective view on the staffing establishments; it being noted that this information was difficult to generate at present and work was on-going with the e-rostering provider to resolve.

RESOLVED: That the proposed actions be approved.

f) Draft Annual Report & Accounts and Quality Report

The Chairman drew attention to the Annual Report and Accounts and asked Board members to provide any further comments by 12th May 2014 prior to the document being finalised on the 21st May 2014.

g) Chief Executive's Update

The Chief Executive's Update, which reflected the range of his work, was provided for information.

38/14 **Chairman's Report**

a) Confirmation of Chairman's Action

Details of the action taken by the Chairman on behalf of the Board of Directors were provided for approval.

RESOLVED: That the action taken by the Chairman on behalf of the Board be confirmed.

b) Affixing of the Common Seal

Board members were requested to confirm the affixing of the Common Seal in respect of documents relating to the Main Entrance Retail Units and Cardiac Framework Agreements.

RESOLVED: That the affixing of the Common Seal be approved.

c) Chairman's Update

The Chairman's Update, which reflected the range of his work, was provided for information.

39/14 Attendance Monitoring

The Chairman referred to the attendance monitoring form and stated that the Board meetings continued to have good attendance from directors.

40/14 Any other Business

a) Bowel Screening

Dr O'Donnell referred to the Bowel Screening Service and drew attention to an IT issue at the host Commissioner; it being noted that this was being reported to the Board because the Trust currently hosted the Bowel Screening Service for the North West.

41/14 Items Recommended for Decision or Discussion by Board Sub-Committees

RESOLVED: That items to be recommended for decision or discussion by Board Sub-Committees would be noted from the minutes of the meeting.

42/14 Questions from the Public

There were no questions from members of the public other than those raised under item 37/14 (a).

43/14 Date of Next Meeting

The next Board Meeting held in public will take place on Wednesday 21st May 2014 at 10.30 am; it being noted that the later start time was due to the Audit Committee meeting taking place immediately before the Board meeting to consider the Annual Report and Accounts 2013/14 prior to sign-off by the Board.

44/14 Resolution to Exclude Members of the Media and Public

The Chairman explained that some items needed to be discussed by the Board in private (Part Two) but assured members of the public that the majority of items were discussed in public (Part One).

The Chairman stated that the Board was now required to discuss items of a confidential and commercially sensitive nature which would not be disclosed under a Freedom of Information request.

RESOLVED: That representatives of the media and other members of the public be excluded from Part Two of the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest." in accordance with Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960) and the Public Bodies (Admissions to Meetings) (NHS Trusts) Order 1997.

Board of Directors Meeting Held In Public

Action List - 30th April 2014

Minute Ref	Date of Board Meeting	Issue	Item to be Actioned	Person Responsible	Date to be Completed	Change of Date	Progress	Current Status	RAG Status
37/14 (a)	30.4.14	**CEO Assurance Report - Quality**	Establish an Assurance Group, with appropriate NED and clinical involvement, to provide assurance to the Board regarding plans to improve waiting times in the A & E Department.	Pat Oliver	21.5.14		This is in the process of being arranged.	Incomplete But Within Date For Delivery	Amber
37/14 (b)	30.4.14	**Review of Strategic and Compliance Reporting Measures**	Review the content of the report and provide feedback to Wendy Swift in advance of further discussion.	Board Members	25.6.14		Feedback has been provided to Wendy Swift and an updated version of the report will be discussed at the SAC meeting on 25.6.14.	Incomplete But Within Date For Delivery	Amber
37/14 (d)	30.4.14	**CQC Hospital Inspection Report**	Arrange for an EDMS update to be provided to the Board.	Wendy Swift	21.5.14		An update will be provided at the Board Seminar in May 2014.	Incomplete But Within Date For Delivery	Amber

RAG Rating	
Green	Complete within date for delivery
Amber	Incomplete but within date for delivery
Red	Not complete within date for delivery
White	Not yet due

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Board of Directors Meeting

21st May 2014

Subject:	Annual Report and Accounts/Quality Report
Report Prepared By:	Tim Bennett, Director of Finance Marie Thompson, Director of Nursing and Quality David Holden, Interim Deputy Director of Corporate Affairs and Governance
Date of Report:	15th May 2014
Service Implications:	The Annual Report and Accounts sets out the Trust's business activities over the last year 1st April 2013 – 31st March 2014.
Data Quality Implications:	Data quality implications if the data is not an accurate reflection.
Financial Implications:	The Annual Report and Accounts details the Trust's business activities covering the period 1st April 2013 – 31st March 2014.
Legal Implications:	The production of the Annual Report and Accounts is a requirement of the Trust's Terms of Authorisation.
Links to the Principles of The NHS Constitution	Links to the Principles 1-7
Links to the Blackpool Way:	Continuous Improvement – it is a requirement of the Trust's Terms of Authorisation to submit our Annual Report and Accounts to Monitor.
Links to Key Organisational Objectives:	The Annual Report and Accounts sets out how the Trust has met its objectives over the last year 1st April 2013 – 31st March 2014.
Links to Care Quality Commission Quality and Safety Standards	Links to all CQC outcomes
In case of query, please contact:	Tim Bennett, 01253 306770, tim.bennett@bfwh.nhs.uk David Holden, Interim Deputy Director of Corporate Affairs and Governance (Ext 5520)

Purpose of Paper/Summary:

The production of an Annual Report and Accounts and Quality Accounts is a requirement of the Trust's Terms of Authorisation. The statutory requirements for the content, preparation and submission required to satisfy Monitor is set out in the NHS Foundation Trust Annual Reporting Manual.

Key Issues:

The Annual Report and Accounts and Quality Accounts has been developed to ensure that the Trust will meet Monitor's submission deadlines.

The draft Quality Accounts has been issued to local stakeholders and a statement has been requested from the Council of Governors, Blackpool Clinical Commissioning Group, Fylde and Wyre Clinical Commissioning Group, Healthwatch Blackpool, Healthwatch Lancashire, Lancashire Health Overview and Scrutiny Committee and Blackpool Health Overview and Scrutiny Committee. Comments received have been included verbatim within the Quality Accounts and any further comments will be included prior to the report being printed.

A Summary Report will be developed for both the Annual Report and Accounts and the Quality Accounts.

The Board is asked to:

- Approve the Annual Report and Accounts 2013/14.
- Approve the Quality Accounts 2013/14.

Risk Rating (Low/Medium/High): Medium **BAF/CRR Number:** BAF 117	**Board Review Date:** May 2015

Report Status – the Author must indicate whether the document is "for information", "for discussion" or "for approval" (please tick).		
1 **For Information** [ ]	**2** **For Discussion** [X]	**3** **For Approval** [X]

Document Status – the Author must indicate the level of sensitivity of the document (please tick). This relates to the general release of information into the public arena.		
1 Not sensitive: **For immediate publication** [X]	**2 Sensitive in part:** **Consider redaction prior release** [ ]	**3 Wholly sensitive:** **Consider applicable exemption** [ ]
Reason for level of sensitivity selected (exemptions attached):	The contents of the report are not sensitive.	

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Blackpool Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts 2013-14

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

(v21 (14.05.14)

Contents

Chairman's and Chief Executive's Statement

The past 12 months has been a year of on-going change within the organisation from new infrastructures to innovative improvements in care, treatments and services.

We have seen a marked reduction in mortality, passed the year milestone for remaining MRSA free, developed successful new clinical pathways, as well as developed the Better Care Now Programme.

Blackpool Teaching Hospitals has also undergone a major investment programme with the opening of our new main entrance, multi-storey car park and midwifery unit. This investment has not been confined to infrastructure, we have also undergone a major recruitment drive which has led to more than 180 new nurses and 45 doctors being employed by the Trust.

Quality and safety of patient care has remained our key priority and the publication of the Keogh Report in the summer highlighted a number of areas of good practice, as well as areas for improvement.

These have been embraced through our Better Care Now Programme which sets the highest possible standards of care, focussing on clinical pathways, waiting times and ensuring we have the right professional workforce with the right skills to deliver high quality care.

The pathways focus particularly on the first 24-36 hours of patient care to ensure that the right care is given by the right person at the right time. The pathways are strictly audited and in present 'real time' feedback so we can address areas where we need to improve quickly.

We have recorded excellent results from these initiatives, the recent nationally released Summary Hospital Mortality Index (SHMI) figures show a reduction from 126 to 117 comparing March 2012 to March 2013 and our current calculation shows a rolling 12 month figure to December 2013 of 112. For all mortality rates a comparison is made between the number of actual deaths for an individual population and the expected number of deaths for the hospital population of England and Wales. A score of 100 is taken as the average. Given the actions underway we project a figure of 110.9 by the end of April 2014, which will be within the expected range for this Trust.

Since the Keogh Review Team visited the Trust we have been under intense monitoring which we have welcomed and embraced as reassuring our patients about the quality of service received at Blackpool Teaching Hospitals. We have met both the Independent Regulator of NHS Foundation Trusts (Monitor) and the Care Quality Commission (CQC) on a monthly basis to report on progress and have demonstrated real improvements delivered at a rapid pace.

In January the CQC carried out an inspection of Blackpool Teaching Hospitals using their new hospital inspection methodology which gives possible ratings of; inadequate, requires improvement, good and outstanding. The report shows the majority of the areas they looked at were rated as "good" – of the 68 ratings given 42 were good, two were "outstanding", 22 were "requires improvement" and two areas were deemed "inadequate". The overall rating for Blackpool Victoria Hospital was "requires improvement" whilst the overall ratings for both Clifton Hospital and Fleetwood Hospital were "good". The overall rating for the Trust was "requires improvement". As we would expect, the CQC identified areas for improvement, many of which we are already working on and making progress. We must focus on those areas where improvement is needed. Based on the progress we have already made, we are confident we can tackle these issues and reach the stage where all our ratings are at least "good". The levels of care and commitment at the Trust are exceedingly high and both the hospital and the Trust overall received a "good" rating for care.

We have also welcomed a new initiative to hold regular Quality Assurance Reviews from our Clinical Commissioning Group (CCG). We had the first of these visits in November with a team visiting our Families Division which found substantial progress in all areas.

The Trust was delighted to announce that it had been more than one year without any reported MRSA bacteraemia cases. In 2006/07 there were 49 cases of MRSA, therefore the improvement is a great achievement which has been accomplished by excellent infection prevention practices. The challenge now is to ensure we maintain our focus on all Healthcare Acquired Infections and remain diligent and follow best practice at all times.

More than £16m has been invested in a new main entrance and multi-storey car park at Blackpool Victoria Hospital. The new entrance gives us an impressive focal point for the hospital allowing patients a better experience from arrival with a main reception, waiting areas, pharmacy, retail units and café. The building is linked to the new multi-storey car park which has secure parking for more than 1,000 cars. This new infrastructure has also given the Trust the opportunity to improve the wayfinding signage around the site. The new structures are a major step forward in the provision of high quality patient care, providing better access to the hospital for patients, visitors and staff.

In August 2013 we opened a £680,000 state-of-the-art midwifery-led unit, which offers a home-from-home birthing environment for expectant mums. The unit runs independently from the existing delivery suite, but is situated just next door, giving mums the option of a less hospital intensive birthing experience but with the safety of the consultant-led facilities just feet away should the need arise. This unit has dramatically improved birthing choices for women and their families who can now choose to have their baby at home, in the delivery suite or in the new unit.

The Trust also officially unveiled its new medical simulation centre this year which offers the latest facilities for health professionals to learn new skills in a simulated hospital environment without compromising patient safety. The realistic rooms are equipped with the latest medical technology and equipment and are home to a family of sophisticated life-sized manikins who are programmed to replicate a number of conditions in unwell adults, children and babies.

During the year, six of our community nurses received one of the profession's highest accolades. The six members of staff were given the title of Queen's Nurse by the Queen's Nursing Institute. The honour is only given to a small number of community nurses each year in recognition of their outstanding contribution to quality of practice and attention to client and patient care. Five of the nurses are from the Blackpool Family Nurse Partnership and the sixth nurse is from the Community Health Monitoring Team. Well done to all of them, an amazing achievement.

The accolades didn't stop there – the Trust's maternity team won the Women's Health Category at the National Care Integration Awards for their integrated care pathway for pregnant women who misuse substances. The pathway resulted in a dramatic reduction in the number of babies requiring admission to specialised neonatal care for the management of withdrawal from drugs.

The Trust's Human Resources team scooped a national Healthcare People Management Award for its coaching and personal development programme and Blackpool Victoria Hospital's Clinical Research Centre beat off stiff competition from some of the country's biggest organisations to take bronze in the PharmaTimes Clinical Research Site of the Year category.

Locally, more than 250 members of staff were honoured for their dedication, commitment and loyalty at the annual Staff Achievement Awards and a record number of entries were received this year in our Celebrating Success Awards.

The NHS Friends and Family Test was introduced to the Trust in April 2013 which is a major step forward in giving patients a greater voice. Blackpool Teaching Hospitals NHS Foundation Trust's 'Transforming the Patient Experience Agenda' has been instrumental in making the organisation more patient and family centred in 2013, with a comprehensive patient feedback system to ensure all service users needs are considered in every decision it makes locally, both at a clinical and a policy level. This has made the organisation a lot more accessible and accountable to patients and their representatives. From weekly ward spot surveys to patient panels and digital first-person patient experiences, patients can now easily and regularly tell us how they feel about their treatment and see first-hand how their feedback is driving improvements. Since the introduction of the Friends and Family Test, the Trust has scored better than the national average. Increasing the patient's voice is fundamental to improving patient care and since the agenda was launched there has been a surge in the amount of feedback the Trust receives, both positive and negative, enabling the Trust to provide better services and, as part of our patient experience initiative, the Trust has also pledged its support for the new "hello my name is" campaign aimed at putting patients at ease with the member of staff who is caring for them.

We believe care starts from the first moment a patient meets a health professional and a proper introduction is the first step to providing compassion and helps put patients at ease whilst using our services.

During the year there have been changes to the Board of Directors with Nicky Ingham appointed to the post of Director of Workforce and Organisational Development and Tim Bennett taking up the role of Director of Finance.

Signed:

Date: 21st May 2014

Ian Johnson
Chairman

Signed

Date: 21st May 2014

Gary Doherty
Chief Executive

Hospital Highlights

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

Para-Olympian Shelly Woods officially opens new Haematology and Oncology Unit

BRITISH Para-Olympian Shelly Woods officially opened the new Haematology and Oncology Day Unit at Blackpool Victoria Hospital.

The Unit opened thanks to funding from Trust charity Blue Skies Hospitals Fund and the League of Friends of Blackpool Victoria Hospital.

The build cost around £500,000 in total to bring to fruition with Blue Skies Hospitals Fund putting £195,000 towards the costs and the League of Friends BVH providing a further £125,000. The Kay Kendall Leukaemia Fund also donated £21,373 towards the build which was spent on furniture and equipment for the Haematology Day Unit.

PIC: Shelly Woods opens the unit looked on by Head of Fundraising Kathy Ancell, Chairman Ian Johnson, Consultant Haematologist Paul Kelsey and Chairman of the League of Friends BVH Larry O'Hara.

PIC: Members of the clinical team with Shelly.

Magical volunteers

THE Trust's volunteers were thanked for giving their time and effort at a special celebration evening.

One hundred and twenty volunteers from acute and community care settings attended the 'Magic of Volunteering' event last Thursday at the De Vere Hotel, Blackpool, which included a three course meal and spectacular entertainment from magician Paul Roberts and comedian Mick Miller.

The Trust volunteers, whose ages range from 16 to 94, perform a variety of duties which complement the work of our paid staff, including helping visitors to navigate their way through the hospital, assisting patients during meal times, collecting patient survey feedback, providing clerical support and working on hospital radio.

At the event they were all praised for their efforts by Volunteer and Community Engagement Officer, Jane Iceton, who tanked the volunteers for their wonderful efforts to improve the quality of patient experience within Blackpool Teaching Hospitals.

As part of the evening a number of volunteers were awarded certificates for completing more than 100 hours of service at the Trust in a new scheme called 'Healthy Futures'

PLACE Assessment

THE Trust has thanked volunteers who helped assess local sites as part of the national Patient Led Assessment of the Care Environment (PLACE) programme. The volunteers are largely provided by the local Healthwatch organisation.

PLACE previously the Patient Environment Action Team (PEAT) study, was changed to ensure it was an independent 'patient led Assessment' with the patient's voice playing a significant role in the result of the survey.

Environment assessments are carried out at ward and departmental level, from a patient perspective with each PLACE visit generating a score in the four areas of cleanliness, food & hydration, privacy, dignity and confidentiality and buildings & grounds.

Nigel Fort, Assistant Director of Clinical Support and Facilities Management at the Trust, said: "The Trust has been extremely fortunate in working in partnership with external patient assessors who have made this new process possible. With their help we have achieved scores in all above areas that were higher than National Average."

Accreditations

Five-star service

FOR the third year running patients can be assured of the highest standards of hygiene in their local hospital kitchen.

Blackpool Teaching Hospitals NHS Foundation Trust kitchen staff are celebrating after being awarded a five star rating for their food hygiene – the highest rating achievable nationally by the Food Standards Agency.

The hospital is assessed by Blackpool Borough Council who make an unannounced visit. An Environmental Health Officer checks the kitchen, looks at how food is prepared and cooked, the food hygiene systems and temperature records.

The award means patients can continue to have confidence in the standards of catering services they are receiving and that the Trust produces food in a safe manner. The kitchens produce more than 3,000 meals every day for inpatients, staff and external visitors.

Excellence award

A BUILDING excellence award has been bestowed on Blackpool Victoria's £40m Surgical Centre. The development, which opened in March 2012, was praised for its quality and complexity at the awards organised by Blackpool Borough Council who praised the quality of the development, particularly in light of its complexity, also saying the construction site was the tidiest they had ever witnessed.

The three-storey surgical unit, which was opened by former Blackpool football manager Ian Holloway, boasts 10 operating theatres, a day-case unit and 61 inpatient beds in a bright and modern environment. Half of the in-patient beds are in single rooms with en suite facilities.

Medical simulation centre opens its doors

BLACKPOOL Victoria Hospital has found new ways to ensure the safety of its patients, with the official unveiling of its Simulation and Skills Suite. The suite offers state of the art facilities for health professionals to try out their skills in a simulated hospital environment without compromising patient safety.

The realistic rooms are equipped with the latest medical technology, equipment and a family of sophisticated life sized manikins who are programmed to replicate a number of conditions in unwell adults, children and babies so clinicians can learn how to operate in a pressurised environment.

An open day was held to celebrate the opening and raise awareness to members of the community and staff on the advancements the hospital has made in the patient safety arena, while acknowledging the challenges that remain. Everyone who attended was given the chance to use the specialist training equipment for CPR and airway management, and watch simulation training displays for both sepsis and post partum haemorrhage with the Sim adult and maternity manikins.

Endoscopy department gets national seal of approval

PATIENTS at Blackpool Victoria Hospital's Endoscopy Unit can be assured of the highest possible quality of care after a national seal of approval.

The unit has achieved accreditation from the prestigious Joint Advisory Group (JAG) on gastrointestinal endoscopy which formally recognises that a high quality endoscopy service is operating in the hospital.

The stringent accreditation means that patients attending for endoscopy can be assured of an excellent service delivered by a highly skilled and fully trained team.

Achieving JAG Accreditation is important not only because it is proof of a high quality endoscopy service at the hospital but is also required for the delivery of the Lancashire Bowel Cancer Screening Service.

The accreditation, which is undertaken by an independent team, is important as it assures patients that the unit delivers the highest quality of clinical care and gives our patients the best experience it can. It also shows that we have a highly trained workforce and proves our commitment to delivering full training packages to our staff to make sure we have a team of highly skilled practitioners.

Staff in the Endoscopy Unit diagnose and treat disorders of the colon, stomach and oesophagus in an environment dedicated to patient safety, privacy and comfort.

HR team wins national award for its coaching programme

THE HR team at Blackpool Teaching Hospitals NHS Foundation Trust has won an award for its coaching and personal development in the Healthcare People Management Association's annual celebration event.

The awards celebrate the best HR practices in all healthcare organisations across the country. The Trust won the award for its project to introduce a leadership style that gave managers the skills to use a coaching style to empower and engage their staff to make decisions that mattered.

An evaluation of the scheme was 100% positive and the organisation is now in the top 20% of Trusts for effective teams showing communication between managers and staff in the country. The judges said the project was a comprehensive programme based on research evidence and a clear case for change that achieved deep employee engagement with clear measures of success.

Nurse-led service recognised in prestigious awards

A revolutionary nurse-led service, which is giving patients their lives back, was shortlisted for a prestigious British Medical Journal award.

The newly-established ascites service at Blackpool Teaching Hospitals NHS Foundation Trust allows liver patients to have excess fluid drained during a day visit rather than being admitted to hospital for a three to four day period.

The service has given patients their lives back and this shortlisting was a testament to the innovation and dedication of our staff. The scheme was devised here and now helps more than 40 patients on a regular basis and gives patients their independence to be able to visit the hospital for just an eight hour session rather than have to be admitted for about four days. Its success has been to reduce the number of readmissions to hospital, reduce the inpatient length of stay and improve the patient's experience.

Patients benefiting from £9M x-ray investment

PATIENTS across Blackpool and the Fylde are to benefit from a £9 million investment in radiology equipment. The Trust has is in the process of installing more than 100 new pieces of state of the art radiology equipment. These include a new CT Scanner, housed within the cardiothoracic unit providing general imaging but is also cardiac enabled to enable imaging of the heart on the coronary arteries. Further equipment includes mobile X-ray units, digital X-ray rooms, a new X-ray screening room and a new vascular intervention lab.

In addition to the new medical imaging equipment a new reporting system (PACS) has also been installed to allow more efficient reporting by the Consultant Radiologists. Several new offices have also been built to accommodate new consultant appointments to manage the ever increasing demand for imaging of patients.

The Trust has also refurbished five of its x-ray rooms at Blackpool Victoria Hospital, two of which are connected to the A&E department, to ensure that instantly viewable, high quality digital x-rays are used where they matter most. The new Imaging rooms can also undertake the full range of Trauma examinations required by the referring clinicians including the full range of Orthopaedic examinations.

New car park and main entrance

Blackpool Victoria Hospital has a new look for 2014.

Patients, visitors and staff are benefitting from an impressive new entrance and multi-storey car park. The new developments have solved two problems which historically affected people using the hospital – where to park and which entrance to use.

Visitors are now directed through to the facility from the Trust's new car park and can access the majority of the hospital from the area guided, where necessary, by one of the Trust's new band of volunteer navigators.
The developments, which took a year to build, are both imaginative and innovative and use space and light to provide a clean and confident first impression of the hospital.

The entrance hall currently includes Costa Coffee, Marks and Spencer and W H Smith retail outlets and has a reception area and access to the first floor of the hospital. The entrance hall is the final stage of a scheme to provide improved access to the hospital and a multi-storey car park and has cost a total of £16.5m. The capital has been borrowed from the Department of Health and will be paid back from income generated through retail and parking charges.

£680,000 Midwifery Led Unit

MUMS-TO-BE can now use the new £680,000 Midwifery-led Unit which opened at Blackpool Victoria Hospital in summer 2013.

The unit, which was officially opened by chief executive of the Royal College of Midwives, Cathy Warwick, offers state-of-the-art birthing facilities for mums who are low-risk in pregnancy, with four spacious en-suite birthing rooms, two with pools, and a home-from-home environment making the birthing experience as normal as possible.

The facility runs independently but is alongside the delivery suite within the hospital's Women and Children's Unit.
It gives a homely environment staffed by midwives with less medical intervention during birth, making it a more normal experience for mums.

Water and movement are predominantly used for pain relief although women are able to access whatever pain relief they require due to the close proximity of delivery suite next door. This unit provides choices that women on the Fylde coast have not previously had. The traditional model, which is still available in the hospital, involves transferring mums and babies from the delivery suite to the ward area until discharge. Mums delivering in the Midwifery Unit will stay for about eight hours before being discharged home.

Directors' Report and Business Review

This section includes information about:

- Our Trust
- Our Services

This section also includes information about our achievements on performance on delivering our plans in the following areas:

- Our Patients
- Our Staff
- Our Performance
- Our Environment
- Our Finances
- Our Future Business Plans

Our Trust

Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust was established on December 1st 2007 under the National Health Service (NHS) Act 2006. In October 2010, the Trust was awarded teaching hospitals status and changed its named to Blackpool Teaching Hospitals NHS Foundation Trust in recognition of this. On 1st April 2012, the Trust merged with the Community Health Services of NHS Blackpool and NHS North Lancashire.

The Trust comprises the following main sites:-

- Blackpool Victoria Hospital
- Clifton Hospital
- Fleetwood Hospital
- Rossall Hospital Rehabilitation Unit
- Bispham Rehabilitation Unit
- Blenheim House Child Development Centre
- National Artificial Eye Service
- Poulton Offices

The services at Bispham Rehabilitation Unit are provided by Spiral Health CIC http://www.spiralhealthcic.co.uk/aboutus.asp

The Trust also provides services across the community or staff bases from a multitude of locations including 70 treatment centres and six support facilities, these locations are lease and freehold properties provided by NHS Property Services Ltd:- http://www.property.nhs.uk/

In addition to this school nursing is provided from over 200 schools.

The Trust's main commissioners are:-

Blackpool Clinical Commissioning Group (CCG)
Fylde and Wyre Clinical Commissioning Group (CCG
Lancashire North Clinical Commissioning Group (CCG)
Cheshire, Warrington and Wirral Area Team (for specialist areas)
Blackpool Council – Public Health
Lancashire County Council – Public Health
National Commissioning Board – Local Area Team

Our Services Jacinta Gaynor

As well as providing the full range of district hospital services and community health services, such as, adult and children's services, health visiting, community nursing, sexual health services and family planning, stop smoking services and palliative care, the Trust provides tertiary cardiac and haematology services to a 1.6m population catchment area covering Lancashire and South Cumbria.

The Trust provides a comprehensive range of acute hospital services to the population of the Fylde Coast, as well as the millions of holidaymakers that visit each year. From 1st April 2012, the Trust also now provides a wide range of community services to residents in Blackpool, Fylde, Wyre and North Lancashire. We employ 7,123 staff, had a turnover in excess of £370m in 2013/14 and have a total of 912 beds.

Between 1st April 2013 and 31st March 2014 we treated approximately 94,355 day cases and inpatients (elective and non elective), 305,185 outpatients and had 82,999 A&E attendances. The total number of community contacts was 1,229,933. Clinicians from Lancashire Teaching Hospitals NHS Foundation Trust provide onsite services for renal, neurology and oncology services. We utilise assets to the value of £192m to support our services.

Our Patients

It is really important to us that we listen to our patients and make improvements to our services in response to their views.

Learning from Feedback

The Trust has many ways in which we can learn from our patients' feedback; this could be positive or negative feedback. We feel that feedback is key to us being able to develop and enhance patient centred services.

We use the national friends and family test as an initial feedback mechanism. This has been used since April 2013 for all over 16 year olds who have been inpatients or those patients who attend our Emergency Department. Since October 2013 we have implemented this across our Maternity Services. The feedback from these tests enables wards to implement changes in real time, so care is enhanced immediately following their feedback.

The friends and family feedback is reported monthly in a 'net promoter score' based on a scoring system on plus 100 to minus 100.

Month	Trust Overall score	Responses	Inpatient Response Rate	Emergency Department Response Rate	Maternity Response rates
April	72	453	19.7%	0.1%	Not surveyed
May	74	724	25.7%	1.5%	Not surveyed
June	76	877	32%	2.5%	Not surveyed
July	72	1021	37.7%	7.4%	Not surveyed
August	73	938	29.4%	4.1%	Not surveyed
September	76	814	25.60%	3.10%	Not surveyed
October	74	1128	30.70%	6.50%	9.7%
November	70	1521	41.2%	13.4%	8.6%
December	73	1816	44%	17.7%	9.8%
January 14	66	2005	43.4%	21.7%	7.9%
February 14	71	1611	41.8%	15.4%	12%
March 14	72	1636	37%	14.1%	19.45%

Following the implementation of the Friends and Family test, we also revised the way we collect feedback from our patients in the local inpatient survey. This survey is now sent to people homes approximately **two** weeks following their discharge, and the information is used in a variety of ways to give our staff feedback and also to support service improvements initiatives.

In order to fully understand the care our patients are receiving we have recruited and trained a team of volunteers called **'the listeners'** who go into patient care areas and ask individual patients a series of questions relating to their stay in that particular area. Again this information is fed back to the clinical team so improvements can be made in a speedier time frame.

All our learning is fed back to the Trust board, placed around our hospital sites and on our web site so people can see the changes that we are making.

You Said...We Did

We have started using this simple tool to highlight areas where patient have given us specific feedback so it is clear as to the specific actions we have taken to ensure the issue is resolved and the patients experience in our care is enhanced.

Examples include:

You Said:

We are really cold on this ward, especially in the night and are using extra blankets to warm ourselves up.

We did:

Senior nursing staff contacted the estates team, who checked the ward temperature and turned it up. It is now being monitored regularly by all ward staff.

You Said:

It would be nice if the nursing staff could spend some more time with us.

We did:

Bay based nursing is now being used on each shift, so staff in their dedicated bays can spend more time with their patients.

You Said:

There are no mirrors on the bathroom in this ward making it difficult for us to shave.

We Did:

A request was submitted to the estates team and mirrors have now been fitted in every bathroom on the ward.

Shared Decision Making

Is a project with partnership with the Advancing Quality Alliance (AQUA) to implement a shared decision tool, this is aimed at ensuring patients are involved in their care by giving greater information about the options that are open to the them during their care pathway.

Giving answers to three set questions enables staff to understand what is important to the individual patient and also helps the patient to make the best decision about their healthcare.

The three questions are:

- What are my options?
- What are the pros and cons of each of these options for me?
- How do I get support to help me make a decision that is right for me?

This toll has been implemented within our maternity services and also within the Heart Failure Rehabilitation team within the Cardiac Centre, there are plans to look at the use of this tool in other areas over 2014/15.

Patient Relations Team

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 2013 to 31st March 2014 we received **4331** thank you letters and tokens of appreciation from patients and their families**, an increase of 959 from the year previously.**

The number of formal complaints received by the Trust during the same period was **498** this includes **402** written complaints registered via the Trust and **62** Community formal complaints. There were also **34** verbal complaints made. The overall numbers of formal complaints show a**n increase of 41** for the Trust figures, however, including the Community figures show an overall **reduction** of **19** compared to the previous year. (Further details are contained in the Quality Report at Annex A).

Enhancing Patient Safety

Patient Safety Walkabouts

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

The Executive Directors carry out adhoc Patient Safety Walkabouts on a weekly basis, averaging approximately 10 walkabouts per month. In addition all Executive Directors take ownership of a number of set wards which they visit regularly. This enables staff to seek Executive assistance if required and to have a named Executive Director to call upon.

Structured Patient Safety Walkabouts are carried out to one specified ward or department on a monthly basis. All areas of the Trust, including those within Community Health Services are included in the annual programme of Patient Safety Walkabouts. The inclusion of Non Executive Directors and Governors of the Trust on the Structured Patient Safety Walkabout has enabled a wider assessment of the safety issues within the wards and departments. During these Walkabouts the patient's views are sought to ensure any areas where they feel their experience could have been enhanced is shared with staff.

All Patient Safety Walkabouts provide an opportunity for staff to discuss their concerns and issues raised by patients. The Patient Safety Walkabouts are also an opportunity for staff to showcase areas of good practice as well as areas where improvements may be considered.

Serious Untoward Incidents and Lessons Learned

There has been a steady increase in the number of untoward incidents reported over the past five years. Patient Safety Incidents account for approximately 75% of all reported untoward incidents. In the year 2013/14, there have been 14,089 untoward incidents reported (35% increase from the previous year) and of these 10,558 were patient safety incidents and as such were reported to the National Patient Safety Agency. The Trust target for incident reporting within 24 hours of occurrence is 95% and 72% of incidents that were graded at level 3-5 (serious, severe harm or death), were reported within 24 hours. In order to address this shortfall all induction, clinical mandatory and specific incident reporting and investigation training incorporates 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 recurrence especially if the incident has resulted in severe harm or death. All incidents graded at level 3-5 also automatically initiate a Root Cause Analysis (RCA), which identifies immediate actions taken, recommendations for improvement or change and shared learning across the organisation.

In 2013/14, there were 43 (0.3% of all incidents reported) that were graded as serious/severe harm. This is an increase on 2012/13 of 42%.

The number of patient safety incidents that resulted in the death of a patient has risen and in 2013/14 there have been 17, which equates to 0.16% of the total. All patient deaths are uploaded to the National Reporting and Learning System (NRLS), where clinical staff in the Patient Safety Division of the NHS Commissioning Board, review all incidents with a degree of patient harm of death or severe harm. When uploading data to the NRLS we need to be clear on the definitions of death or severe harm from patient safety incidents. It is not always possible to say that a death was or wasn't attributed to a patient safety incident. Where it is reasonably clear at the outset that a death has occurred from natural causes, or natural progression of an illness, this is not reported as a death. A death is only reported to the NRLS where there is a degree of harm or where an actual impact of long term harm has occurred to the patient. All grade 4 and 5 patient safety incidents are investigated within the Serious Untoward Incident (SUI) process. There have been a total number of 73 SUI's in the last financial year, which is an increase of 34 from last year, of these 36 met the criteria of being externally reported on the Strategic Executive Information System (StEIS) and are monitored by the commissioners. 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 is monitored and reviewed by the Divisions and the Board.

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/departmental meetings, governance meetings and the Lessons Learnt Newsletter published Trust wide monthly. Lessons learnt are also discussed at the Learning from

Incidents and Risk Incident (LIRC) Committee held monthly. The LIRC Committee has also initiated project group working to review and make recommendations in relation to the four key areas of concern for patient safety incidents, i.e. pressure sores, medication errors, incorrect labelling of samples and patient falls. All completed SUI reports are published on the Trust intranet site so that any member of staff can access and use this documentation 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 continues to undertake training sessions where staff who were involved in the 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 a patient was 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 versions of events and this is reflected within the report. Following completion of the investigation report they are given the opportunity to discuss the findings, recommendations for change and actions taken to prevent further occurrence.

TalkSafe Initiative

TalkSafe aims to gain commitment to the behaviours required to truly champion patient safety ensuring that the Trust has the highest possible patient and staff safety standards. The concept has been used in industry in many years and has clearly demonstrated an impact on an organisation's safety culture. There is very strong evidence that the safest companies in the world all use an approach emphasising creation of a positive safety culture through management leadership together with guided on the job risk assessments using the vehicle of personal behavioural safety conversations.

Across the Trust, we now have 26 Lead Trainers that are now attached to areas of practice so that they can help to support new TalkSafe practitioners in holding the safety based conversations. There are both cultural and practitioners sessions available for all members of staff across the Trust.

Staff Trained in TalkSafe Conversations		
2011-2012	2012-2013	**2013-2014**
20	220	**331**

In order to help facilitate the release of staff to undergo the training, it has been reviewed for 2014. These are now two half day sessions available, one that explores the safety culture within the organisation and the other that allows staff to become TalkSafe practitioners.

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by health care providers. None have been reported in the last financial year. This is a measure of the concerted effort and focus of those working within the Organisation towards embedding patient safety.

New guidance was issued from the Department of Health in December 2013, which details the criteria list of 25 never events. The document is unchanged from previous versions except where clarification has been made around the definition of 'Retained foreign object post procedure'. The never events list provides a lever for those in the NHS to improve patient safety through greater focus, scrutiny, transparency and accountability when serious patient safety incidents occur It provides healthcare workers, clinicians, managers, board and accountable officers with clarity about their responsibilities, in particular clear guidance on what is expected in terms of preventing never events and the response if they should occur.

Incidents are considered never events if
:

- The incident either resulted in severe harm or death or had the potential to cause severe harm or death.
- There is evidence that the never event has occurred in the past and is a known source of risk (for example through reports to the National Reporting and Learning System or other serious incident reporting system).

- There is existing national guidance or safety recommendations, which if followed, would have prevented the incident from occurring.
- Occurrence of the never event can be easily identified, defined and measured on an ongoing basis.

Quality - Our Patients

A more detailed report in relation to quality and safety in patient care is outlined in our Quality Report at Annex A.

Our Staff

During 2013/14, the Trust had a number of key workforce initiatives under the Quality, Innovation, Productivity and Prevention programme order to deliver the Trust's share of NHS efficiency savings requirement.

Our staff are an integral part of delivering our vision as an organisation to deliver top quality patient care, excellent education and world class research. Our aim is to deliver success through our people. We understand the importance of having all our people focused on excellent outcomes, staff who care, teach and research, managers who manage and leaders who lead.

As an organisation we want to:

* enable staff to deliver of their best
* care for people who care
* work in partnership to deliver focussed, proven workforce practices
* ensure our workforce is focused on delivering excellent patient care.

We strive to be the Trust of choice for both our patients and our staff. We are driven by our belief that an engaged and flexible workforce who are valued and supported deliver safe, effective and personal healthcare for every patient, every time.

Staff Survey

What our staff said:-

In our 2013 survey we maintained our response rate, achieving 49%. This is the same as the previous year and places us in the average category for returns. Overall, the responses to the survey are very positive and show no material change compared to the 2012 results. The survey was undertaken between October and December 2013, the results were formally published by the Care Quality Commission in February 2014. The survey is an annual survey which seeks the views of staff on a variety of questions including their experiences of staff satisfaction, training, line management, appraisals, work related stress, violence and abusive behaviour and making a difference to patients.

Our staff engagement score is 3.79 compared with a national average for acute trusts of 3.74. This engagement score is calculated from 3 Key Findings:

- KF22: staff ability to contribute towards improvements at work – highest (best) 20%.
- KF24: staff recommendation of the trust as a place to work or receive treatment – average.
- KF25: staff motivation at work – highest (best) 20%.

Out of 28 Key Findings the Trust was found to be:

- in the best 20% of Trusts nationally for 13 out of the 28 key findings,
- above/better than average for 7 out of the 28 findings, and
- average for 8 out of the 28 key findings.

The Trust did not have any negative findings (i.e. were not in the worst 20% of acute Trust, were not worse than average, nor significantly worse than 2012).

Based upon the NHS England requirements the Trust issued 800 paper surveys. However, our Survey supplier, Picker, enabled us to engage with more of our employees via additional paper based surveys plus our second year participating via an on-line version. The Trust elected therefore to undertake a further 200 paper surveys and 1000 on-line surveys. The combined participation rate for 2013 was 47% with a total of 938 completed surveys being processed (478 paper and 460 on-line). In 2012 a total of 981 surveys were completed (480 paper and 501 on-line).

Survey Questions	2012/13 %		2013/14 %		Trust Improvement/ Deterioration
Response Rate	Trust	National Average	Trust	National Average	
	49.9%	45.6%	47%	46.9%	2.9% Deterioration*

NHS England base their participation rate on the paper surveys only, and the Trust achieved a participation rate of 48.5% in 2013 which compared favourably with the national acute rate of 48.7%.

*In 2013 the opportunity for all staff to participate in the survey, via the newly created HR portal was available. Take up in 2013 was extremely low, however as familiarisation with the Portal grows across the Trust, it is hoped that this will increase in 2014.

Survey Questions	2012/13 %		2013/14 %		Trust Improvement/ Deterioration
Top 5 Ranking Scores	Trust	National Average	Trust	National Average	
Percentage of staff experiencing discrimination at work in last 12 months	11%	11%	7%	11%	4% improvement
Percentage of staff working extra hours	64%	70%	62%	70%	2% improvement
Percentage of staff agreeing that their role makes a difference to patient care	91%	89%	94%	91%	3% improvement
Percentage of staff experiencing physical violence from staff in last 12 months	2%	3%	1%	2%	1% improvement
Percentage of staff appraised in last 12 months	93%	84%	92%	84%	1% deterioration

Survey Questions	Staff Survey Results 2012/13 %		Staff Survey Results 2013/14 %		Trust Improvement/ Deterioration
Bottom 5 Ranking Scores	Trust	National Average	Trust	National Average	
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	91%	90%	90%	90%	1% deterioration
Staff recommendation of the trust as a place to work or receive treatment	3.65	3.57	3.65	3.68	No change
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	15%	15%	15%	15%	No change
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	27%	30%	29%	29%	2% deterioration

Percentage of staff having well structured appraisals in last 12 months	36%	36%	38%	38%	2% deterioration

Actions to Address Areas of Concerns

It is extremely encouraging that the Trust has been able to achieve an overall position of above average. However in order to maintain and improve this position over the coming year it is essential that the Trust achieves ongoing improvements aligned to anticipated changes and challenges for the future. As such the priorities for action for 2014/15 are as follows:

- Continuing to engage and involve staff at all levels to be proud of the Trust, reflected in their willingness to recommend it as a place to work and receive care
- Continuously improve knowledge and timely use of error and incident reporting systems resulting in real time organisational learning
- Continue to support staff development, health and wellbeing

To support the priority actions, the Trust will introduce quarterly surveys to measure staff satisfaction which will incorporate the nationally required Staff Friends and Families test. This data will also be used to support wider quality, safety and productivity requirements and achievements.

Engaging with our Staff

Blackpool Teaching Hospitals NHS Foundation Trust continues to engage with staff and has held a number of Big Conversations with staff across community and hospital to develop refreshed Trust core values that will be launched in 2014/15 and integrated with our HR processes. Our aims is to be a high performing organisation delivering high quality and compassionate care and our values and behaviour framework has been developed and tested with staff throughout 2013. Staff survey results demonstrate that the trust scored better than average for staff engagement in 2013 with a score of 3.79 (which is comparable with the 2012 score) and the trust was in the top 20% for staff feeling that they could contribute to improvements at work and also feeling motivated. In 2014 we will work hard to ensure that more staff would recommend the trust as a place to work through focusing on our values and behaviours and a broad clinical engagement strategy.

We will continue to engage with our staff to seek feedback both corporately and also at a local level, particularly around ideas to improve quality, safety, innovation, productivity and prevention.

We have well-established partnership working with trade unions and professional organisations that play a key role in ensuring the future success of the Trust. We will continue to build on and strengthen partnership working going forward.

The coming year will see a major focus on how we can best engage with staff across the Trust, including improving our internal communication methods, launching a series of listening events, delivery of appropriate training to support improved engagement, creating a better experience for our staff and ultimately our patients.

Promoting Equality and Diversity

Equality and Diversity (E&D) is an important part of the Trusts overall work to improve service provision. The Trust's Equality Objectives are now part of the overall business objectives, showing the commitment being given to equality and diversity across the Trust. The Public Sector Equality Duty expects all public sector organisations to promote equality and diversity by:

- eliminating discrimination, harassment and victimisation
- advancing equality of opportunity
- fostering good relations between people who share a protected characteristic and those who do not share it.

Some of the ongoing work includes:

- Butterfly Project to assist patients with Dementia
- Memory Wall and Boxes to assist patients with Dementia
- Using yellow paper for appointments assists people with sight impairments
- Larger font on correspondence
- Emailing correspondence to blind or visually impaired service users
- Improving support mechanisms for people with learning difficulties when attending hospital

- Introducing Health Passports for people with a learning difficulty
- Understanding the needs of minority/hard to reach groups and making healthcare accessible

The Trust continues to review how best to support all patients and service users, irrespective of any protected characteristic they may have to ensure we meet their needs.

Equality Objectives

The Trust Equality Objectives are monitored by the Trust's Equality Diversity and Human Rights Steering (ED&HRS) Group. Following the outcome of the 2013 Equality Delivery System (EDS) public consultation and engagement event the objectives were reduced from eight to two. The ED&HRS group made the decision to focus on two objectives that had been graded from achieving down to developing at the consultation. By amending the equality objectives it provides the ideal opportunity for the Trust to focus on areas perceived to require improvement. EDS continues to assist the Trust to meet the following requirements:

- Compliance with the Public Sector Equality Duty
- Deliver on the NHS Outcomes Framework
- NHS Constitution for Patients and Staff
- CQC Essential Standards

The Trust will hold its third Equality Delivery System (EDS) public consultation and engagement event in March 2014 at venues in Blackpool and Lancaster. The report from the consultation will be submitted later in the year around May. The outcome of the EDS will continue to influence which of the equality objectives require further attention or adjustment.

Equality and Diversity Policies

There are a number of policies that come under the equality and diversity heading, all of which are monitored and reviewed on a regular basis. New policies are introduced as required for example a new policy written this year was 'Gender Reassignment: Support in the Workplace'. The adaptation of the Trusts Equality Analysis Procedure has been very successful. The questions in the initial assessment make staff think differently about the impact policies; procedures etc have across all the protected characteristics. In turn this provides the Trust with continuing evidence on its work to reduce discrimination and increase inclusion for both service users and staff.

The Trust operates the Two Ticks symbol whereby anyone who discloses a disability during application and meets the essential criteria of the person specification, is automatically shortlisted. The Trust does not monitor as a specific requirement the numbers of staff who become disabled during their employment. The Trust's Equality and Diversity Lead assists in supporting staff by working with managers and our Occupational Health to ensure we provide the right support and reasonable adjustment. We use our capability/management of absence procedures along with reasonable adjustments to ensure an employee who becomes disabled can remain in employment. This would include the consideration of training for suitable alternative roles. The Trust does not offer any specific training for staff that may become disabled, but utilises the support and advice of our occupational health service to introduce adjustments as recommended facilitating an employee to remain in employment. The advice of Access to Work is also sought and the recommendations from their reports are implemented.

The Trust does not have a specific policy on career development or promotion for disabled people, but by operating a positive culture ensures we never unfairly discriminate and maintain this ethos in all that we do. Career development / promotion opportunities are subject to our equal opportunities procedure and required to be advertised so all staff have an equal ability to apply and be considered.

Equality Diversity and Human Rights Training

Equality and Diversity (E&D) continues to be part of the Trust's induction and mandatory training programmes to maintain awareness and emphasise the importance of E&D in all aspects of employment and service provision. The training includes:

- E-learning modules
- Rolling programme of monthly workshops covering additional areas e.g. Learning Disabilities and Sexual Orientation including issues faced by older people.
- Deaf and Disability Awareness
- Transgender issues

Since its inception in February 2011 the Staff Equality and Diversity Network has trebled in membership. The enthusiasm of the group continues to reflect the importance staff view equality and diversity from both an employee and service user perspective. The Staff E&D Group held its fourth E&D conference in October 2013 and was again a resounding success bringing new knowledge and perspectives of E&D issues to Trust staff.

Table: Summary of Performance – Workforce Statistics

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

The table below identifies the breakdown of staff groups for April 2013 to March 2014.

The results of the staff survey showed that 90% of staff reported having received E&D training or updates which is a further improvement on our 2012 survey results. This is a key priority for the Trust and E&D updates form part of mandatory training as well as being part of the Induction Training. We expect to continue improving in this area year on year.

Organisation	Ethnic Origin	Full Time Equivalent (FTE)	Headcount
Blackpool Teaching Hospitals NHS Foundation Trust	0 White	8.90	11
	4 Indian	5.20	6
	5 Pakistani	2.00	2
	7 Chinese	8.47	9
	9 Not given	0.00	1
	A White - British	4,850.32	5,714
	B White - Irish	32.84	38
	C White - Any other White background	90.96	98
	C3 White Unspecified	0.51	1
	CA White English	1.00	1
	CB White Scottish	0.53	1
	CFWhite Greek	1.00	1
	CK White Italian	2.00	2
	CP White Polish	7.09	7
	CY White Other European	17.00	17
	D Mixed - White & Black Caribbean	6.27	7
	E Mixed - White & Black African	2.67	3
	F Mixed - White & Asian	9.41	11
	G Mixed - Any other mixed background	7.80	9
	GC Mixed - Black & White	1.00	1
	GF Mixed - Other/Unspecified	1.60	2
	H Asian or Asian British - Indian	106.87	112
	J Asian or Asian British - Pakistani	30.13	31
	K Asian or Asian British - Bangladeshi	2.53	3
	L Asian or Asian British - Any other Asian background	40.49	44
	LA Asian Mixed	1.00	1
	LE Asian Sri Lankan	1.00	1
	LH Asian British	1.00	1
	LK Asian Unspecified	2.00	2
	M Black or Black British - Caribbean	6.00	6
	N Black or Black British - African	15.78	17
	P Black or Black British - Any other Black background	2.00	2
	R Chinese	7.03	10
	S Any Other Ethnic Group	53.62	58
	SC Filipino	15.80	16
	SD Malaysian	2.00	2
	SE Other Specified	7.60	8

	Undefined	17.85	183
	Z Not Stated	203.39	251
Total		**5,572.67**	**6,690**

The Trust's Equality Diversity and Human Rights Steering Group, chaired by the Director of Human Resources and Organisational Development, has an inclusive membership reflective of the protected characteristics including representation from Trust staff, partner organisations and patient groups.

Priorities for 2014/15 include:

- Continued compliance with the Equality Act 2010 and NHs Regulation Framework
- A fifth Trust E&D conference for 2014
- Progress area requiring development as highlighted in the 2014 EDS report
- Prepare for the third submission to the national Equality Delivery System (EDS)
- Hold the third EDS public consultation and engagement event with service users
- Continue to develop and expand the work undertaken for EDS
- Continue work to improve working/service practices for staff and service users who are hearing impaired
- Continue working to develop practices for staff and service users who are sight impaired
- Review E&D training to identify gaps in knowledge and understanding regarding protected characteristics
- Increase social value (ongoing) by improving links with local schools, Fire Service, Police

Recruiting and Retaining the Best Staff

Blackpool has faced challenges in recruiting to nursing and medical positions but has made steady progress in filling key vacancies, however there is still much to do. We have extended our searches internationally and been successful in recruiting qualified nurses from Spain and Portugal. There has been significant investment by the Trust to increase Consultant numbers to the establishment and in support of this a recruitment campaign was developed in response to stakeholder feedback about the potential barriers to attracting individuals to work for the organisation. The 'Change Your Landscape' campaign www.changeyourlandscape.co.uk has been designed to challenge people's thinking through images and words, as well as celebrate the significant investment the Trust has made to improve delivery of services. It challenges what Blackpool is and what it isn't and guides people to make connections between locality, lifestyle, personal aspirations and shaping patient care.

The campaign has resulted in a good number of applications in specialties where the Trust has historically struggled to recruit to, and also increased the number of applicants in other specialities providing more choice for the organisation. It has also proved significant in raising morale amongst existing staff, as it highlights the positives to working for and in Blackpool, and gives a valuable tool for others to spread this message.

It is the intention to build on this further by using materials to promote jobs internationally, and use the imagery at Recruitment Fairs. We are also keen to incorporate the images and messages into on-boarding material so there is a feeling of consistency for the candidate throughout the employee life cycle.

There is still a great deal to do in this regard as the NHS has similar challenges so we need to work on promoting the Trust as the employer of choice and fully express the opportunities for staff in working within an integrated organisation offering many career opportunities across acute and community care. We need to work with our current staff who have committed their working lives to Blackpool and share their experiences with prospective recruits.

We need to focus our attention equally on the retention of our staff to ensure we are providing the necessary support during their 'on-boarding' to the Trust but also through their transition into their role. We launched an electronic exit questionnaire during 2013/14 which has been well received and the completion rate high thus enabling us to examine common trends and themes that we need to proactively respond to.

Developing our Staff

During the year we continued to make improvements in the ways we support our integrated workforce in learning and continuous development, which we believe are key to delivering quality patient centred care across the Trust. We continued to offer a range of leadership development and learning opportunities to all staff at every level throughout the organisation. Our clinical leadership programme aimed at clinical and non-clinical leaders is now in its fourth cycle and has received excellent reviews. Leaders on the programme are introduced to the

latest thinking on leadership practice, gain and overview of their own leadership styles and personality preferences, and learn techniques to problem solve alongside techniques to engage and motivate their teams. The skills required to lead local and organisational change programmes, manage projects, and lead service improvement are equally high on the learning agenda.

In addition, the development of team leaders, supervisors and first line managers has been well established with our in-house programmes being accredited through CETAD which is Lancaster University's work based learning arm. An evaluation study of the new and junior leadership development programme identified the following impacts:

- 99% of delegates have improved their knowledge and skills in the workplace overall with 99% of delegates applying their learning back in the workplace
- Key areas of improvement included motivating others, influencing others, communication styles, giving a receiving feedback, empathy, emotional intelligence and self awareness
- Line managers cited improvements in individual participants performance, behaviours, self awareness, service improvements and levels of success
- Improvements to confidence and wellbeing were also evident

We were very proud in 2013 to win the prestigious national HPMA award for our coaching culture, which we introduced to help embed our engagement strategy and improve performance through increased self-awareness, confidence and performance. Our in-house coaches are now able to complete an accredited programme in-house through CETAD and we have continued to train line managers as coaches to help our staff maximise their potential and performance.

During 2013, we launched our Patient Experience Revolution *'Compassionate Care through Compassionate Attitudes' training* programme across the Trust. The overall purpose of this programme is *'To create the environment and commitment for caring so that high quality patient care can thrive in the Trust'*. We were delighted when this was highlighted as good practice from the Keogh review team who spent a week looking at patient safety. We have trained 1,015 staff in 2013/14 and the results have been very positive with over 90% of those who attended the training using the skills either most of some of the time. Those units who had a high number of staff trained all report a higher than peer average friends and family test result.
The specific objectives centre on the three areas of Self, Team and Patient.

Self	To encourage and support your care of **YOURSELF** so that you can fulfil your dedication and vocation of caring for others • Develop your self-awareness and understand the need for caring for yourself • Understand a significant cause of stress and pressure • Enhance your capability to deal with stress and pressure • Increase your commitment to caring for yourself
Team	To encourage and support your care of **MY TEAM** so that you can fulfil your dedication and vocation of caring for others • Develop your understanding of what creates great teamwork • Enhance your capability to practice as a great team member • Increase your commitment to caring for your team
Patient	To encourage and support your care of **PATIENTS** and their **CARERS** so that you can fulfil your dedication and vocation of caring for others • Develop your understanding of what creates great patient care • Enhance your capability to practice as a great carer • Increase your commitment to caring for your patients

Once again improving the uptake of appraisal has been a core theme and we continue to work to achieve the target of 90%, but our year end performance was 82%. Our goal is to ensure that not only are appraisal taking place, but that they are of a good standard. This needs to be our focus going forward and we will continue to audit the quality of appraisals that have taken place and provide support where there is room for improvement. Our evaluation of appraisals in 2013/14 has identified some top tips for the future and our training for 2014 will be targeted and will include advice to managers who have more than 12 staff to appraise in the window.

Mandatory training is also a key target which unfortunately we failed to achieve during 2013/14, 79% were recorded as having undertaken all the required modules of mandatory training against a target of 90%. There has been a review of mandatory training to ensure a flexible approach which allows staff to access the training in a range of ways including ELearning which was established this year and work will continue to ensure staff are able to complete training requirements' in a more timely and convenient way, allowing a more blended approach to learning.
Induction is a key time in the life cycle of our employees as it helps to welcome staff as well as embed our values and behaviours. Following a review of the content and attendance, the team have improved induction compliance

to 85% and will launch a revised programme in April aligned to our revised values. We plan to test effectiveness through focus groups of recent recruits on an ongoing basis.
We have been able to offer a range of education, training and development opportunities that underpin workforce and organisational development. These opportunities are available to all staff groups often in partnership with universities, colleagues and other education providers. Our Practice Education team works closely with the universities and in practice, to ensure a high quality learning experience for student nurses.
Current challenges demonstrate that the Trust needs to increase leadership and management capacity and competence in order to improve organisational effectiveness and productivity through the pursuit of an engagement culture. It is fair to say that more emphasis needs to be placed on accountability, competency and performance ensuring that everyone is clear on expectations' and receives identified necessary support, but, importantly understands the consequences of non-delivery.

We are accredited Investor in People Gold and underwent a diagnostic exercise with IiP in November 2013. This diagnostic exercise indicated that the broad principles of the Investors in People Framework are being met. A number of positive features emerged from the review, not least the fact that:

- a significant amount of progress has been made on the harmonisation of people management processes across all areas of the Trust
- staff perceive that there has been real progress in terms of the integration of the three Trusts
- Moreover, a key characteristic of high performance workplaces is the achievement of desired results. Through the documentary submission, presentations and interview feedback a wide range of outcomes were highlighted in relation to quality, safety, people, delivery and environment.
- These included:

    - improvements in National Patient Survey scores
    - lowest ever infection rates
    - Information Standard accreditation
    - achievement of a patient safety award
    - 90%+ VTE compliance
    - improvements in staff survey scores
    - reductions in sickness absence
    - achievement of a Best Communications Team in the NHS Award
    - achievement of a national coaching award
    - A&E performance that ranks amongst the best in the country
    - a score of excellent across all areas in the PEAT inspection

These results are testimony to the effectiveness of people management strategies, and indeed to the knowledge, skills and dedication of the workforce. The above outcomes are given additional resonance given that they have been achieved against a backdrop of significant challenges such as:

- changes in senior leadership positions
- the Keogh Review
- financial pressures
- the ongoing integration project

Knowledge and Library Services

The Blackpool Knowledge and Library Service continues to support effective patient care by ensuring access to information and evidence for clinical and managerial decision making, research and innovation, staff development, and clinical governance.
Building upon its current links with other organisations in the academic and healthcare sectors, the Library has renewed its Service Level Agreement with the University of Central Lancashire and has formed a new partnership agreement with the Public Health domain of Blackpool Council.
As part of its Learning and Development Agreement with the NHS North of England, the Trust is required to submit an annual self-assessment against the national standards contained in the Library Quality Assurance Framework. The standards are designed to help develop high quality knowledge and library services that enable the entire workforce to access the evidence base and acquire the skills to use, evaluate, and implement evidence in clinical and management decision making. We are pleased to report that in 2013 the service scored 94% following validation, which is above the regional average of 91%.
In alignment with the Trust's strategy for delivering integrated services, the Library is working with community-based teams to develop an outreach function that will provide remote access to services and information skills training for staff. Additionally, the Library is developing its links with the Risk Management team and, going forward, will provide information regarding evidence based practice to those areas within the organisation where learning opportunities have been identified through incident reporting.

We look forward to working with our colleagues to ensure that knowledge and information services continue to support evidence based practice and clinical decision making in both an acute and community setting, thereby improving productivity, optimising resources, and supporting staff in the delivery of better care for our patients.

Staff Communication

The Trust communicates, informs and involves its staff on key issues such as quality, safety, finance and performance via a number of methods.

Staff from across all areas of the Trust are invited to a face-to-face monthly Team Brief, where the Chief Executive and members of the Executive Team brief staff on the key decisions that have been made at the Board of Directors' meeting, and update staff on developments within the six areas of our vision – Quality, Safety, Delivery, People, Environment and Cost.

This meeting is podcast and made available to all staff who were unable to attend and is also available in a written document on the intranet and is emailed out to all staff within the organisation. Staff are given the opportunity to ask questions and give feedback on these issues. There is also a rumour board where staff can raise questions anonymously if they wish to.

Sickness Absence

Work continues within the Trust to pro-actively manage and support the absence process.

Increased focus has been placed on the importance of entering accurate absence reason codes on both the E Rostering and web data entry systems to enable trend analysis and monitoring. We are striving to improve the quality of data input to enable more detailed analysis of the reasons reported for absence to identify areas requiring closer scrutiny and to identify targeted interventions to reduce sickness absence.
The Occupational Health Department launched a new Physiotherapist service in February 2014 as a 12 month pilot for staff to 'self refer' into the service. It is anticipated that this will help act as a preventative treatment and support staff to remain in work through early intervention (who may have previously gone off sick). The early indication is that the service has been well received and this will evaluated towards the end of the initial 12 month period to determine whether further funding for the service will be sought. Occupational Health continues to offer a variety of health initiatives to support staff to be empowered to manage their own health by accessing therapeutic interventions, healthy lifestyle checks, weight management and exercise classes. Mindfulness taster sessions have been introduced and all courses have been fully subscribed.

The Trust Sickness Absence policy has been reviewed and this was trialled within the Unscheduled Care division over the last six months of 2013. The evaluation report was submitted to the JNCC meeting recently and it was agreed that the policy would be implemented Trust-wide following some revisions that are required. Divisions continue to monitor absence compliance on an ongoing basis through monitoring of reports and through regular meetings with line managers to guide and support them in compliance to the absence policy with support as appropriate from Occupational Health. Long term sickness cases are also monitored closely across all divisions and appropriate supportive discussions and actions are taken in a timely manner.

Sickness absence for the year 2013/14 ended slightly higher than the previous year on 3.92% as detailed in the table below. However, it is envisaged that with concerted effort the Trust will achieve or improve on the new 3.5% target for 2014/15, helped by the introduction of the harmonised Attendance Management policy across the Trust.

Overall Trust Sickness Absence Rates	
Year	**Sickness Absence Results**
2009/2010	4.47%
2010/2011	4.23%
2011/2012	3.52%
2012/2013	3.85 %
2013/2014	**3.92**%

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

Statistics Produced by IC from ESR Data Warehouse		Figures Converted by DH to Best Estimates of Required Data Items		
Quarterly Sickness Absence Publications	iView Staff in Post			
National Average of 12 Months (2013 Calendar Year)	Average FTE 2013	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
4.24%	1,050,781	33,815,725	1,410,395	9.5

Improving the Health and Well-being of our Staff

A healthy energised workforce is good for the Trust and for the care of our patients. We are committed to maintaining and improving the health and wellbeing of our staff and run a variety of services and activities to encourage people to take responsibility for their own health and wellbeing.

The workplace health and wellbeing department retained its Safe Effective Quality Occupational Health Services (SEQOHS) accreditation during 2013/14 which is put simply a quality assurance standard for Occupational Health providers. Our seasonal flu campaign achieved an uptake of 71% and we were shortlisted by NHS Employers at the Flu Fighters awards. The team implemented an electronic management referral process to ensure timely referrals and improvement of our service to managers.

In order to improve services for our staff we have now introduced a physiotherapist to the team to support our staff with musculo-skeletal problems to facilitate them to gain more timely access.

As a core part of our staff wellbeing offer, we have continued to offer subsidised health activities including Zumba, Yoga and Slimming World.

The department also offers services to a number of external organisations which provides additional income that is reinvested into the service and the Trust for the benefit of our staff.

Medical Revalidation

The process of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and practicing to the appropriate professional standards. The revalidation process was approved by the Secretary of State in December 2012, and the local process of implementation commenced in April 2013. The Professional Regulator, the General Medical Council (GMC) expects all doctors working in the Trust will be revalidated by March 2016. The Trust has made recommendations for 20% of doctors in 2013/14. We are expected to make recommendations for 40% of our doctors in 2014/15 and 2015/16 respectively and thereafter the process will continue as per regulation.

Health and Safety – A Safe Working Environment

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

There has been a decrease of 18.5% in needlestick injuries from 108 to 88.

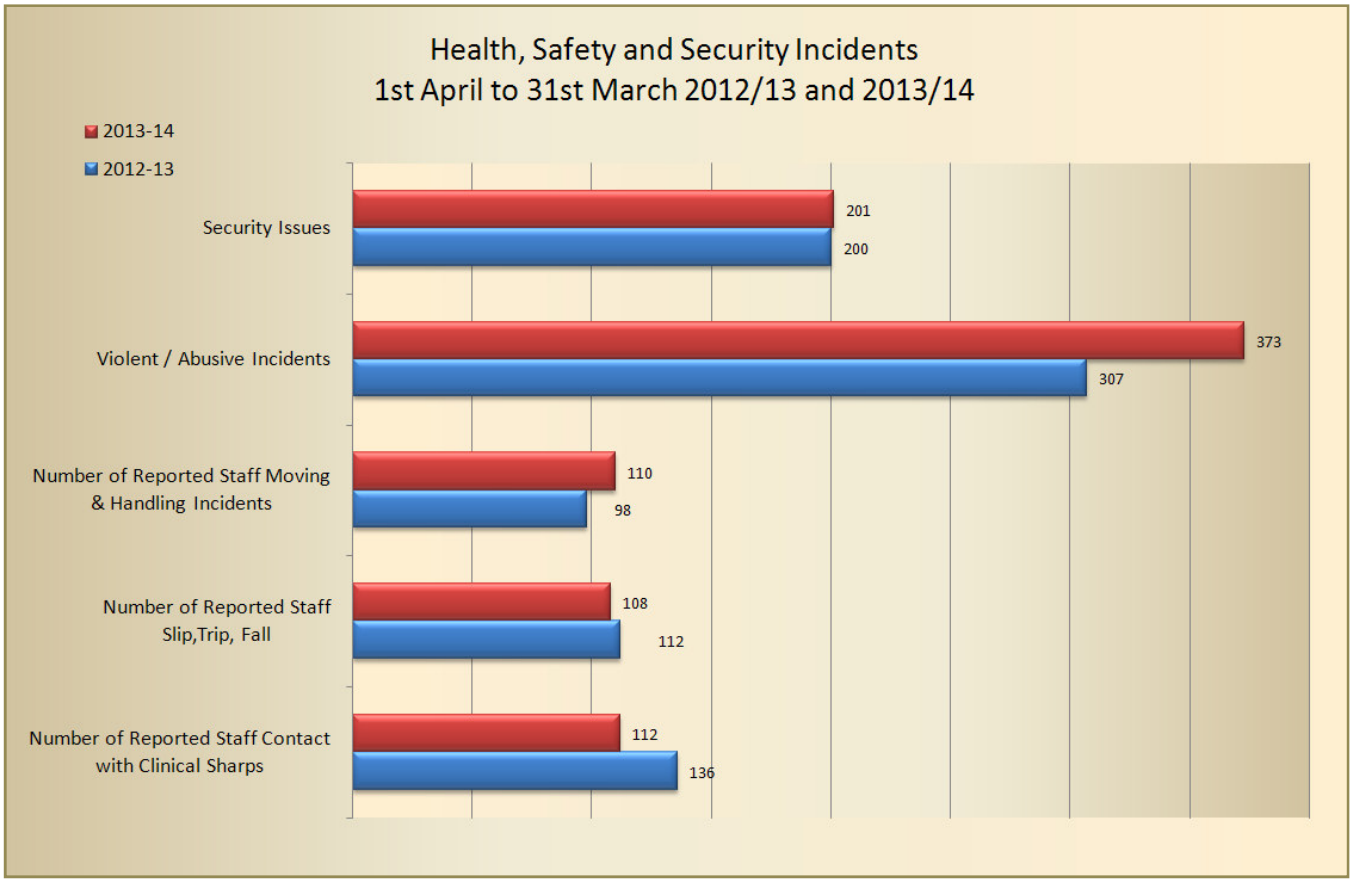
Moving and handling incidents have shown a slight increase of 2%, a increase of 1 injury over the previous year. The use of better manual handling aids has helped keep the increase to a low level, but this increase must be judged against more patients being treated, many with mobility problems in the Trust, and the decrease in the number of bariatric patients being treated, which cause staff problems when having to move or assist them with their mobility.

Slips, trips and falls have decreased by 10%, down by 11 incidents over the year; this is an excellent result bearing in mind additional activity and some bad weather which increases the risk of falling during the winter

months 2013/14. The Trust dress-code policy was revised to include guidance on suitable footwear and this has clearly been instrumental in the reduction of this type of injury.

There is overall a slight increase on reporting of Health and Safety incidents, this increase should be judges against the current amount of staff employed within the Trust due to the integration with the Community Trusts (NHS Blackpool and North Lancashire Primary Care Trust). Ongoing work continues to effectively reduce the number of incidents and drive forward a pro-active health and safety culture across the Trust.

The graph below details reported Health and Safety, Security and Violence and Abusive Incidents 1st April 2013 to 31st March 2014 compared with 1st April 2012 to 31st March 2013.



Security Management

The security of staff, service users, carers, relatives, visitors and property is a key Trust priority. The delivery of high levels of safety and security is critical to the delivery of the highest possible standards of clinical care and Blackpool Teaching Hospitals NHS Foundation Trust is committed to improving the environment and sense of overall personal security for those who access our services and for those who provide those services.

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

The number of verbal abuse and/or aggressive incidents reported between 1st April 2013 and 31st March 2014 were **374**, compared to **307** reported incidents in the previous financial year, showing an **increase** of **22**%. The A&E Department accounted for 17% (63 reported incidents) of all violence and aggression reported across the Trust.

Wherever possible the Trust seeks to minimise risk by deterrence, all security related incident reports are reviewed by the LSMSs on a weekly basis and investigations instigated as appropriate and if required a review undertaken of any security measures in place for effectiveness.

The Trust employs a security team for the Blackpool Victoria hospital site. The team are trained to a high standard and form an integral part of the Trusts deterrence strategy.

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

We are committed to ensuring that Trust staff are properly protected and appropriate training is recognised, as a key factor Conflict Resolution Training with the addition of Breakaway Techniques Training as well as Security Awareness Training being rolled out to all front line staff. Conflict Resolution theory is included as part of the Corporate Induction also.

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

The Trust CCTV working group continues to oversee and develop the Closed Circuit Television (CCTV) monitoring system, for the Blackpool Victoria, Clifton and Fleetwood sites. . There have been some new camera instillations during the 2013/14 period which were highlighted as gaps by the CCTV Working group and they cover what would be considered critical assets to the Trust. The CCTV improvement enhanced throughout a number of premises is anticipated this will enhance the chance of criminals being caught and act as a visual deterrence to people mindful of committing criminal offences. The security room both monitor and control some 150 cameras

Security audits have been introduced within the Trust by the Local Security Management Specialists, (LSMS) where visits to individual departments are conducted so any security/safety issues can be addressed and the LSMS can work with the department to produce its own individual Lockdown Action Card**.**

Our Performance

Despite being an extremely busy and challenging year, the Trust delivered on the majority of national and local performance targets and standards and has delivered on a number of strategic development initiatives.

• National Quality Standards

The Trust continued to deliver **excellent operational** performance during 2013/14, **and met the majority of national and local performance targets.** A summary of our performance against key operational targets is given below.

Quality Standard	2012/13	2013/14
Cancelled operations - Percentage of operations cancelled	Achieved	Failed
Cancelled operations - Percentage of cancelled operations not treated within 28 days	Achieved	Achieved
Reperfusion: Primary PCI waiting times	Achieved	Achieved
A&E Four hour wait	Achieved	Failed
18 weeks Referral to Treatment (admitted pathway)	Achieved	Achieved
18 weeks Referral to Treatment (non-admitted pathway)	Achieved	Achieved
Patient experience	Achieved	**Achieved**
Cancer diagnosis to treatment waiting times	Achieved	Achieved
Cancer diagnosis to treatment waiting times - Subsequent Surgery	Achieved	Achieved
Cancer diagnosis to treatment waiting times - Subsequent Drugs	Achieved	Achieved
Cancer urgent referral to first outpatient appointment waiting times - GP	Achieved	Achieved
Cancer urgent referral to first outpatient appointment waiting times - Breast symptoms	Achieved	Achieved
Cancer urgent referral to treatment waiting times – GP	Achieved	Achieved
Cancer urgent referral to treatment waiting times - Screening	Achieved	Achieved
Staff satisfaction	Achieved	Achieved

National Quality Standards Performance in more detail

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

Bowel Cancer Screening Centre

The NHS Bowel Cancer Screening Programme (NHS BCSP) in Lancashire has seen one of its most challenging years to date since its inception in April 2008, with the commencement of a new Bowel Scope screening service for participants aged 55. The Lancashire Screening Centre hosted by Blackpool Teaching Hospitals was successful in a bid to become a first wave Bowel Scope Programme and was the first centre in the North West to start a phased roll out in December 2013 with the first flexible sigmoidoscopy procedure list being undertaken in February 2014 on the Endoscopy Unit at the Blackpool Victoria Hospital site.

The next phase of the roll out will commence in April 2014 with a further list to be rolled out on Thursday evenings at the Blackpool site. We have established a new clinical and managerial structure within the service to ensure we achieve roll out within expected timescales and plan to increase publicity and health promotion activity once the initial lists are established. The service so far has proved popular with participants and it is anticipated that we will be fully operational across Lancashire at Blackpool Fylde & Wyre, East Lancashire and Preston sites within 2 years.

In terms of our Faecal Occult Blood Test (FOBt) screening programme more than 580,000 screening invitations have been sent to GP registered populations. The extended age range up to and including those aged 74

completed its phased roll out in 2011 and has resulted in increasingly complex patients with co-morbidities being assessed.

During our seven years in operation, the Lancashire Screening Centre has also seen nearly 350,000 FOBt kits returned by participants to the BCSP Regional Hub in Rugby, Warwickshire. Following the processing of these kits, the results showed that more than 5700 participants received a positive cancer screening result. The service has continued to produce quality outcomes in terms of the health benefits for patients taking up the offer of screening within our population, especially relating to early detection and treatment of cancers.

On commencement of the programme in 2008, the cancer detection rate was seen to be 11% with the rate for 2013-14 at a level of around 8.33%. This is an ongoing testament to the early detection and prevention ethos of the screening initiative.

Since April 2008, we have diagnosed 475 patients with cancer at an earlier stage. We have also seen an increase in the bowel polyps removed from patients who underwent a colonoscopy. Last year 46 % of patients had polyps removed and in 2013-14 this has risen to 48%, therefore reducing the risk of cancer in the future.

Our clinical teams of Specialist Screening Practitioners and Screening Colonoscopists continue to participate in joint meetings which are now well established and ensure QA standards are met. The achievement of these standards ensures we keep high quality patient care at the forefront of our service. This will also stand us in good stead for our forthcoming 3 yearly QA Visit from the North West Regional Quality Assurance team, which is due in November 2014.

Emergency Access Targets

Performance against the 4 hour national standard was strong in Quarters 1 and 2, with performance at 96.4% and 96% respectively. However, in the second half of the year performance has been below the national standard, with performance at 94% in Quarter 3 and is forecast to be at 90% for Quarter 4. Performance has deteriorated due to higher levels of bed occupancy, which has caused patients requiring an admission to a non-elective bed to wait for a longer period of time in the Emergency Department. An Improvement Plan is in place which is being led by the Unscheduled Care Divisional Management Team. This plan is focused on providing more care in the community and reducing bed occupancy to ensure there is adequate bed capacity available to meet peaks in demand. We have also approved plans to increase the number of doctors and nurses in the Emergency Department to provide timely, effective and compassionate care to patients.

Better Care Pathways

The Better Care Now project - pathways stream, was launched in August 2013 and links our quality and safety initiatives under one umbrella. It has 3 workstreams:

- Pathways
- Waits
- Staffing

It has been proven that the use of clinical pathways supports standardised management and delivery of patient care and, as a result, improves patient outcomes and can contribute to a reduction in mortality, hospital complications and length of stay. One of the reasons for this is they enhance communication between clinical staff and clinicians to patients by presenting clear plans that provide an understanding of the treatment and care to be delivered.

The pathways identified and developed to date are ones that impact most on our mortality and morbidity. Five pathways have been implemented to date:

- Pneumonia
- Sepsis
- Stroke
- Cardiac Chest Pain
- Acute Kidney Injury

A work plan for 2014/15 agreed to address other high mortality areas has been developed.

Data is collected real time and fed back to clinicians and teams to allow immediate improvements to be made. All pathways have seen an improvement in compliance with the mission critical points of the pathways, and there

has been a downward trend in mortality for pneumonia, sepsis and stroke the first three pathways to be launched. (See table 1 below). It is envisaged that the other pathways will demonstrate this trend when mortality figures are released.

Table 1 - indicates downward trend in mortality for pneumonia, sepsis and stroke pathways.

Pathway	Launch Date	Baseline compliance of all mission critical points	Compliance as of all mission critical point end December 2013	12 month rolling SHMI Dec 2012	12 month rolling SHMI Dec 2013
Pneumonia	28.08.2013	0%	42.6%	117.57	104.63
Sepsis	25.09.2013	0%	30.34%	122.96	94.82
Stroke	23.10.2013	0%	31.76%	128.4	116.78
Cardiac Chest Pain	20.11.2013	N/A	74.73%	91.4	106.2
Acute Kidney Injury	06.01.2014	0%	(1 we 6.1.14) 23.07%	N/A	N/A

COPD / Diabetes

Improving Diabetes Management:

The Trust continues to work closely with commissioners and partners across the Fylde Coast to support the implementation of the new diabetes pathway. This includes drawing up a detailed model of diabetes care for the future which includes diabetes care at primary care level (in GP Practices), Intermediate care level (in neighbourhood team clinics) and complex and specialist care level within the Acute setting. Work is underway to ensure that all appropriate patients are discharged back to primary care management. Pilot sites for intermediate care level clinics are currently being identified.

The diabetes foot care pathway was launched successfully in this last year and this has seen a significant rise in referrals for review at the Diabetes Foot care MDT clinic. As a result, Diabetes foot care provision will be reviewed in early 2014/15.

COPD Patients:

The Trust is working in partnership with commissioners and partners in implementation of the COPD pathway across the Fylde Coast. Key metrics have been developed to monitor progress in COPD management across the health economy. The steering group has overseen the introduction of specific care bundles for End stage COPD, End of life care in COPD, Discharge Care and Early Supported discharge. Works is now ongoing to embed these new care bundles. Acute management of COPD has been reviewed and a new acute care pathway will be launched in May/ June 2014.

Further information on performance improvements is identified in the Quality Accounts at Annex A.

Information Governance and Identifying / Managing Risks

The Health Informatics Committee (HIC) is responsible for all aspects of Information Management, Information Governance and Information Communications Technology throughout the Trust known collectively as Information Management; this includes the identification and management of information and data security risks. The HIC is chaired by the Deputy Chief Executive who is also the nominated Board Lead for Information Governance and the Senior Information Risk Owner (SIRO) for the Trust.

The reporting and investigation of incidents is an integral part of all employees' duties. It applies to ALL staff and all untoward events and near misses. Information Security Incidents are known as an 'Information Governance related Serious Incident Requiring Investigation' (IG SIRI). As a guide this includes any incident which involves actual or potential failure to meet the requirements of the Data Protection Act 1998 and/or the Common Law of Confidentiality.

Using information about the context, scale and sensitivity of what has occurred IG SIRI's are categorised into one of the following levels:

0 - Near miss/non-event.

1 - Confirmed IG SIRI but no need to report to Information Commissioner (ICO), Department of Health (DoH) and other central bodies.
2 - Confirmed IG SIRI that must be reported to ICO, DoH and other central bodies.

During 2013/14 the Trust has incurred no incidents classified as an IG SIRI severity level 2. Should an incident of this level take place a detailed report would be included in the Trust's Annual Report.

Incidents classified at severity level 1 are aggregated and reported in the table below.

Table: Summary of Level 1 Personal Data Related Incidents 2013/14		
Category	**Breach Type**	**Total**
A	Corruption or inability to recover electronic data	2
B	Disclosed in Error	20
C	Lost in Transit	6
D	Lost or stolen hardware	4
E	Lost or stolen paperwork	15
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	1
J	Unauthorised access/disclosure	13
K	Other	4

The Trust achieved Information Governance Toolkit (IGT) internal assessment compliance score of 82% in 2013/14 compared to 84% in 2012/13. The IGT submission is subject to independent audit, the Trusts' auditors, KPMG have reviewed the evidence provided as part of the Version 11 submission and provided an overall Moderate Assurance opinion in respect of our process of Self Assessment.

Eight Elements of Compliance with regards to Governance – Judith Oates

Monitor uses the term governance to describe the effectiveness of an NHS Foundation Trust's leadership. In relation to the eight elements of compliance with regards to governance the position is as follows:

1) Legality of Constitution

The legality of the Constitution remains, however, there have been a number of changes/amendments to the Constitution in 2013/14.

In summary, the amendments relate to the public constituency, composition, tenure for Appointed Governors, conflicts of interests for Directors and Governors, and mergers/significant transactions.

2) Growing Representative Membership

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

The Trust understands the importance of having a reflective and robust membership and continues to prudently maintain our database with regular cleansing, this can result in a loss of members following every cleanse.

The Trust has a robust Membership Development Strategy and in October 2012, in agreement with the Trust's Council of Governors identified three key strategic objectives to enhance delivery of the strategy. The objectives are:-

- Objective 1:- To build and maintain membership numbers to ensure representation of the population the Trust serves
- Objective 2:- Communicate effectively with all members
- Objective 3:- Engage with members and encourage involvement within the Trust.

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

3) Appropriate Board Roles and Structures

In October 2012, the Board commissioned a Quality Governance Review to be undertaken by KPMG. The review commenced in January 2013 and the outcome was reported to the Board in February 2013. During 2013 the Board implemented the recommendations from the KPMG report and has monitored progress on a quarterly basis to ensure compliance.

A subsequent review was undertaken by KPMG in September 2013 in relation to Governance Arrangements and the overall report rating provided significant assurance. Work is on-going to implement the medium/low priority recommendations outlined in the report, all of which were completed by 31st March 2014.

There were a number of changes to the membership of the Board of Directors during 2013/14 as follows:-

- Gary Doherty took up his position as newly appointed Chief Executive on 1st April 2013.
- Paul Olive resigned from the Trust with effect from 31st May 2013.
- Jacqui Bate was appointed Interim Director of HR & OD on 3rd June 2013 following the resignation of Janet Benson, Acting Director of HR & OD, on 2nd June 2013.
- Following the recruitment process to find a replacement NED and an additional NED, Jim Edney was appointed as a Non-Executive Director on 1st June 2013 and Michelle Ibbs was appointed as a Non-Executive Director on 1st September 2013.
- Following a rigorous recruitment process, Nicky Ingham was appointed as Director of HR & OD in July 2013 and took up post on 1st November 2013.
- Jacqui Bate continued to work within the HR & OD Department until she left the Trust on 19th December 2013.
- Following a rigorous recruitment process, Tim Bennett was appointed as Director of Finance in July 2013 and took up post on 25th November 2013.
- Feroz Patel was appointed Acting Director of Finance on 5th November 2012 and continued in that role until Mr Bennett took up post in November 2013.
- Robert Bell, Director of Clinical Support & Facilities Management, left the Trust on 22nd November 2013.

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

With regard to the termination of Non-Executive Directors, removal is in accordance with the procedures outlined in the Trust Constitution:

- Any proposal or removal must be proposed by a Governor and seconded by no less than 10 Governors, including at least two elected Governors and two Appointed Governors
- Written reasons for the proposal shall be provided to the Non-Executive Director in question, who shall be given the opportunity to respond to such reasons
- In making any decision to remove a Non-Executive Director, the Council of Governors shall take into account the annual appraisal carried out by the Chairman
- If any proposal to remove a Non-Executive Director is not approved at a meeting of the Council of Governors, no further proposal can be put forward to remove such Non-Executive Director based upon the same reasons within 12 months of the meeting.

4) Co-operation with NHS bodies and local authorities

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

5) Clinical Quality

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

6) Service Performance against Healthcare Targets and Standards

The Trust is required to register with the CQC and its current registration status is compliant. The CQC has not taken enforcement action against the Trust for the reporting period 2013/14 and remains registered with no conditions.

Further information is detailed in section 2.2.5 of the Quality Report at Annex A.

7) Other Risk Management Processes

The Trust has maintained compliance with Level 3 National Health Service Litigation Authority (NHSLA) Risk Management Standards, which is the highest level possible that can be achieved. We have also successfully achieved compliance with Level 2 Clinical Negligence Scheme for Trusts (CNST) Maternity Standards demonstrating that we have a high performing Maternity service.

In view of the Trust participating in the NHSLA Schemes this has enabled the Trust to demonstrate that we have aimed to achieve the following:

- Reduce the number and cost of claims
- Reduce the number and severity of incidents
- Have a structured framework for risk management systems and processes
- Have a proactive approach to improvement in patient safety and well-being of staff
- Empower staff within the organisation to manage their own risks
- Embed risk management in organisational culture
- Provide assurance to the Board of Directors and stakeholders

- In light of the Francis Report on Mid Staffordshire Hospitals and the Trust being identified as having high mortality rates, the Trust was selected as part of the review by a national advisory group set up by NHS Medical Director, Sir Bruce Keogh into 14 hospitals which had higher than expected mortality rates. Further details are outlined in section 7. The review took place from the 17th June 2013. Sir Bruce Keogh published his report summarising the findings and actions the Trust needed to take. From this, the Trust produced an action plan based on the findings of the Keogh review, and monitored and has now successfully implemented the vast majority of the action plan matters. Those actions which required ongoing improvement, including the Trust's objective to continue to reduce mortality rates will be combined with the new CQC inspection action plan which will be formulated following the CQC visit in January, 2014.

Further details are outlined in Part 3 section 3.4.1 of the Quality Accounts which can be found in Annex A.

8) Provision of Mandatory Services

There are no foreseeable service changes that threaten the delivery of mandatory services provided by the Trust, nor are there any issues of accreditation that threaten the viability of a service in 2013/14.

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

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

- # Strategic Development

Relationship with Commissioners and Stakeholders

The Trust's relationships with its stakeholders have been further developed during 2013/14, with representatives from the Trust's Executive Directors attending local groups such as the Blackpool Overview and Scrutiny Committee. Cross-organisational groups, such as the Fylde Coast Commissioning Advisory Board which includes representatives from commissioners and providers of health and social care, sets the local strategic direction as well as approving new ways of working, monitoring the progress of agreed plans and initiatives, and ensuring alignment across various aspects of care provision.

Our Executive Directors have supported the newly established Clinical Commissioning Groups (CCGs), and have continued to work in partnership with these groups to identify strategies to promote and improve the health of the local population, with an emphasis on improvements to the quality and safety of patient care. The organisations have worked together to develop short and long-term plans for the local health economy that are aligned across primary, community and secondary care. These plans include agreed pathways of care that meet local and national quality and safety requirements, as well as being cost effective in order to meet the financial challenges facing the NHS. Regular meetings are held between the Trust and the local CCGs to review and, where necessary, redesign care provision to better meet the needs of the population.

The Trust's Board of Directors has participated in numerous Board-to-Board sessions with local CCGs and acute Trusts, which provides a shared understanding of local service delivery and any plans for change.

A sub-group of the Council of Governors was established to assist the Board of Directors in short-term (2-year) and strategic (5-year) planning. This has provided the opportunity for early involvement by the Governors in discussions regarding the key challenges facing the organisation; our proposed plans relating to quality, operations, workforce and finance; Board assurance on these plans; and longer-term strategic plans regarding models of care provision.

Improving Patient Care

100 Day Pathway

The Scheduled Care Division has been working in collaboration with local commissioners to standardise pathways for the majority of patient referrals into the service. A series of 100 day pathway events have been run during the last 12 months, which have enabled all aspects of high volume pathways to be agreed with Commissioners. Clinicians from the whole health economy contributed to the evolution and signoff of the pathways of care, incorporating many improvements. These pathways commenced in GP practices and incorporated the inpatient and discharge phase of their management.

Clinical referral templates have been worked up with primary care colleagues and uploaded into the EMIS GP system for the first time. This will enable GP's to use the templates to train more junior colleagues and contribute to an improvement in the quality of referrals. All pathways are available electronically to all clinicians.

Further pathway work has been undertaken to support the patients referred as an emergency to the hospital. Alternative pathways are being devised to reduce admissions, avoid readmissions and reduce the length of stay for those patients who need an emergency inpatient stay.

Other projects have run as a result of the success, which have included reviews of various service and highlighted potential improvements that can be undertaken. These include the Breast Service (Clinical Triage Project), Transcatheter aortic valve implant and a referral to discharge surgical event. This was with a focus on optimisation pre-operatively/pre-habilitation with enhanced recovery through the inpatient journey and expediting patient discharge to an appropriate facility for on-going management.

Better Care Now: Waits

The Trust's Strategic Direction, as set out in the 2013/14 Strategic Plan, identifies the aim of zero delays for patients. Better Care Now: Waits is a Trust wide improvement programme to reduce delays for inpatients supporting the delivery of this ambition.

The Waits project aims to improve the quality and safety of care and the experience for patients through a reduction in the time patients spend waiting for assessments and diagnostics, with a standard referral to assessment timescale of 24 hours or less.

The approach taken to establish the top internal 'waits' has allowed for targeted action to be taken to improve access to these services. This work will mean that rather than waiting a number of days for services such as a CT scan or an occupational therapy review, patients can expect to be waiting less than 24 hours. To support this project has been the roll out of 'Board Rounds' across the Trust. These daily ward based meetings involve the full multidisciplinary team briefly discussing each patient to ensure their care is being progressed appropriately and that patients do not experience delays in their inpatient stay. This proactive management of the patient's journey through their inpatient stay will improve the quality of care we provide, thereby improving the experience and outcomes for patients.

The Better Care Now: Waits Project continues to target improvements in each of the highest wait areas to ensure that patients receive timely access to services supporting earlier discharge from hospital and improved patient experience.

Disclosure of Public Interest

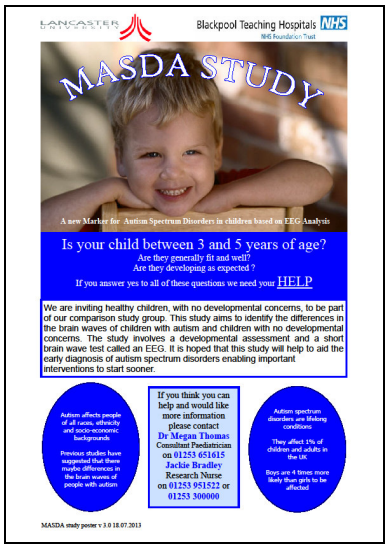
The Trust has held no public consultations between 1st April 2013 – 31st March 2014

Research and Development

Grant Successes

MASDA – Marker for Autism Spectrum Disorders based on EEG Analysis for Autism Spectrum Disorders based on EEG Analysis

Dr Megan Thomas, Consultant Paediatrician and Director of Research and Development is collaborating with Professor Aneta Stefanovska, a Bio-Physicist and Professor Peter McClintock, Emeritus Professor of Physics, and colleagues from Lancaster University to explore a potential new biomarker for autism spectrum disorder.
Diagnosis of autism spectrum disorders currently depends on the clinical recognition of significant problems with an individual's communication, social interaction and flexible thought processes. There is no definitive test to confirm or rule out the diagnosis. Finding a way of making the diagnosis before symptoms are well established may increase the impact of interventions. This study is looking at an innovative technique based on the nonlinear analysis of EEG waves measured from children diagnosed with this condition. In order to achieve this, brain waves of young children with a diagnosis of an autism spectrum disorder will be compared with the brain waves of similar young children who have no developmental problems. This study has received a research grant from the charity Action Medical Research.



United Kingdom Frozen Shoulder Trial (UK FroST)

Mr Bambos Charalambous, Consultant Orthopaedic Surgeon is a co-applicant with Professor Amar Rangan, Clinical Professor at South Tees Hospitals NHS Foundation Trust and colleagues on the UK FroST study.
Frozen shoulder is a painful and debilitating condition causing stiffness and disability in the affected shoulder and arm. Most patients with frozen shoulder are treated in the community by their family doctor. Around 1 in 10 patients with this condition, who do not improve with simple treatment, get referred to hospital. The aim of this research is to evaluate commonly used interventions for management of the frozen shoulder in secondary care. It will look at the effectiveness and cost effectiveness of the more invasive and costly surgical interventions that are most commonly used in the NHS and compare them with early structured physiotherapy. The acceptability of these interventions to patients and clinicians and important outcomes to patients will be explored. The study has been nominated for funding from the National Institute for Health Research Health Technology Assessment Programme.

Trust sponsoring locally developed studies

The sponsor of a research is responsible for ensuring that specific duties are performed, properly distributed, allocated and accepted by investigators and their employing institutions and care organisations, and for the governance of the research study from conception to final completion, including design, management, and finance.

The Trust is now sponsoring a number of studies including:

The TINSELS Trial – Simulated learning is an established approach for skill acquisition. It provides the opportunity for core knowledge and skills into the practical/work environment in a safe and effective way. The study is designed to investigate the design, applicability and effectiveness of simulated learning in a variety of clinical settings. The ultimate outcome for this study will be a production of simulation based training packages. Dr Morris Gordon, Consultant Paediatrician, Mrs Helen Box, Associate Director of Medical Education.

TAVI QL- Aortic stenosis (narrowing of the heart valve) is the most common valve disease of elderly people in the western world. Surgical valve replacement has been the treatment choice in symptomatic patients with severe aortic stenosis for decades. Approximately 30% of patients are declined surgery as they are high risk. Transcatheter Aortic Valve Implantation (TAVI) has emerged as an alternative treatment for high risk patients. This study aims to assess the quality of life of TAVI patients in the North West of England and will help in the future selection of patients for TAVI. Dr David Roberts, Consultant Cardiologist, Dr Joanne Sanderson, Clinical Psychologist and Dr Izhar Hashmi, Research Speciality Doctor in Cardiology.

Research Recognition – First Global Patient

Recruiting the first global patient (first patient in the world to join a study) is a key performance indicator for the pharmaceutical industry in clinical research as it shows that the NHS can support the rapid set-up of clinical trials on the international stage.
The Trust is pleased to report that it has achieved first global patient in a clinical trial in liver failure for Conatus Pharmaceuticals. Dr Peter Isaacs, Consultant Gastroenterologist and Associate Research and Development Director is the local investigator. The Trust was widely recognised by the National Institute for Health Research and commended by Conatus Pharmaceuticals for the rapid set-up of this trial.

NIHR Leadership Support and Development Programme – Easier and Faster Research: The NIHR – Ashridge Development Process

The Government wants to make health research easier and faster so that research findings can benefit patients more quickly and we can make this country a competitive location for life science industry research. In recent years significant progress has been made on developing research in the NHS. However, the NHS is not where it needs to be if health research is to have the maximum impact on patient care, and the NHS is to meet the challenging national benchmarks for research initiation and delivery. The R&D function in NHS Trusts is at the heart of the research process, and the leadership of the R&D Director and R&D Senior Manager is critical.

Dr Megan Thomas, Director of Research and Development and Michelle Stephens, R&D Manager were successful in being accepted on Cohort 2 of the NIHR / Ashridge Development in Spring 2012. This programme lasts for a year and includes workshops, one-to-one coaching, small group work, Master classes, and a conference. All these activities are designed to provide hands-on practical support, learning from others' experiences and offering relevant and timely strategies for bringing about sustained improvement in the Trust.

NHS
National Institute for
Health Research

Research Team developing with the help from the Trust's Organisation Development Team

The Research Team are being supported by the Trust's Organisational Development Team to take part in the Aston University Team based working programme. This will allow us to examine the team and look at ways to increase our effectiveness. The team has already had an 'away day' to look at how they felt we were working together; the impact of personality styles and developed team based operating principles. The next stage will be to cascade the Aston organisational development team based working programme from the senior team to the operational team.

Thank you!

This past year has been extremely busy and challenging in Research and Development, but we would like to take the opportunity to thank all of the patients who have joined one of the clinical trials. Your contribution is very much appreciated.

Our Environment

Sustainability Reporting

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

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

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

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

- Manage transport requirements
- Use energy, water and other finite resources responsibly and efficiently
- Reduce overall waste disposal, reduce the hazards from waste and increase reuse and recovery of resources where feasible

- Prevent pollution resulting from discharges to water or emissions to air – including emissions of CO_2 and other greenhouse gases

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

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

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

Day to day responsibility for implementing the sustainability agenda is delegated to the Estates & Facilities Divisions. A quarterly Environmental and Sustainability Management Forum brings together key team members throughout the Trust to ensure performance and targets are delivered.

Environmental Performance in Key Areas for 2012/13 and 2013/14

Table: Environmental Performance

		Non Financial Data		Cost	
		2012/13	2013/14	2012/13	2013/14
Waste Minimisation	Waste Arising (Total waste from all sources)	1,490 tonnes	1,506 tonnes	£287,960	£302,342
	Clinical Waste (waste disposed of via high temperature incineration)	631 tonnes	658 tonnes	£213,909	£232,404
	Waste sent to landfill	89 tonnes	12 tonnes	£9,315	£1,140
	Recycled waste	638 tonnes	660 tonnes	£33,488	£34,642
	Non Hazardous Incineration (Energy from waste)	119 tonnes	169 tonnes	£12,455	£16,055
	Electrical and Electronic waste items	7.62 tonnes	7 tonnes	£1,100	£1,173
	Percentage of Waste subject to a recycling or recovery exercise	94% (43% Recycled)	94% (54% Recycled)	n/a	n/a
Management of Finite Resources	Water	152,992 m3	**161,208 m3**	£501,133	**£510,194**
	Electricity - Imported	30,915 GJ	**36,486 GJ**	£993,429	**£1,172,819**
	Total Electricity – Imported + CHP generated	64,028 GJ	**64,778 GJ**	£1,196,641	**£1,352,936**
	Gas	223,909 GJ	**206,625 GJ**	£1,851,567	**£1,826,227**
	Other Energy – Heating Oil	1,232 GJ	**1,214 GJ**	£23,162	**£22,305**

	Fuel used in Blackpool Teaching Hospital Trust owned transport		See Dave Riley	£46,003	See Dave Riley
	Fuel used in ex North Lancashire Primary Care Trust owned transport		See Dave Riley	£87,310	See Dave Riley
Direct Green House Gas (GHG) Emissions	Direct emissions from the energy sources above only – excluding CHP generated electricity	16,168 tonnes	15,161 tonnes	n/a	n/a
Explanatory notes	-Data published in 2012/13 has been corrected to best available data for the purposes of this report. -To bring this report in line with internal monthly reports waste costs (including those for 2012/13) are reported exclusive of VAT. All other costs are inclusive of VAT. -This figure represents a maximum based on in year purchases. The actual figure consumed is likely to be slightly lower. -Above data excludes non-acute community sites *-The information above is an extrapolation of the best available data at the time of compilation (January 2014). Actual year end figures may therefore differ slightly from those presented. In the event of any difference between this data in this report and that presented in our annual Estates Returns Information Collection (ERIC) return the ERIC figures are to be preferred.*				

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

A key achievement in 2013/14 saw the Estates Department awarded £1.3million from the Department of Health to invest in energy efficiency technologies. These technologies include the replacement of ageing steam calorifiers with modern efficient plate heat exchangers, a 100kW CHP unit at Clifton Hospital and improvements to the central steam distribution system, all of which will generate annual savings of £300,000 which will be re-invested into patient care.

Light-Emitting Diode (LED) lamps are now installed as standard throughout the Trust, where a compatible bulb is available for existing fittings, when bulbs reach their end of useful life. The new multi-storey car park and main entrance has implemented LED lighting technology and an intelligent lighting control strategy to turn off un-necessary lighting if Lux-levels are sufficient or if no motion is detected. This strategy will save the Trust in the region of £32,000 per annum on running costs of the building compared to if standard fluorescent lights were fitted with no controls.

Sustainability and life-cycle management were at the forefront of design for the new multi-storey car park and main entrance, as not only is LED lighting and controls utilised throughout, but also other energy efficient technologies including air source heat pumps linked to under floor heating in the main atrium, revolving doors to reduce heat loss and variable speed drives on motors and fans. This all reduces the environmental impact of the building and creates a welcoming and pleasant start to the patient experience.

2013/14 continues to see the financial benefits of the 1.2MW CHP onsite at Victoria Hospital. Although there was a period of downtime during the months of September and October, the CHP has still achieved an annual net saving of £165,584 for the Trust and prevented 1,892 tonnes CO2 emissions being emitted into the atmosphere.

The Carbon Reduction Commitment Energy Efficiency Scheme is in the third year of reporting, with an estimated liability under the scheme of £212,000 for 2013/14. The cost per tonne of CO_2 is currently £12, although this is forecast to increase to £16 per tonne from April 2014, highlighting the importance of energy efficiency and reducing consumption within the Trust.

2013/14 has been a period of consolidation and investigation of current operations for Waste Management. Ongoing review of the Non Clinical Waste Streams has led to changes in contractor service resulting in reduced collections via bulking with larger containers and improved costs/revenues. Additional manpower in the Waste Compound has allowed improved pre assessment and sorting of waste streams along with the ability to improve site wide collections of confidential waste, Batteries and Printer Cartridges.

The new Mill Size Cardboard Baler will allow reductions in operator time & storage plus increased revenue. The existing baler has been retained at a significant cost saving which will permit the recovery and recycling of plastic which will supply another good revenue stream whilst reducing the cost and collection frequency of the current general waste compactor.

Work is ongoing to improve compliance with regards to food waste disposal and to that end Catering/Waste Management will be running a trial of food waste digesters in early 2014 in conjunction with W2O/Mechline. The trial will aim to confirm improvements in food waste processing which will reduce costs in Energy /Water consumption, infrastructure maintenance and enable the current general waste stream to be re classified as Dry Mixed Recycling producing significant cost savings.

In the 1st quarter of 2014 initial auditing and trials will take place to further improve Clinical Waste Compliance and Segregation. In partnership with Sharpsmart/Clinisafe we will look at introducing re- usable sharps containers, improved packaging and a "bag to bed" system for the compliant segregation of all Clinical Waste. The new segregation system will improve the patient environment by removing all clinical waste to sluices/dirty utilities following treatments were possible, supply improved training and information on compliant segregation via e-learning, one to one training, information posters and labelling of waste bins. A new Waste Data Base is being established in partnership with the Trust's Information Management Team. This will improve waste information gathering and will be linked into the Trust Intranet along with the e-learning suite provided by Sharpsmart/ Clinisafe Project.

Clinical Waste Pre Acceptance and Dangerous Goods Safety Audits were completed by an independent contractor in the 4th Quarter of 2013 and will be use to assist in improvements in Clinical Waste and Transport Compliance during 2014 and reviewing policy and procedure.

Going forwards into 2014/15, we are keen to begin integrating Environmental and Sustainability target performance data for the non-acute community sites into the combined Trust annual reporting, and at present are concentrating on ensuring all data collected is sufficient, accurate and relevant to the requirements of our patients and staff.

Social and Community Issues

The situation of challenging the improvement of life expectancy and reducing inequalities in Blackpool, Fylde and Wyre is provided in detail below.

Reduced life expectancy is perhaps the ultimate health inequality as well as a population scale series of human tragedies. It is also a general indicator of a population's health and wellbeing. Low life expectancy is accomplished by a longer period spent in ill health, with all the associated suffering and problems.

The Fylde Coast's mortality and life expectancy is a challenge faced by local partners. An outline of some of the key approaches and future directions are detailed below:-

- secondary prevention for cardiovascular (CVD) events
- improving diabetes management
- treating CVD risk among Chronic Obstructive Pulmonary Disease (COPD) patients
- reducing smoking in pregnancy
- reducing harmful alcohol consumption providing stop smoking interventions
- providing flu vaccination for those with existing health conditions

Modelling the possible impact of these interventions shows that, if fully implemented, they have the potential to reduce deaths. Improving life expectancy and reducing inequalities across the Fylde Coast is a massive challenge in view of the strong and well-evidenced link between deprivation, economic performance and life expectancy.

Our Finances

Income and Expenditure Performance

As a result of a detailed analysis of the Trust submitted Q2 2013/2014 Monitoring Return, the independent regulator Monitor highlighted a material change to the Trust's financial projections and accordingly requested that the Trust submit a reforecast for the remainder of the 2013/2014 financial year.

Table 1 below therefore compares performance against the 2013/2014 reforecast submitted in mid - December 2013.

Before the reporting of exceptional items the Trust achieved a surplus of £3.4m for the year, however taking into account a net loss on the revaluation of assets £14.7m, net loss on disposal of assets of £0.2m, and net restructuring costs of £0.9m, the deficit is £12.4m for the year.

Full details of the Trust's financial performance are set out in the accounts for 1st April 2013 to 31st March 2014 that accompanies the Annual Report in Annex G.

Table 1 compares the 2012-13 actual performance to the 2012-13 plan.

Table 1	Reforecast £'m	Actuals £'m	Variance £'m
Total income	365.9	370.5	4.6
Expenses	(350.9)	(356.0)	(5.1)
EBITDA*	15.0	14.5	(0.5)
Depreciation	(6.2)	(6.0)	0.2
Dividend**	(4.5)	(4.0)	0.5
Loss on asset disposal	0	(0.2)	(0.2)
Gain on Revaluation	0	(14.7)	(14.7)
Restructuring costs	(0.8)	(0.9)	(0.1)
Interest income	0.1	0.1	0.0
Interest expense	(1.2)	(1.2)	0.0
Surplus(Deficit)	2.4	(12.4)	(14.8)

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

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

Chart 1: Surplus performance

	2009/10 £'m	2010/11 £'m	2011/12 £'m	2012/13 £'m	2013/14 £'m
Surplus / (Deficit)	(5.4)	(23.1)	3.3	3.2	(12.4)

Chart needs to be updated (Printers maybe?)

The financial performance prior to exceptional items was £0.8m above plan.

Chart 2: Completed Patient Spells

	2009/10 Spells	2010/11 Spells	2011/12 Spells	2012/13 Spells	2013/14 Spells
Completed Spells	92,020	97,390	97,422	108,100	94,355

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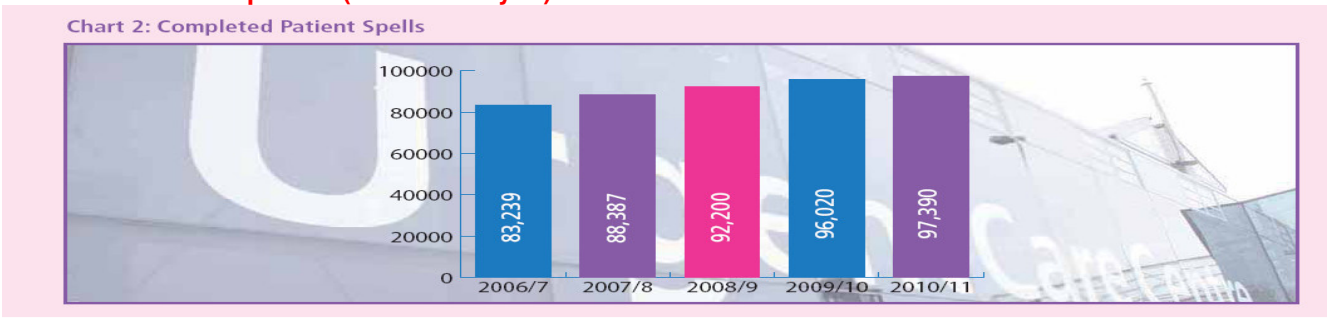

Chart 3: Outpatient Attendances

	2009/10 Attendances	2010/11 Attendances	2011/12 Attendances	2012/13 Attendances	2013/14 Attendances
Outpatient Attendances	285,731	276,442	287,014	296,917	305,185

Chart needs to be updated (Printers maybe)

Chart 4: A&E Attendances

	2009/10 Attendances	2010/11 Attendances	2011/12 Attendances	2012/13 Attendances	2013/14 Attendances
A&E Attendances	91,448	83,187	80,572	83,002	82,999

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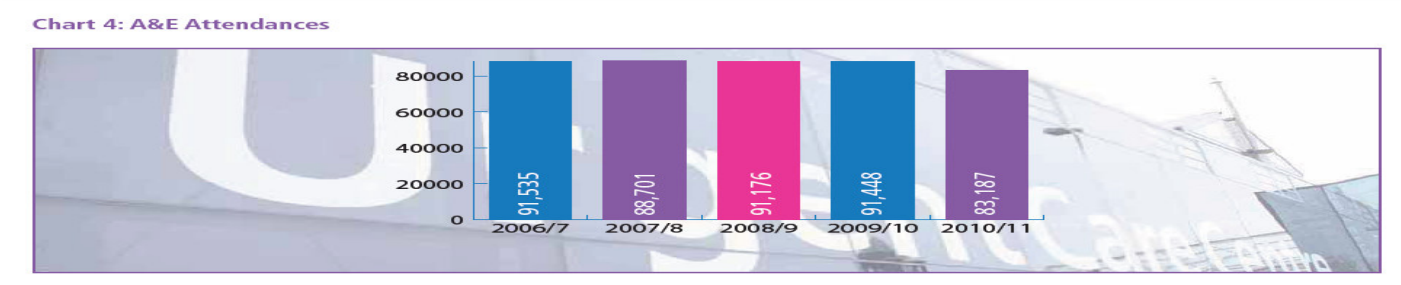

Income from providing clinical services to NHS patients, as below, represents the majority of the Trust's income (£335.3m or 91%; 2012/13: £325.7m or 90%). The provision of these services is covered by contracts with Clinical Commissioning Groups and other NHS commissioners. The terms of these contracts are agreed locally between the Trust and commissioners based on the national contract

published by the Department of Health and priced using the National Tariff or locally agreed prices as appropriate.

Chart 5 summarises clinical income recovery by Commissioners.

Chart 5: Clinical Income by Commissioner

Commissioner	2013/14 Clinical Income (£'m)
Blackpool CCG	120.1
Fylde & Wyre CCG	93.7
Lancashire North CCG	15.1
NHS England - Specialist Commissioning	61.1
NHS England - Other Commissioning	23.8
Other Associate PCTs / CCGs	10.1
Non-contracted CCGs	11.4
Total	**335.3**

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Chart 4: A&E Attendances

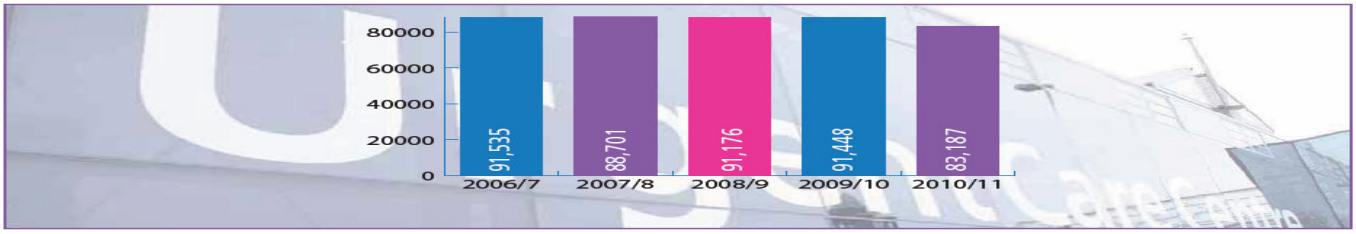
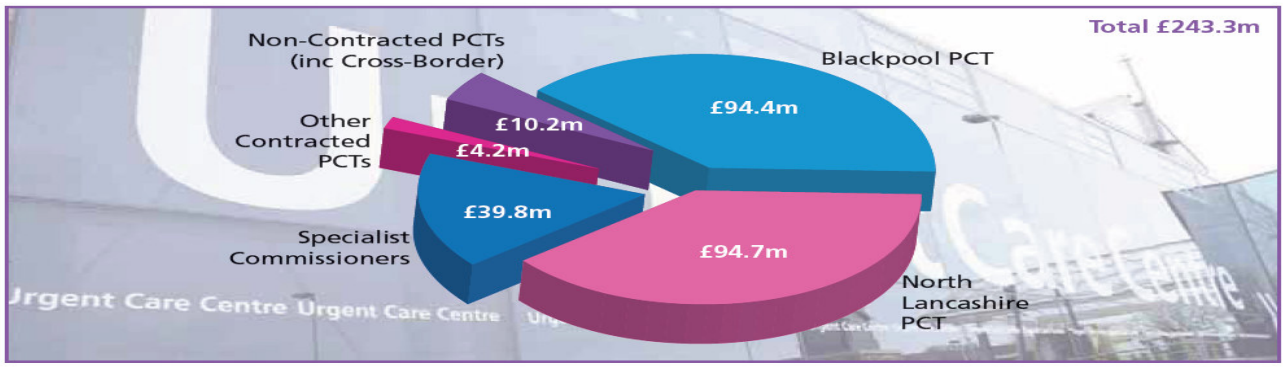


Chart 5: Clinical Income by Commissioner



In addition to the NHS Clinical income described above, the Trust receives a number of other income streams. The trend in this income is summarised in Chart 6 and performance in 2013/14 is summarised in Chart 7. Performance in 2013/14 is broadly in line with previous years with the most significant variation relating to predominately exceptional items as set out below.

A full asset revaluation was carried out in March 2014 this resulted in upward valuation of previously impaired assets as a result of a combination of re use and change in indices.

Chart 6: Non-NHS Clinical/Non-Clinical Income 2009/10 to 2013/14

	2009/10 £'m	2010/11 £'m	2011/12 £'m	2012/13 £'m	2013/14 £'m
Non-NHS Clinical & Non-Clinical Income	30.3	30.0	33.0	34.4	37.9

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Chart 6: Non-NHS Clinical/Non-Clinical Income 2006/07 to 2010/11

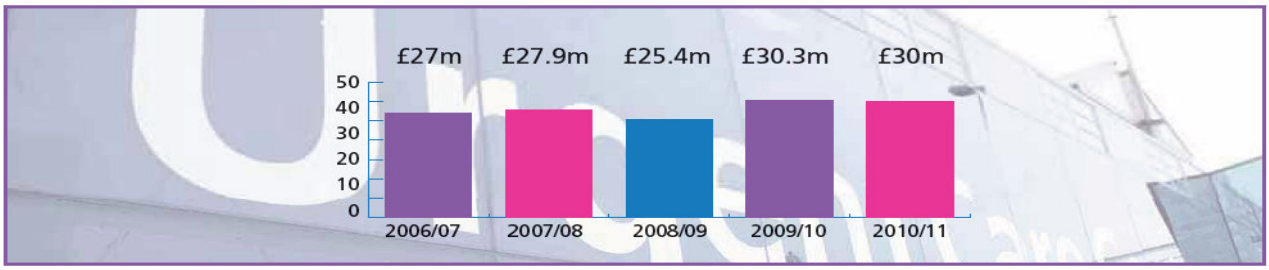
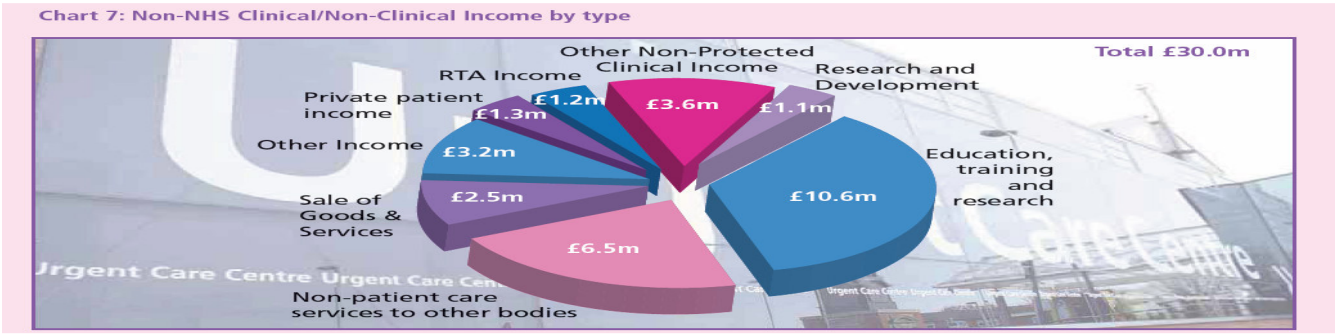


Chart 7: Non-NHS Clinical/Non-Clinical Income by type

	2012/13
	£'m
Private patient income	1.9
RTA Income	1.3
Other Non-Protected Clinical Income	0.8
Research and Development	1.8
Education, training and research	11.6
Non-patient care services to other bodies	5.0
Sale of Goods & Services	2.6
Charitable/other contributions	9.2
Reversal of impairments	2.5
Other income	1.2
Total	37.9

Chart needs to be update (Printers maybe)

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



These income streams equated to £37.9m or 10.2% of the total income earned for the year. Of this £26.0m or 7.0% relates to the provision of other services not directly related to healthcare, including catering and car park income. Any surplus from these services help reduce the cost of patient related activities.

With effect from 1st October 2012, the statutory limitation on private patient income earned by NHS Foundation Trusts under section 44 of the National Health Service Act 2006 was repealed by the Health and Social Care Act 2012. Consequently the Trust is no longer required to disclose private patient income against the base year (2002/03).

Chart 8: Private Patient Income 2009/10 – 2013/14

	2009/10	2010/11	2011/12	2012/13	2013/14
	£'m	£'m	£'m	£'m	£'m
Private Patient Income	1.4	1.3	1.2	1.4	1.9

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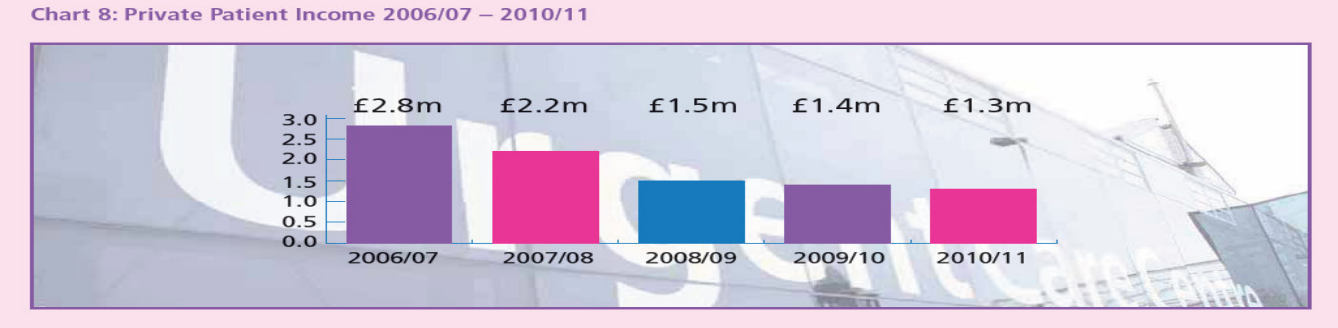

The level of private patient income is decreasing as a proportion of total patient income, reflecting the improvement in waiting times and the reduction in private healthcare insurance in the current economic climate.

Chart 9 shows the expenditure for 2013/14 broken down by expenditure type.

Chart 9: Expenditure

	2009/10	2010/11	2011/12	2012/13	2013/14
	£'m	£'m	£'m	£'m	£'m
Expenditure	276.8	298.1	281.0	364.6	385.6

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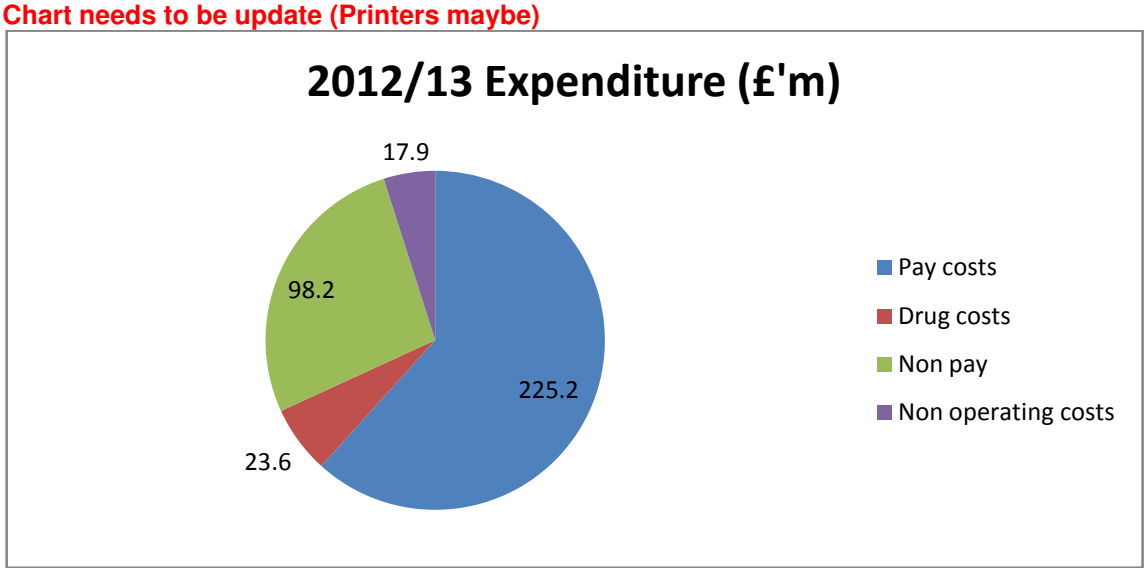

The above expenditure reflects the higher than planned activity delivered, additional CCG funding for developments and winter, additional expenditure to meet the Keogh Action Plan and the achievement of £12.7m of QIPP. In addition, the Trust has also accounted for an impairment charge as a result of downward valuation of £17.2m which has a significant impact on non- operating costs.

The Trust has in place a Programme Management Office to scrutinise QIPP planning and delivery. In addition, the Trust is utilising external support to identify areas of improvement and develop / implement action plans to deliver the required efficiency. During the last three years the Trust has delivered savings of £15.5m in 2011/12, £19.2m in 2012/13 and £12.7m in 2013/14.

Significant progress has already been made in the identification and delivery of efficiencies for 2014/15 with the full £20.6m identified

During the year the Trust spent £5.3m on management costs which represents 1.45% of turnover. By comparison, in 2012/13, management costs as a percentage of turnover were 1.57%.

The definition of management costs used by the Trust is any one in non-clinical posts at band 8b and above.

Senior employees remuneration is set out in the Remuneration Report section of this report.

Cash Flow and Balance Sheet

The Trust's cash balance at the end of the financial year was £25.3m against a reforecast balance of £13.6m. The cash balance was £11.7m above the reforecast primarily driven by capital cash slippage of £2.8m, deferred income above plan by £1.0m primarily relating to the North West Leadership Academy, an increase in provisions above plan of £4.5m and active management of working capital balances £3.4m.

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

Chart 10: Year-end Cash Balances

	2009/10 £'m	2010/11 £'m	2011/12 £'m	2012/13 £'m	2013/14 £'m
Year end cash balances	11.7	15.4	19.6	27.4	25.3

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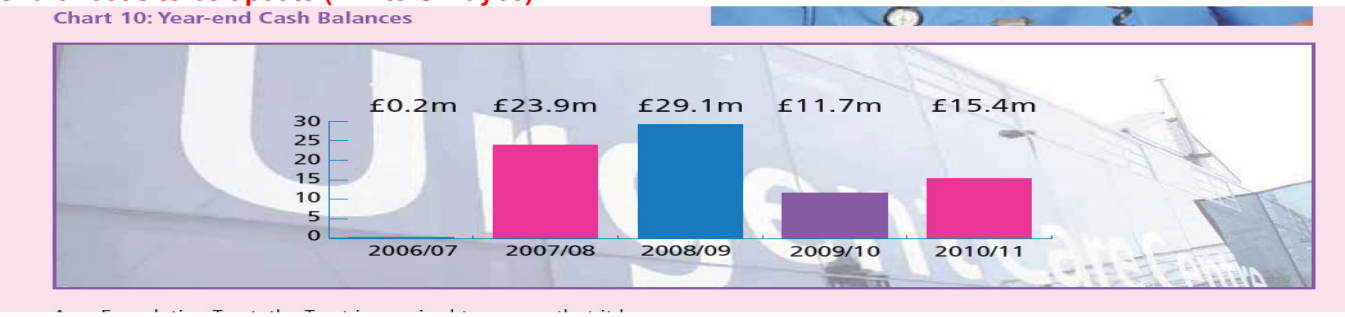


As a Foundation Trust, the Trust is required to ensure that it has enough liquidity to support its working capital requirements. The Trust has a worked hard to maintain sufficient cash and liquidity to support ongoing demands.

To comply with best practice the Trust is required to pay 95% of undisputed invoices within 30 days of receipt. The table below summarises the performance for 2013/14.

Chart 11: Better Payment Practice Code

Subject	Number 2013/14	£'000 2013/14	Number 2012/13	£'000 2012/13
Total Non-NHS trade invoices paid in the year	97,021	136,233	82,529	111,042
Total Non-NHS trade invoices paid within target	34,042	61,080	25,991	43,691
Percentage of Non-NHS trade invoices paid within target	35.1%	44.8%	31.5%	39.3%
Total NHS trade invoices paid in the year	2,698	32,937	2,851	29,159
Total NHS trade invoices paid within target	1,183	18,302	1,140	16,046
Percentage of NHS trade invoices paid within target	43.8%	55.6%	40.0%	55.0%

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

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

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

The Trust invested over £18.8m in capital schemes during 2013/14. Expenditure during the period included the following investments;

	£m
Main Entrance / Multi Storey Car Park	**11.6**
Stoke Unit	**0.9**
A&E upgrade	**3.3**
Other Schemes	**3.0**

Financial assistance for the 13/14 capital programme was sourced from the ITFF (£6.1m) and PDC drawdown of £2.6m, the remainder being internally funded.

The Trust has a capital programme of £9.6m for 2014/15. A significant element of this spend £5.6m relates to the on-going clinical equipment replacement programme which will be financed by ITFF loan drawdown. The Women's and Children's and Main entrance Multi Storey Car Park schemes were completed and commissioned in 2013/14.

As a NHS Foundation Trust, the Trust has greater freedoms to borrow money in order to finance capital investment as described above.

Performance Against Monitor's Compliance Framework

Monitor is the Independent Regulator of Foundation Trusts. Monitor has devised a system of regulation described in its Compliance Framework, which is available from the Monitor web site. http://www.monitor-nhsft.gov.uk/home/our-publications?id=932. A brief description of Monitor's regulatory ratings is provided below. Monitor takes a proportionate, risk based approach to regulation. The assessment of risk by Foundation Trusts and by Monitor was articulated during 2013/14 by the application of two risk ratings which are updated each quarter in relation to:

- Continuity of Service Rating (COS) rated 1-5, where 1 represents the highest risk and 5 the lowest); and
- Governance risk rating (rated red, amber-red, amber-green or green).

These results are shown in the table below.

Financial Risk Rating

In August 2013 Monitor the independent regulator of Foundation Trust's released the Risk Assessment Framework 2013/14 which replaced the Compliance Framework 2013/14. The Risk Assessment Framework 2013/14 introduced a revised financial risk rating the Continuity of Services Risk Rating.

Continuity of Service Risk Ratings are allocated using a scorecard which compares key financial information across all Foundation Trusts. A rating of 4 reflects the lowest level of financial risk and a rating of 1 the highest. When assessing financial risk, Monitor will assign quarterly and annual risk ratings using a system which looks at two common measures of financial robustness.

- **Liquidity: days of operating costs held in cash or cash equivalent forms, including wholly committed lines of credit available for drawdown; and**
- **Capital servicing capacity: the degree to which the organisation's generated income covers its financial obligations.**

The risk rating is forward-looking and is intended to reflect the likelihood of an actual or potential financial breach of the Foundation Trust's Terms of Authorisation. The Continuity of Service Risk Rating system is on a scale of 1-4 as follows:

1. **Highest risk – For licence holders demonstrating a significant level of financial risk and could result in Monitor taking formal enforcement action.**
2. **Material level of financial risk and Monitor may subsequently investigate whether the organisation is in breach of the continuity of services licence which may result in further regulatory action including monthly monitoring.**

3. **Regulatory concerns in one or more components the licence holder may be asked to provide a limited amount of financial information on a monthly basis,**
4. **No regulatory concerns**

Governance Risk Rating

Monitor uses the term governance to describe the effectiveness of an NHS Foundation Trust's leadership. They use performance measures such as whether Foundation Trusts are meeting national targets and standards, e.g. a reduction in Clostridium Difficile rates, as an indication of this, together with a range of other governance measures described below. Monitor consider these areas when assessing governance risk at Foundation Trusts, as reflected in the risk ratings which they publish for each Trust

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

The Governance Risk rating system is on a scale of Red - Green as follows:

- Red - Likely or actual significant breach of Terms of Authorisation
- Green – No material concerns

Financial Performance – Against Monitor's Compliance Framework

Based on its 2013/14 Annual Plan resubmission, the planned risk rating was assessed at Continuity of Service Risk Rating 3. Actual performance for 2013/14 is a Continuity of Service Risk Rating of 3 and the table below summarises the Trust's performance against the Risk Assessment Framework (Continuity of Service Risk Ratings were not reported for 202/13):

	Target (level 3 risk)	2013/14 plan	2013/14 Re-plan	2013/14 Annual Performance
Liquidity ratio	**>-7 days**	**-11 days**	**-14 days**	**-12 days**
Capital Service Cover	**>1.75%**	**2.18x**	**1.77x**	**1.80x**

Governance Performance – Against Monitor's Compliance Framework

Monitor has rated BTHFT **'Green'** for governance risk throughout 2013/14. The Trust has strengthened its performance management structure in relation to delivering the Care Quality Commission (CQC) quality and safety standards and has **maintained progress to deliver top 10% performance for clinical quality**. Over the next 12 months, the Trust will continue to focus on the quality of services that we are offering to our patients and the implementation of our Strategic Framework. The Strategic Framework sets out the approach that this will take and the measures that the Board of Directors have identified as being key to delivering quality care and how success in these areas will be measured.

On a quarterly basis, the Trust is required to submit monitoring returns to Monitor, as the regulator, for performance regarding finance and governance. A report is submitted to the Board each quarter regarding the following key purposes:

- to set out the Trust's Monitor Governance Declaration, Governance Risk Rating and supporting documentation in accordance with its Terms of Authorisation and the Monitor **Risk Assessment** Framework requirements **2014/15** and;

- to provide information and assurance to the Board, and to Monitor, that the necessary actions are being implemented to address any issues or concerns raised

Further information regarding arrangements in place to govern service quality is outlined in the Quality Report at Annex A and in the Annual Governance Statement at Annex E.

The tables below provide a summary of regulatory risk rating performance throughout the year and a comparison to the previous year.

The tables below also provide a summary of the actual quarterly regulatory risk rating performance compared with expectations in the annual plan.

Regulatory Ratings Report 2012/13					
Subject	**Annual Plan 2012/13**	**Q1 2012/13**	**Q2 2012/13**	**Q3 2012/13**	**Q4 2012/13**
Financial Risk Rating	**2**	**2**	**2**	**2**	**3**
Governance Risk Rating	**Green**	**Green**	**Green**	**Green**	**Green**

Regulatory Ratings Report 2013/14					
Subject	**Annual Plan 2013/14**	**Q1 2013/14**	**Q2 2013/14**	**Q3 2013/14**	**Q4 2013/14**
Continuity of Service Rating	**3**	**3**	**3**	**3**	**3**
Governance Risk Rating	**Green**	**Green**	**Green**	**Green**	**Green**

During 2013/14, the Trust has achieved a surplus before exceptional items of £3.4m (and a deficit of £12.4m after exceptional items), The exceptional items impact relates to asset impairments of £14.7m and restructuring of £0.9m.

At its meeting of 26th March 2014, the Finance Committee considered the budget for 2014/15 and going concern assessment. The budget is based on activity assumptions that have been agreed with commissioners, combined with expenditure budgets that have taken into account the likely cost risks in this period and the requirement for efficiencies of £20.6m.

On the basis of these plans, "after making enquiries, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts."

The Trust's main accounting policies, including policies for pensions, that are used to prepare the accounts are set out in Annex G to this report. Details of the Directors' remuneration is included in the Remuneration Report. The format of the accounts and the supporting accounting policies were reviewed by the Trust's Audit Committee at its meeting on 30th April 2013.

In the opinion of the Directors there are no reportable events after the reporting period.

Income Disclosures

As per Section 43(2A) of the NHS Act 2006, the Board is not aware of any circumstances where market value of fixed assets is significantly different to carrying value as described in the Trust's financial statements. The Trust's auditors have provided an opinion on our 2013/14 accounts, which is outlined at Annex F.

Blackpool Teaching Hospitals NHS Foundation Trust has met the requirement for the 2013/14 Financial Year that the income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

Where Blackpool Teaching Hospitals NHS Foundation Trust has received income other than income from the provision of goods and services for the purposes of the health service in England, this other income and any associated expenditure has not had a detrimental impact on the provision of goods and services for the purposes of the health service in England and where appropriate has contributed to / supported the provision of goods and services for the purposes of the health service in England.

Financial Instruments

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

Credit Risk

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

Liquidity Risk

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

Market Risk

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

Cost Allocation and Charging

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

External Contracts

The Trust has a number of external contracts as detailed below:-

Blackpool Clinical Commissioning Group (CCG)
Fylde and Wyre Clinical Commissioning Group (CCG)
Lancashire North Clinical Commissioning Group (CCG)
Cheshire, Warrington and Wirral Area Team (for specialist areas)
Blackpool Council – Public Health
Lancashire County Council – Public Health
National Commissioning Board – Local Area Team

The Trust also has contractual arrangements with the following essential organisations:-

Pricewaterhouse Coopers (PwC) - who are the Trust's External Auditors
KMPG LLP – who are the Trust's Internal Auditors (1st October 2012 – present)
Hempsons Solicitors – who are the Trust's solicitor
Spiral
NHS Supply Chain provider of medical consumables and capital items for general wards and theatres Medtronic UK provider of general medical technologies and services
ISS Facilities Healthcare provider of facilities services
Siemens Healthcare Diagnostics provider of general medical goods and services
Boston Scientific provider of general medical technologies and services

External Auditors

The Council of Governors previously approved the appointment of PwC as the Trust's external auditors until 31st March 2014. PwC were paid £50,500 in respect of statutory audit fees. A supplementary fee included £12,500 for the independent reporting work in relation to the Independent Auditor's report in the annual quality report.

A formal competitive tendering process was initiated early in 2014 to select and appoint a provider for External Audit Services for 2014/15 and beyond, under the NHS Shared Business Services Framework Agreement NHS/11/SG/ZY/6982. Based on the findings of the evaluation panel, the Trust recommended the appointment of

PricewaterhouseCooper (PwC) as their provider of External Audit Services until May 2017 with the option to extend the appointment for an additional year until May 2018, and this recommendation was approved by the Council of Governors at their meeting on 17th March 2014.

The Trust limits work undertaken by the external auditors outside the audit code to ensure independence is not compromised. In 2013/14 PwC did not provide any other services to the Trust.

Counter Fraud

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

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

Principal Risks and Uncertainties

The NHS is changing rapidly and for the Trust this gives many opportunities as well as risk and uncertainty. The Board of Directors has identified the strategic risks facing the Trust. These risks are formally reviewed on a quarterly basis by the Board of Directors'. Current strategic risks are identified in the Annual Governance Statement in the table at section 4.4 and appropriate risk management and mitigation plans are in place for each.

Future Development and Performance of the Business

Following the integration of hospital and community services, this has helped improve the pathway of patient care through the provision of seamless services that are accessible, clinically effective and of a high quality. Following on from the current year's performance of integrating services, the Trust's is planning to undertake the following developments, in 2013/14, to continue to improve the performance of the business in the following areas:-

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

A Strategic Framework for the Trust moving forward to 2020 has been created identifying the new vision and values for the organisation, strategic objectives, aims and targets. This strategy will also link in with and support the wider health economy strategy for future health and care services, specifically working in collaboration with the Fylde Coast Unscheduled Care Board, the Fylde Coast Commissioning Advisory Board and our other partnership organisations. (Further information is available in the Trust's Future Business Plans section of this report).

Our Future Business Plans

The Board of Directors recognises that the changing environment and external factors, such as The Operating Framework 2014/15, the current financial climate, patient choice and the quality improvement agenda impact on our future business plans.

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

The Trust's Strategic Direction, as set out in the Annual Plan 2014/15, and our Vision and Values, as reviewed and agreed by the Board of Directors in 2013, underpin the work programme for 2014/15. Over the last 12 months we have undertaken a great deal of work to develop our approach to delivering our future Vision.

Whole Health Community Vision

The vision for the local health economy is to introduce new models of care that will see our approach change to be more holistic, focused on continuous and proactive care provision instead of the reactive, episodic approach that has traditionally been used by the NHS.

The Trust's strategic plan, which is supported by our local Clinical Commissioning Groups, is to improve joint working across its acute and community services to provide integrated care that is safe, effective and caring. Our models of delivering care will change so that we can better support improvements in the health and well-being of the population through partnership working with health and social care, focusing on ill-health prevention, management of long term conditions, and timely access to treatment. We will ensure that as much care as possible is provided in community settings, preventing unnecessary admissions to hospital by providing better support to the most needy and frail patients. Our people-centred workforce will provide safe, high quality care, with patients and their carers involved in decisions about their care.

Our vision is based on three key themes:

Community-centred models of care

The elderly and those living with long term conditions will be better supported by an holistic health and social care system that provides coordinated care in a domiciliary setting or community health centre. Patients will have well-defined care plans that allow health and social care professionals to maintain continuity of care and follow appropriate treatment plans that prevent unnecessary acute admissions. The use of telehealth to support monitoring of patients in their own homes will be introduced, along with the use of electronic patient records that allow professionals to share records more readily. The use of early supported discharge schemes and 'prehabilitation' models across therapy services will mean shorter lengths of stay for those patients who do require a hospital admission.

In-hospital care

Admission to hospital will only occur when acute care is necessary, and standardised care pathways will be used across the diagnostic, treatment, recovery and rehabilitation stages of patient care. The management of emergency admissions will be streamlined to deliver care in an appropriate setting, with improved integration between in-hospital and community-centred services to ensure that patients do not stay in hospital any longer than is necessary. Operating theatres and diagnostic services will be used efficiently and effectively, with support from community health and social care services pre- and post-surgery to ensure that length of stay in an acute setting is optimised, with no unnecessary delays at discharge.

Regional partnerships

The Trust will be a key partner in the planning and delivery of safe, high quality, sustainable care across Lancashire and South Cumbria through its willingness to participate in the federation of services and to share resources across local public sector providers.

Plans for the use of Information Technology

Since 2009 the Trust has been implementing electronic ways of working to benefit patients and staff and moving to an Electronic Patient Record (EPR). An EPR system will support the delivery of high quality patient care, whilst also improving services and empowering clinicians to make the necessary changes in clinical practice. This requires systems that provide real time, high quality clinical information.

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

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

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

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

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

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

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

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

The Trust plans to roll out the components to an EPR system across inpatient and outpatient areas in, with all departments using the relatively simple elements, followed by a layering of the more complex functionality once clinicians have gained confidence in using the systems..

During 2013/14 the Trust has rolled out a clinical portal to overlay existing clinical and administrative systems to enable clinical staff to access patient level information through one interface, this includes radiology results, pathology results, clinical correspondence, patient related activity, theatres information, existing co-morbidities and access GP information through the MIG.

The Trust also rolled out order communications functionality to all inpatient wards covering all pathology and radiology plain film x-rays, allowing clinicians to order tests and view reports electronically negating delays associated with paper referrals and results reporting.

During 2014/15 the Trust is bringing all aspects of Information Management and Technology back under one directorate to ensure efficiency and consistency in the road map to delivering a fully integrated EPR. The aim over the next three years is to deliver a fully integrated community administrative and clinical system, electronic prescribing, electronic documentation storage, electronic referrals and a fully integrated acute patient administration and clinical system.

Contracting

The Trust's contract to provide services during 2013/14 was co-ordinated by NHS Blackpool on behalf of the associate commissioners with each agreeing their respective activity baselines. All parties have worked together to ensure that the range of services and activity levels within the contract are adequate to meet the needs of the population. As previously, part of the contracting process included the agreement of a range of schemes against which the Trust will receive CQUIN (quality incentive) monies. These schemes have been targeted to areas which will benefit patients through a focus on improving outcomes.

During the year the Trust worked with commissioners to understand the emerging national health care agenda and impact of the reorganisations of local commissioning teams. Relationships with Clinical Commissioning Groups have been developed and strengthened to support contract discussions for 2014/15.

• Environmental Development

The financial year 2014/15, will see further improvements in our environmental management and performance. We will continue to explore third party funding opportunities, such as, Salix finance, to support energy efficiency projects and seek innovative technologies to deliver cost savings to the Trust.

Continued improvements to our building management system will be a key focus for 2014/15 to ensure all plant is operating as efficiently and economically as possible, while maintaining a safe and comfortable patient environment. Developments in lighting technology will allow for the installation of automatically controlled lighting, via PIR sensors, in non-patient areas alongside further utilisation of LED technology. The later stage of 2014/15 will see the implementation of an Energy Campaign to engage with staff and visitors focusing on energy awareness and reducing consumption throughout the estate.

These measures should allow us to continue to reduce our direct CO_2 emissions, however with wholesale energy prices forecast to rise by between 5% and 10%; it is unlikely that we will be able to achieve an overall reduction in energy cost.

In 2014/15, we will continue to work with contractors and suppliers to identify alternative products and systems to improve compliance and reduce costs. Our key focus will be on the reduction of Clinical Waste for Incineration. As these changes are implemented within more areas, we should see an improvement in compliance rates and cost reductions in clinical waste disposal.

We will look to further extending our partnership with ISS Mediclean within Waste Management through 2013/14 with improvements in waste compound operations and investigations into waste storage at production level through to on site waste movement and collection systems.

Further work over the next year will look to achieve 100% landfill diversion and on reducing disposal and processing costs by segregating food and organic waste. Work with all our disposal and recovery contractors' means we will exceed our target of 41% for recycling in 2014/15.

Board of Directors' Report

Management Commentary and Principal Activities

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

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

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

The Board of Directors comprises seven Non-Executive Directors (including the Chairman) and six Executive Directors (including the Chief Executive). In addition, there is one non-voting Executive Director. The names of the Board members during the financial year are outlined in the "Profile of the Board" section. Each director has a shared and equal responsibility for the corporate affairs of the Trust in strategic terms and for promoting the success of the Trust.

There were a number of changes to the membership of the Board of Directors during 2013/14 as detailed under 'Board Roles and Structures'.

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

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

- Attend Council of Governors meetings – the Chairman, Chief Executive, Director of Strategy, Director of Finance and Director of Operations attend all meetings and two Non-Executive Directors attend on a rotational basis. Attendance was extended in 2013 to include at least one of the remaining Executive Directors from amongst the Director of Nursing, Medical Director and Director of Workforce & OD.
- Attend meetings of the Membership Committee - one nominated Non-Executive Director attends meetings of the Membership Committee.

In addition, in order for the Council of Governors to understand the views of the Board of Directors, Governors undertake the following:-

- Attend, as observers, Board of Directors meetings which have been held in public since July 2013.
- Attend, as observers, Board sub-committees, for example, Finance Committee, Quality Committee.
- Attend monthly service visits and monthly formal patient safety walkabouts.

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

The Chairman is committed to spend a minimum of three days per week on Trust business. The Chairman's other significant commitments are outlined in the "Profile of the Board" section. The Non-Executive Directors are committed to spend a minimum of four days per month on Trust business. Both the Chairman and the Non-Executive Directors routinely spend in excess of their commitment of three days per week and four days per month respectively on Trust business.

The Board of Directors meets in public a minimum of eight times per year and the Board Agenda is produced to ensure that sufficient time is devoted to matters relating to patient safety and quality, finance and workforce. The Board takes strategic decisions and monitors the operational performance of the Trust, holding the Executive Directors to account for the Trust's achievements. In addition, Board Development Events are held on a monthly basis to ensure that sufficient time is devoted to strategic issues and to consider specific issues in depth.

There is a clear division of responsibilities between the Chairman and the Chief Executive. The Chairman ensures that the Board has a strategy which delivers a service which meets and exceeds the expectations of its served communities and an Executive Team with the ability to execute the strategy. The Chairman facilitates the contribution of the Non-Executive Directors and facilitates the constructive relationships between Executive and Non Executive Directors. The Chairman also leads the Council of Governors and facilitates its effective working. The effectiveness of both the Board and the Council, and the relationships between the Board and Council, are reviewed by the Chairman. The Chief Executive is responsible for executing the Board's strategy for the Trust and the delivery of key targets, for allocating resources and for management decision-making.

On a day to day basis the Chief Executive is responsible for the effective running of the hospital. Specific responsibilities, **for example operational performance,** are delegated by the Chief Executive to the Executive Directors, comprising the Director of Finance, the Director of Operations; the Medical Director, the Director of Nursing & Quality and the Director of Workforce and Organisation Development. The Director of Strategy also reports directly to the Chief Executive.

The composition of the Board of Directors is regularly reviewed and, following the recent changes, it is considered to be balanced and appropriate to the requirements of the Trust.

The Board recognises that a regular evaluation of its collective and individual director performance is critical to continuous development and high performance. The performance of the Board of Directors in its entirety has been regularly reviewed during the past few years. **Following the Board Effectiveness Review in 2010/11, the purpose of which was to review the Board's performance and governance arrangements to ensure that the Board was appropriate and effective in undertaking its role, both KPMG and Deloitte issued a detailed report and action plan. During 2011/13, the Board of Directors implemented the recommendations from the KPMG and Deloitte reports which were monitored on a monthly, and subsequently quarterly, basis to ensure compliance. A follow-up review was undertaken by Deloitte in December 2011/January 2012 to ascertain whether the recommendations contained in Deloitte's detailed action plan had been implemented. The outcome of the follow-up review was that "the Board has responded positively and promptly to the points raised and significant improvements in the effectiveness of the Board have been made and that decision making is effective with no material concerns noted". In October 2012 the Board commissioned KPMG to undertake a Quality Governance Review which commenced in January 2013 and the outcome was reported to the Board in February 2013. An action plan was developed and all recommendations were implemented by 31st July 2013.** More recently, a Risk Management Review and a Governance Arrangements Review have been undertaken with positive outcomes. Action plans have been developed to ensure that all recommendations are implemented within agreed timescales..

More information about the evaluation of the Board in 2013/14 can be found in "Our Finances" section under the heading "Performance Against Monitor's Compliance Framework" and in the "Board of Directors' Report" section under the heading "Compliance with the NHS Foundation Trust Code of Governance".

Board of Directors' meetings have taken place as follows in 2013/14:-

- Formal Board Meetings – 7
- Extraordinary Board Meeting – 1
- Confidential Board Meetings – 7
- Corporate Trustee Meetings – 4
- Board Seminars – 7
- Away Days - 1

Following a review of the committee structure early in 2013, there are three statutory committees of the Board and three sub-committees of the Board.

The statutory committees are as follows:

- Nominations Committee
- Remuneration Committee
- Audit Committee

The sub-committees are as follows:

- Quality Committee
- Finance Committee
- Strategy & Assurance Committee

Attendance at the Board of Directors' meetings, Board statutory committee meetings and Board sub-committee meetings (former structure) is summarised in the following table:-

Board Members	Board of Directors	Extraordinary Board of Directors	Finance & Business Monitoring Committee	Audit Committee	Charitable Funds Committee	Healthcare Governance Committee	HR, OD & Education Governance Committee *	Remuneration Committee
Number of Meetings	**7**	1	2	6	4	**2**	1	**7**
Ian Johnson	**7**	**1**	**2**	**N/A**	**1**	**1**	**N/A**	**7**
Paul Olive (until 31.5.13)	**2**	**1**	**2**	**2**	**N/A**	**N/A**	**N/A**	**1**
Tony Shaw	**7**	**1**	**2**	**N/A**	**N/A**	**N/A**	**N/A**	**7**
Doug Garrett	**7**	**1**	**2**	**6**	**4**	**N/A**	**N/A**	**6**
Karen Crowshaw	**6**	**1**	**2**	**N/A**	**N/A**	**N/A**	1	**7**
Alan Roff	**6**	**1**	**2**	**6**	**3**	**N/A**	**N/A**	**7**
Jim Edney (from 1.6.13)	**5**	**N/A**	**N/A**	**4**	**N/A**	**N/A**	**N/A**	**5**
Michele Ibbs (from 1.9.13)	**4**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**3**
Marie Thompson	**7**	**1**	**1**	**N/A**	**0**		**1**	**N/A**
Dr Mark O'Donnell	**7**	**1**	**2**	**N/A**	**1**		**N/A**	**N/A**
Robert Bell ** (until 22.11.13)	**0**	**0**	**0**	**N/A**	**N/A**		**N/A**	**N/A**
Pat Oliver	**7**	**1**	**2**	**N/A**	**N/A**	**2**	**1**	**N/A**
Wendy Swift **	**7**	**1**	**2**	**N/A**	**1**	**0**	**N/A**	**N/A**
Feroz Patel (5.11.12 – 25.11.13)	**5**	**1**	**2**	**5**	**1**	**0**	**1**	**N/A**
Janet Benson (1.1.13 to 2.6.13)	**2**	**1**	**2**	**N/A**	**N/A**	**0**	**1**	**1**
Jacqui Bate (3.6.13 - 19.12.13)	**1**	**N/A**	**1**	**N/A**	**N/A**		**N/A**	**N/A**
Gary Doherty	**7**	**1**	**2**	**1 (by invitation)**	**N/A**		**1**	**N/A**
Nicky Ingham (from 1.11.13)	**3**	**N/A**	**N/A**	**1**	**N/A**		**N/A**	**1**
Tim Bennett (from 25.11.13)	**3**	**N/A**	**N/A**	**1**	**1**	**N/A**	**N/A**	**N/A**

* Human Resources and Organisational Development & Education Governance Committee
** Non-voting members of the Board of Directors

Attendance at the Board of Directors' meetings, Board statutory committee meetings and Board sub-committee meetings (existing structure) is summarised in the following table:-

Board Members	Board of Directors	Extraordinary Board of Directors	Strategy & Assurance Committee	Finance Committee	Audit Committee	Quality Committee	Remuneration Committee
Number of Meetings	**7**	1	4	11	6	**3**	**7**
Ian Johnson	**7**	**1**	**4**	**11**	**N/A**	**3**	**7**
Paul Olive (until 31.5.13)	**2**	**1**	**N/A**	**N/A**	**2**	**N/A**	**1**
Tony Shaw	**7**	**1**	**4**	**10**	**N/A**	**N/A**	**7**
Doug Garrett	**7**	**1**	**3**	**3**	**6**	**N/A**	**6**
Karen Crowshaw	**6**	**1**	**4**	**9**	**N/A**	**N/A**	**7**
Alan Roff	**6**	**1**	**4**	**3**	**6**	**N/A**	**7**
Jim Edney (from 1.6.13)	**5**	**N/A**	**4**	**9**	**4**	**N/A**	**5**
Michele Ibbs (from 1.9.13)	**4**	**N/A**	**2**	**7**	**N/A**	**3**	**3**
Marie Thompson	**7**	**1**	**3**	**1**	**N/A**	**3**	**N/A**
Dr Mark O'Donnell	**7**	**1**	**3**	**0**	**N/A**	**3**	**N/A**
Robert Bell ** (until 22.11.13)	**0**	**0**	**0**	**0**	**N/A**	**N/A**	**N/A**
Pat Oliver	**7**	**1**	**3**	**9**	**N/A**	**N/A**	**N/A**
Wendy Swift **	**7**	**1**	**4**	**10**	**N/A**	**N/A**	**N/A**
Feroz Patel (5.11.12 – 25.11.13)	**5**	**1**	**3**	**8**	**5**	**N/A**	**N/A**
Janet Benson (1.1.13 to 2.6.13)	**2**	**1**	**0**	**N/A**	**N/A**	**N/A**	**1**
Jacqui Bate (3.6.13 - 19.12.13)	**1**	**N/A**	**2**	**N/A**	**N/A**	**N/A**	**N/A**
Gary Doherty	**7**	**1**	**4**	**10**	**1**	**3**	**N/A**
Nicky Ingham (from 1.11.13)	**3**	**N/A**	**1**	**5**	**1**	**1**	**1**
Tim Bennett (from 25.11.13)	**3**	**N/A**	**1**	**6**	**1**	**N/A**	**N/A**

** Non-voting members of the Board of Directors

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

Compliance with the NHS Foundation Trust Code of Governance

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

Monitor has produced the NHS Foundation Trust Code of Governance (updated in December 2013). This code consists of a set of Principles and Provisions and may be viewed on Monitor's website at: www.monitor.nhsft.gov.uk/publications.php?id=930.

The Board of Directors has previously established governance policies in the light of the main and supporting principles of the Code of Governance.

Foundation Trusts are required to report against this Code each year in their Annual Report on the basis of either compliance with the Code provisions or an explanation where there is non-compliance. The compliance statement below reflects the Trust's declaration regarding compliance with the Code as stated in the latest Annual Report 2013/14.

"The Board of Directors and Council of Governors of the Trust are committed to the principles of good corporate governance. The Audit Committee has reviewed the Trust's performance against this Code and can confirm that the Trust has achieved compliance with most of the revised Monitor Code of Governance. The Trust will wish to obtain external (audited) assurance before advising on its level of compliance. The Trust is fully supportive of the new Code and the "comply" or "explain" methodology."

Statement as to Disclosure to Auditors

The Board of Directors is not aware of any relevant audit information that has been withheld from the Trust's auditors. Each individual member of the Board has taken all necessary steps they ought to have taken, as a director, in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of said information, by making such enquiries of their fellow directors and the Trust's auditors for said purpose and exercising reasonable care, skills and diligence.

Profile of the Board

Voting members of the Board of Directors:-

Ian Johnson (Chairman)
Term of Office from 16.4.12 to 15.4.15 (First Term)

Experience:

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

Qualifications:

- Master of Arts (M.A)
- Master of Laws (LL.M).

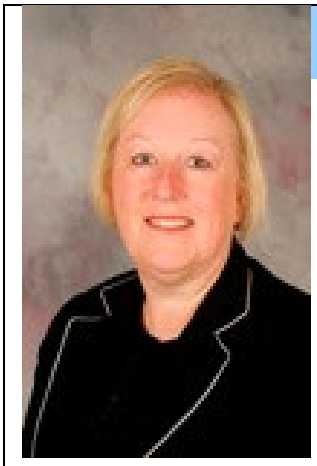
Paul Olive (Non-Executive Director and Deputy Chairman)
Term of Office from 20.5.10 to 31.5.13 (Extended Third Term)

Experience:

- Former Finance Director of Stanley Leisure plc
- Former Non-Executive Director of Crown Leisure plc
- Former Governor of Blackpool Sixth Form College
- Former Trustee of Age Concern

Qualifications:

- Chartered Accountant – Fellow of the Institute of Chartered Accountants



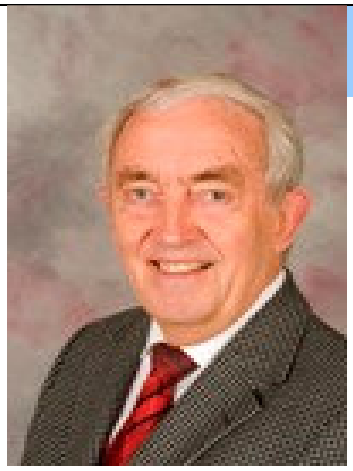
Karen Crowshaw (Non-Executive Director and Deputy Chairman)
Term of Office from 1.6.11 to 31.5.14 (First Term)

Experience:

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

Qualifications:

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



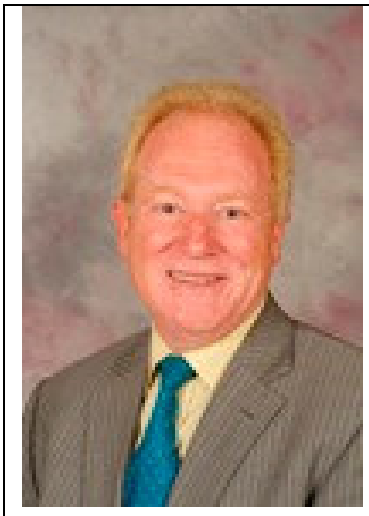
Tony Shaw (Non-Executive Director) (Senior Independent Director)
Term of Office from 1.7.10 to 30.6.13 (First Term)
and from 30.6.13 to 29.6.16 (Second Term)

Experience:

- Former Managing Director Business Link Fylde Coast
- Former General Manager at Blackpool Gazette and Herald
- Former Managing Director at Blackpool Gazette and Herald
- Former Director of United Provincial Newspapers
- Former Non-Executive Director of Blackpool, Wyre and Fylde Community Health Services NHS Trust
- Former Chairman of Blackpool PCT
- Chair of Trustees of the Blackpool Ladies Sick Poor Association
- Trustee/Director/Treasurer of Age UK, Blackpool and District

Qualifications:

- Certified Accountant (Retired)



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

Experience:

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

Qualifications:

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

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

Experience:

- Current CEO/Director - private businesses
- Current national and international trade in antiques, sport and leisure, property investment via companies
- Regeneration in Blackpool and Belfast - £1.5 billion of investment and 25,000 jobs
- Operations management, marketing and advertising
- Company Director – R & Z Houses of Fashion
- Company Director - Closelink
- Company Director – House of Roma
- Company Director – Rackhall Ltd
- Chairman/Trustee of Groundwork Trust North West
- Trustee/Trustee of the St Annes Community Trust
- Trustee Curious Minds (Arts Charity)
- Chairman of Blackpool Enterprise Board

Qualifications:

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

Jim Edney (Non-Executive Director)
Term of Office from 01.06.2013 to 31.05.16 (First Term)

Experience:

- Director of Coleridge Interim Limited
- Board Member of University of Central Lancashire (UCLAN)
- Former Deputy Chief Executive and Executive Director of Resources at Lancashire County Council
- Former Chief Financial Officer at Essex County Council
- Former Deputy County Treasurer at Lincolnshire County Council

Qualifications:

- CPFA (Chartered Institute of Public Finance & Accountancy
- BA (Hons) History

Michele Ibbs (Non-Executive Director)
Term of Office from 01.09.2013 to 31.08.16 (First Term)

Experience:

- Non-Executive Director – Marsden Building Society
- Former Board Director/Pro-Vice Chancellor (Marketing, Commercial & International) - Liverpool John Moores University
- Former Marketing Director - Princes Limited, Mitsubishi Corporation
- Former Marketing Director UK – Waterford Wedgwood plc

Qualifications:

- B.A (Hons) English Language & Literature
- PGDip Marketing & Market Research
- Diploma of the Market Research Society

Gary Doherty (Chief Executive)
Appointed in April 2013

Experience:

- Former Chief Operating Officer/Deputy Chief Executive of Wirral University Teaching Hospital NHS Foundation Trust
- Over 20 years general management experience in the NHS including senior posts at Central Manchester & Manchester Children's University Hospital and North Cheshire Hospitals NHS Trust
- Joined NHS as Management Trainee

Qualifications:

- B.A. (Hons) – Politics & Economics

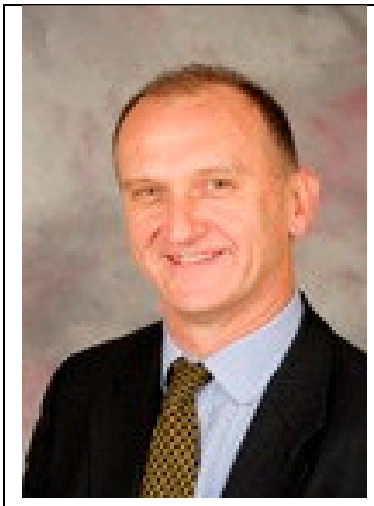
Pat Oliver (Director of Operations)
Appointed in April 2011

Experience:

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

Qualifications:

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



Dr Mark O'Donnell - (Medical Director)
Appointed in April 2012

Experience:

- Consultant Physician in Stroke Medicine at Blackpool, Fylde and Wyre Hospitals NHS Trust since 2007
- Consultant Geriatrician at Blackpool, Fylde and Wyre Hospitals NHS Trust from 1994
- Private Medical Practice
- Medical Director of Lancaster Diocese Lourdes Pilgrimage

Qualifications:

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

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

Experience:

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

Qualifications:

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

Feroz Patel (Acting Director of Finance)
Appointed in November 2012 (until November 2013)

Experience:

- Former Associate Director of Finance at Blackpool Teaching Hospitals NHS Foundation Trust
- Former Contract Manager at Wrightington, Wigan and Leigh PCT.
- Former Clinical Financial Advisor at Countess of Chester
- Former National Finance Management Trainee

Qualifications:

- BA (Hons) – Economics
- Chartered Public Finance Accountant

Janet Benson (Acting Director of Human Resources and Organisation Development)
Appointed in January 2013 (until June 2013)

Experience:

- Former interim Head of Employee Relations at Greater Manchester Police
- Former Head of Employee Relations, Policy of HR Strategy at AEGON UK
- Former Senior HR Business Partner at AEGON UK
- Former HR Manager at Guardian Royal Exchange

Qualifications:

- BA (Hons) English Language & Literature
- Chartered Institute of Personnel & Development
- Associate of Chartered Insurance Institute

Tim Bennett (Director of Finance)
Appointed in November 2013

Experience:

- Former Director of Finance and Deputy Chief Executive at University Hospitals of Morecambe Bay NHS Foundation Trust
- Former Director in a Primary Care Trust
- Former Director in a large Health Authority.
- Former chair of the Healthcare Financial Management Association (North West)
- Former Chairman of the student conference of the Finance Skills Development Association
- Non-Executive Board Member of a local cancer charity.

Qualifications:

- Qualified Accountant with an MBA

Nicky Ingham (Director of Workforce & Organisational Development)
Appointed in November 2013

Experience:

- Former Director of Workforce & OD and Acting Deputy Chief Executive at Bolton NHS Foundation Trust.
- Former Director of HR & OD at Alder Hey Children's Hospital
- Chair of Cumbria and Lancashire HRD Forum
- Member of the North West Social Partnership Forum
- Member of the Cumbria and Lancashire LWEG
- Member of the HENW LETB
- HPMA HR Director of the Year in 2010

Qualifications:

- Fellow of the Chartered Institute of Personnel and Development
- MSc HR Leadership
- BA (Hons) Business Studies
- NLP Practitioner

Non-voting member of the Board of Directors:-

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

Experience:

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

Qualifications:

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

Wendy Swift (Director of Strategy)
Appointed in December 2013
(formerly Managing Director of Community Services and Transformation from November 2011)

Experience:

- Former Chief Executive of Blackpool Primary Care Trust
- Chair of the NHS North West 111 Programme Board
- Lead commissioner role for the North West Ambulance Service
- Former Deputy Chief Executive of Blackpool Wyre and Fylde Community Health Services Trust
- Former Director of Planning and Operations in East Lancashire Hospitals
- 32 years extensive experience of working in Acute, Community and Primary Care services
- Trustee of Collegiate High School National Challenge Trust
- Governor of Collegiate High School
- Trustee of Palatine High School National Challenge Trust
- Chairman of Spiral Health CIC
- Trustee of Rock Centre (Learning Disabilities)
- Trustee of Blackpool Football Club Community Trust
- Trustee of Lancashire Community Foundation

Qualifications:

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

In addition Jacqui Bate was appointed as the Interim Director of HR & OD from June 2013 until December 2013.

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

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

Telephone: 01253 306856

Email: judith.oates@bfwhospitals.nhs.uk

Council of Governors

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

The Council has the following three main roles:-

i) **Advisory** – to communicate with the Board of Directors the wishes of members of the Trust and the wider community;
ii) **Guardianship** – to ensure that the Trust is operating in accordance with its Constitution and is compliant with its authorisation; and
iii) **Strategic** – to advise on a longer-term direction to help the Board effectively determine its policies.

The essence of these roles is elaborated on within Monitor's document entitled "*Your Statutory Duties – A reference guide for NHS Foundation Trusts Governors".* This document is provided to all Governors.

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

- To appoint or remove the Chairman and other Non-Executive Directors.
  This duty was exercised during 2013/14.

- To approve the appointment (by the Non-Executive Directors) of the Chief Executive.
  This duty was not exercised during 2013/14, however, it was exercised in 2012/13 resulting in a newly appointed chief Executive with effect from 1st April 2013.

- To decide the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors.
  This duty was exercised during 2013/14.

- To appoint or remove the Foundation Trust's External Auditor.
  This duty was exercised during 2013/14 resulting in the appointment of PricewaterhouseCooper (PwC) following a robust evaluation process and involvement/approval by the Council of Governors.

- To appoint or remove any other External Auditor appointed to review and publish a report on any other aspect of the Foundation Trust's affairs.
  This duty was not exercised during 2013/14, however, the appointment of the Trust's External Auditor in 2013/14 has been agreed by the Council.

- To be presented with the Annual Accounts, any report of the External Auditor on the Annual Accounts and the Annual Report.
  This duty was exercised during 2013/14.

- To provide their views to the Board of Directors when the Board of Directors is preparing the document containing information about the Foundation Trust's forward planning.
  This duty was exercised during 2013/14.

- To respond as appropriate when consulted by the Board of Directors in accordance with the Constitution.
  This duty was exercised during 2013/14.

- To undertake such functions as the Board of Directors shall from time to time request.
  This duty was exercised during 2013/14.

- To prepare and, from time to time review the Foundation Trust's Membership Strategy and its policy for the composition of the Council of Governors and of the Non-Executive Directors and, when appropriate, to make recommendations for the revision of the Trust's Constitution.
  This duty was not exercised during 2013/14.

The Council of Governors and the Board of Directors continue to work together to develop an effective working relationship. Board members regularly attend Council of Governors Meetings to ensure that members of the Board develop and gain an understanding of the Governors' and Members' views about the Trust.

The Council of Governors comprises a total of 34 Governors, including 18 Public Governors (elected from the constituencies of Blackpool, Fylde, Wyre, Lancashire and South Cumbria and the North of England), six Staff Governors (elected from the staff groups of Medical & Dental, Nursing & Midwifery, Clinical Support, Non-Clinical Support and Community Health Services) and 10 Appointed Governors (from a range of key stakeholder organisations).

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

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

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

APPOINTED GOVERNORS	ROLE
Principal Local Councils – 2: Blackpool Council (1) Lancashire County Council (1)	To represent key local non-NHS Local Health Economy partners.
Principal University – 1: University of Central Lancashire	To ensure strong teaching and research partnership and to represent other University interests.
Voluntary Sector – 1: Council for Voluntary Services	To engage and assist the Trust in identifying the needs of the local community.
Lancashire Care Foundation Trust - 1	To engage and assist the Trust in identifying needs of local community.
Blackpool Youth Council – 1	To engage and assist the Trust in dialogue with the younger catchment population.
University of Liverpool – 1	To ensure strong teaching and research partnership and to represent other University interests.
Institute of Directors (Lancashire Branch) – 1	To engage and assist the Trust in dialogue with the wider catchment population of Lancashire.
Citizens Advice Bureau (Blackpool Branch) – 1	To engage and assist the Trust in identifying the needs of the local community.
VACANCY – 1	TO BE CONFIRMED
Total Appointed Governors – 10	

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

ELECTED PUBLIC AND PATIENT GOVERNORS To represent:-	ROLE
Area 1 - Blackpool – 8	To represent patients who are resident in Blackpool.
Area 2 - Wyre – 4	To represent patients who are resident in Wyre.
Area 3 - Fylde – 3	To represent patients who are resident in Fylde.
Area 4 - Lancashire & South Cumbria – 2	To represent of patients who are resident in the wider environs of South Cumbria and Lancashire.
Area 6 – North of England – 1	To represent patients who are resident in the wider environs of the North of England.
Total Elected Public and Patient Governors – 18	

TOTAL MEMBERSHIP OF COUNCIL OF GOVERNORS
Appointed Governors (nominated) – 10 (currently one vacancy)
Staff Governors (elected) – 6
Public Governors (elected) - 18 (currently three vacancies)
Total membership of Council of Governors – 34

TOTAL MEMBERSHIP OF COUNCIL OF GOVERNORS
Appointed Governors (nominated) – 10 (currently one vacancy)
Staff Governors (elected) – 6
Public Governors (elected) - 18 (currently three vacancies)
Total membership of Council of Governors – 34

There were elections to the Council of Governors during 2013/14 as follows:-

Public Governors:-

Blackpool Constituency
Carol Measures
Neal Brookes
Zacky Hameed
Robert Hudson

Fylde Constituency
Clive Barley
Gillian Wood
Sheila Jefferson

North of England Constituency
Sam Wallace *

Staff Governors:-

Nursing and Midwifery
Sharon Vickers

Clinical Support
Ashok Khandelwal

Community Health Services
Mike Phillips

Janet Briers

Appointed Governors:-

Blackpool Council	Lancashire County Council	University of Liverpool
Councillor Martin Mitchell	County Councillor Ron Shewan	Ceri Coulby

* Resigned from the Council of Governors (6th November 2013).

The next elections to the Council of Governors will take place in July 2014 for the following vacancies:-

Blackpool - 4
Fylde - 2
Wyre - 2
Lancashire & South Cumbria - 2
North of England - 1

Nursing & Midwifery - 1
Non Clinical Support - 1
Medical & Dental - 1

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

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

Name	Constituency/ Organisation	Term of Office
Public Governors		
John Butler (from September 2011) **	Blackpool	3 years
Clifford Chivers (from September 2011) **	Blackpool	3 years
Hannah Harte (from December 2010) *	Blackpool	3 years
Chris Thornton (from December 2010) *	Blackpool	3 years
Eric Allcock (from September 2010) *	Blackpool	3 years
Mark Chapman (from December 2010) *	Blackpool	3 years
Chris Smith (from September 2011) **	Blackpool	3 years
George Holden (from September 2011) **	Blackpool	3 years
Anne Smith, OBE (from September 2011) *	Fylde	3 years
John Longstaff (from September 2011) *	Fylde	3 years
Tony Winter (from September 2010) *	Fylde	3 years
Peter Askew (from September 2011) **	Wyre	3 years
Ramesh Gandhi,JP. DL. OBE. FRCS. (from December 2010)	Wyre	3 years
John Bamford (from December 2010)	Wyre	3 years
Lynden Walthew (from September 2011) **	Wyre	3 years
Vacant	Lancashire and South Cumbria	3 years
Vacant	North Lancashire (until August 2013)	3 years
Vacant	Lancashire & South Cumbria (from August 2013)	3 years
Staff Governors		
Dr Tom Kane (from September 2011) **	Medical and Dental	3 years
Sam Woodhouse (from September 2011) *	Nursing and Midwifery	3 years
Andrew Goacher (from September 2010) *	Nursing and Midwifery	3 years
Tina Daniels (from September 2011) **	Non-Clinical Support	3 years

Cherith Haythornthwaite (from September 2010) *	Clinical Support	3 years
Claire Lewis (from April 2012) *	Community Health Services	3 years
Appointed Governors		
Councillor John Boughton (from September 2011) *	Blackpool Council	3 years
Councillor Martin Mitchell (from May 2013)	Blackpool Council	3 years
County Councillor Paul Rigby (from September 2011) *	Lancashire County Council	3 years
County Councillor Ron Shewan (from July 2013)	Lancashire County Council	3 years
Mike Bullock	Council for Voluntary Service	3 years
Susan Rigg **	Lancashire Care Trust	3 years
Jean Taylor **	University of Central Lancashire	3 years
Ceri Coulby (from September 2013)	University of Liverpool	3 years
James Morrison-Eaves *	Blackpool Youth Council	3 years
Phillip Hargreaves (from April 2014)	Institute of Directors (Lancashire Branch)	3 years
Tony Winter (from April 2014)	Citizens Advice Bureau (Blackpool)	3 years
Vacant	To Be Confirmed	3 years

* Resigned / Not Re-Elected or Re-Appointed in 2013
** Due for re-election / re-appointment in 2014

Meetings of the Council of Governors took place on the following dates in 2013/14:-

- 21st May 2013
- 16th August 2013
- 15th November 2013
- 17th March 2014 (rescheduled from 14th February 2014)

Attendance at Council of Governors Meetings:

Governor Attendance

Governors	Number of Meetings (4)
John Butler	4
Clifford Chivers	3
Hannah Harte *	1
Chris Thornton *	1
Eric Allcock *	1
Mark Chapman *	0
Chris Smith	3
George Holden	4
Carol Measures **	1
Neal Brookes **	1
Zacky Hameed **	1
Robert Hudson **	1
Anne Smith *	2
Tony Winter *	0
Clive Barley **	2
Gillian Wood **	1
Sheila Jefferson **	1
Peter Askew	3
Ramesh Gandhi	4
John Bamford	2
Lynden Walthew	4
Sam Wallace **	0
Dr Tom Kane	3
Andrew Goacher *	2

Tina Daniels	3
Sharon Vickers **	2
Janet Briers **	1
Ashok Khandelwal **	1
Mike Phillips **	2
Councillor John Boughton *	0
Councillor Martin Mitchell **	2
County Councillor Paul Rigby *	0
County Councillor Ron Shewan **	2
Jean Taylor	2
Susan Rigg	3
Ceri Coulby **	0
Mike Bullock	2

* Resigned / Not Re-Elected or Re-Appointed in 2013
** Elected / Appointed during 2013/14

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

- The Annual Report and Accounts and the Quality Report 2013/14.
- The Annual Plan 2014/15.
- Membership Sub-Groups
- Membership Task & Finish Groups

With regard to the Annual Plan, a Governors' sub-group meeting took place in March 2014 which included a detailed presentation by the Director of Strategy and the Director of Finance followed by useful feedback from the Governors and an overview at the subsequent Council of Governors meeting. The Annual Plan was approved in principle at the Council of Governors meeting in March 2014 and signed-off by the Lead Governor on behalf of the Governors by the deadline of the 4th April 2014.

The Chief Executive, Director of Strategy, Director of Finance and Director of Operations routinely attend meetings of the Council of Governors. Two Non-Executive Directors attend the Council of Governors Meetings on a rotational basis. Attendance of Executive Directors was extended in 2012 to include one additional Executive Director from amongst the Director of Nursing, Medical Director, and Director of Workforce and OD.

During 2013/14, the Council of Governors received regular assurance reports/updates from the Chief Executive plus regular strategic, finance, performance and membership reports.

Presentations/reports were also given to the Council in respect of the following:-

- Voluntary Services
- Board Processes
- Fylde Coast Public Consultation
- Review into the Care and Quality of Treatment Provided by 14 Hospital Trusts in England
- Mortality Reduction Action Plan
- Nurse Staffing Levels
- Annual Report & Accounts and Quality Accounts
- Finance Statements Audit
- Quality Accounts Review
- Multi Storey Car Park and Main Entrance Project
- Provision of External Audit Services
- Keogh Review/Berwick Report
- Fleetwood Hospital/Rossall Hospital Developments
- Annual Plan
- Governors Development Programme

Other items discussed at the Council of Governors Meetings included the Compliance Monitoring Assurance Report, Serious Untoward Incidents, Chairman's and Non-Executive Directors' Appraisals/Objectives/ Remuneration, Declarations of Interests, Trust Constitution, Governor Elections, Membership of the Foundation Trust Governors' Association, Patient Experience, Clinical Audit, Board Assurance Framework, Corporate Risk Register and Lead Governor Role.

Following the resignation of Anne Smith, Public Governor (Fylde Constituency) / Lead Governor, in September 2013, Peter Askew, Public Governor (Wyre Constituency), was appointed Lead Governor. **The duties of the Lead Governor include acting as the point of contact between the Council of Governors and the Trust,**

playing a pivotal role in the relationship with the Chairman, the Board of Directors and External Agencies as well as the community served by the Trust, acting as the point of contact between the Council of Governors and Monitor (should this be necessary) and meeting routinely with the Chairman of the Board of Directors and the Council of Governors and with the Foundation Trust Secretary to plan and prepare the agenda for Council of Governor meetings.

Following the Governor elections in September 2013, a Governors' Introductory Meeting took place in October 2013 which included the following:-

Welcome and Introductions / Role of the Governor / Presentation on Current & Future Challenges for the Trust / Feedback from Election Process / Question and Answer Session / Networking Opportunities / Tour of the BVH site.

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

- Board Sub-Committees.
- Governors' Patient Experience Committee (including visits)
- Formal Patient Safety Walkabouts.
- Attendance at Board Meetings, initially as observers at private meetings and, subsequently, as observers at meetings held in public.
- Governors' Sub-Group Meetings.

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

- Foundation Trust Governors Association National Development Day.
- North West Governors' Forum.
- GovernWell Events.

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

Governor Attendance at Nominations Committee Meetings:

Committee Members (4)	Number of Meetings (2)
Ian Johnson (Chairman)	2
Peter Askew	1
Eric Allcock (until September 2013)	2
Jean Taylor	1

Governor Attendance at Membership Committee Meetings: Jacinta Gaynor

Committee Members (9)	Number of Meetings (4)
Anne Smith** (Chairman) (until September 2013)	2
Chris Smith (Chairman) (from October 2013)	4
Peter Askew (from October 2013)	1
Clive Barley* (from January 2014)	1
John Boughton** (until May 2013)	0
John Butler	4
Clifford Chivers (until January 2014)	4
Hannah Harte** (until September 2013)	2
George Holden	4
Sheila Jefferson* (from January 2014)	1
Sharon Vickers* (from October 2013)	1
Lynden Walthew	3
Gillian Wood* (from January 2014)	1

* Elected in 2013/14
** Resigned in 2013/14

Governors are also involved in a number of Trust Committees, namely the Health Informatics Committee, Charitable Funds Committee, Patient Experience Action Team (PEAT), Healthy Transport Committee, Waste Management Committee, Equality, Diversity and Human Rights Committee, Staff Car Parking Working Group and Fire Committee.

The Governors' Patient Experience Committee, which was established during 2011/12, continued to meet on a quarterly basis until it was disbanded in February 2014. Governors will be involved in the Patient & Carer Experience & Involvement Committee and will continue to have the opportunity to visit wards/departments/clinics on a monthly rather than a quarterly basis.

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

Governor Expenses* 2012-13

Name and title	Apr 2013	May 2013	June 2013	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	March 2014
Andrew Goacher									375.87			
Anne Smith												
Brian Rowe												
Cherith Haythornthwaite												
Chris Lamb												
Chris Smith												
Chris Thornton												
Claire Lewis		15.00			62.07							
Clifford Chivers												
Councillor John Boughton												
County Councillor Paul Rigby												
Denys Smith-Hart												
Dr Tom Kane		170.01	31.86			15.52	21.11					
Dr Tom Kennedy												
Eric Allcock												
George Holden							95.94					
Gillian Wood											37.80	
Hannah Harte							45.00					
James Morrison-Eaves												
Janet Briers												59.70
Jean Taylor												
Joanne MacDonald												
John Bamford												
John Butler												
John Longstaff			30.00									
Lynden Walthew			100.85						67.00			
Mark Chapman												
Mike Bullock												
Nicole Burke												
Peter Askew												
Ramesh Gandhi												
Roy Fisher												
Sam Woodhouse	57.95	57.95	57.95	64.58							290.11	
Sheila Jefferson												102.60
Susan Rigg							41.80					
Tina Daniels			124.84		168.84				292.26	153.41		
Tony Winter												

*Governor expense claims relate to travel expenses.

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

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

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

Telephone: 01253 306856

Email: judith.oates@bfwhospitals.nhs.uk

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

Membership Report

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

Public Members

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

Staff Members

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

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

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

Growth of Public Members

The number of public members has **slightly** decreased over the last 12 months. The Trust's public membership currently stands at **5,647**.

Membership Report for Blackpool Teaching Hospitals NHS Foundation Trust for 2013/14 (data extracted as at 11th March 2014).

Public constituency	*Last year (2013/2014)*	*Population*	*Index*
As at start (April 1)	5,715		
New Members	303		
Members leaving	371		
At year end (March 31)	5,647	14116496	
Staff constituency	*Last year (2013/2014)*		
As at start (April 1)	6,585		
New Members	379		
Members leaving	304		
At year end (March 31)	6,660		
Patient constituency	*Last year (2013/2014)*		
As at start (April 1)	0		
New Members	0		
Members leaving	0		
At year end (March 31)	0		
Public constituency	*Number of members*	*Population*	*Index*
Age(years):			
0 - 16	38	185578	51
17 - 21	148	891883	41
22+	4,635	13039035	88
Ethnicity:			
White	4,511	12810542	88
Mixed	13	204218	15
Asian	64	841400	19
Black	15	175554	21
Other	12	84782	36
Socio-economic groupings:			
ABC1	4,520	4924618	229
C2	694	1678574	103
D	107	2063232	13
E	285	1898831	37
Gender analysis:			
Male	2,828	7015689	100
Female	2,765	7100807	97
Patient constituency	*Number of members*		
Age(years):			
0 - 16	0		
17 - 21	0		
22+	0		

Recruitment of Members

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

- Membership information displayed at entrances to hospitals and in outpatient departments.

- Recruitment stands at events for the public and community meetings, such as Area Forums in conjunction with Blackpool Council.
- Distribution of recruitment posters and leaflets to GP surgeries throughout the Fylde Coast.
- Continue to liaise with public health organisers from Primary Care in order to attend health road shows held within local companies.
- Continue to use the Trust's Face book social network site to engage and inform members and the wider public of developments and events at the Trust.
- Continue to use the Trust's Twitter social network page to attract new members, in particular target young members. Currently the Trust has over 1,116 followers.
- The Membership Volunteer continues to come in two afternoons a week and help out in recruitment, engagement of members and administration.
- The Trust has a dedicated Membership and Governors Officer who acts as link between the members, Council of Governors and the Trust.
- The Trust has dedicated membership telephone line on 01253 306673 and email address:- members@bfwhospitals.nhs.uk

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

Retention of Members

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

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

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

- Continue to make members' seminars more interactive by involving patients/members to relay their experiences of the treatment/services provided by the Trust.
- Introduced Chief Executive's Public Question Time so that members can engage with the Executive Team.
- Continue to produce the newsletter 'Your Hospitals', which keeps members informed on current developments within the Trust, keeps members up-to-date with Fundraising activities and asks members their opinions on a wide range of topics through consultations. The newsletter also gives details of a wide variety of local services and businesses that provide discounts for members, on production of their membership card. Copies of 'Your Hospitals' are also available on the Trust's website from Issue 1 to Issue 16. In January 2013 the Trust changed the name of the member's newsletter to reflect the integration of community services to 'Your Health'.
- Continue to use the 'Consultation Corner' section of the newsletter to gain valuable opinions from members on a variety of topics. The information is collated and used to influence decisions that are made about the Trust services. The most recent consultation has been on 'Improving the WiFi Experience' for inpatients and visitors.
- Membership seminars continue to be held monthly and are well attended, with a range of topics from 'Diabetes', 'Chief Executive's Public Question Time' and 'The Role of a Governor'.
- Members are able to contact the Membership Office with any queries or ideas via a dedicated membership hotline and email address.
- All members were invited to the Annual Members' and Public Meeting in September 2012, a formal meeting to discuss the Trust, its developments, future services and membership. This was attended by around 300 staff and public members.
- Following the monthly health seminars, Governors have made themselves available to members to deal with any queries or issues members may have.
- Continue to keep members up-to-date with events at the hospital, such as the health seminars, official openings of new facilities and fundraising activities via email.

In October 2012, a revised Membership Strategy was ratified by the Board of Directors. The Board requested that a two-page summary document be produced identifying the delivery of the Membership Strategy. A document entitled 'Implementation of the Key Elements of the Membership Development Strategy 2012-2015' was produced. This has continued to be implemented during 2013/14.

The document sets out a summary of the Trust's strategic objectives for membership and identifies the key aims of delivery of these objectives.

Membership Committee Sub Groups

The Trust recognises the importance of having a membership that is informed and representative of the community it serves.

The Membership Committee agreed in January 2014 that any future projects would be progressed by establishing Task and Finish Groups, the membership of which would be extended to all Governors enabling those with relevant experience to become involved.

Two Task and Finish Groups have been established to review the following: -

- **Key membership messages and promotional material**
- **Proposal for engagement with members**

Both groups are progressing this work and will be providing feedback to the Membership Committee on a regular basis.

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

Membership Representation

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

Audit Committee Report

Role of Audit Committee

The prime function of the Audit Committee is to provide the Board of Directors with an independent assurance over the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) with the aim of supporting the achievement of the Trust's objectives. It provides assurance on the independence and effectiveness of both external and internal audit. It ensures that standards are set and that compliance is monitored in all areas of the Trust that fall within the remit of the Committee. The Audit Committee takes the lead in reviewing the integrity of the Annual Financial and Quality Accounts and the related External Auditor's Reports. In addition it reviews the Annual Governance Statement prepared by the Chief Executive in his role as the Accountable Officer.

External Auditors

The Council of Governors, on 16th August 2013, approved the continued appointment of PricewaterhouseCoopers as the Trust's external auditors for a further year (2013/14). Payment of £50,500 (excluding VAT) was paid to PwC in respect of statutory audit fees. A supplementary fee included £12,500 for the independent reporting work in relation to the Independent Auditor's Report in the Annual Quality Report.

The Trust limits work undertaken by the external auditors outside the audit code to ensure independence is not compromised. In 2013/14 PwC did not provide any other services to the Trust.

The Board maintains a policy on the engagement of the external auditor for the provision of non-audit services, which was approved by the Audit Committee and Board of Directors in July 2011 and August 2011 respectively. The effect of the policy is that if the Executive Team retains the external auditor for the supply of non-audit services with a value of more than the annual external audit fee, the express approval of the Council of Governors would need to be sought and obtained for any further work.

A formal competitive tendering process was initiated early in 2014 to select and appoint a provider for External Audit Services for 2014/15 and beyond, under the NHS Shared Business Services Framework Agreement NHS/11/SG/ZY/6982. Based on the findings of the evaluation panel, the Trust recommended the appointment of PricewaterhouseCooper (PwC) as their provider of External Audit Services until May 2017 with the option to extend the appointment for an additional year until May 2018, and this recommendation was approved by the Council of Governors at their meeting on 17th March 2014.

Composition of the Audit Committee

The Committee operates in accordance with the revised Terms of Reference (as per the new Audit Committee Handbook) agreed by the Board of Directors on 31st July 2013 and has met on six occasions during the year ended 31st March 2014. Since June 2013 the Committee's membership has consisted of three Non-Executive Directors (NEDs). Each member's attendance at these meetings complied with the criterion for frequency of attendance as set out in the Audit Committee's Terms of Reference. All meetings since June 2013 were attended by all three NEDs.

The Committee is chaired by Mr Jim Edney (CPFA), who joined the Trust in June 2013. The Board considers Mr Edney to have relevant financial experience following his role as a qualified accountant and former Finance Director of two large local authorities. In addition to the Committee members, standing invitations are extended to the Finance Director, External and Internal Audit representatives, the Local Counter Fraud Officer, the Deputy Director of Corporate Affairs and Governance and the Assistant Finance Director (**and Acting Finance Director).** In addition other officers have been invited to attend the Audit Committee where it was felt that to do so would assist the Committee to effectively fulfil its responsibilities; **these included the Chief Executive, the Managing Director for Community Development and Transformation, the Director of Workforce and Organisational Development, the Financial Accountant, the Head of Procurement and the Assistant Director, Clinical Support & Facilities Management.**

Administrative support has been provided by Miss Kayleigh Briggs and Mrs Paula Clark, former and current PA to the Finance Director.

Audit Committee Financial Activities

The Committee reviewed the Draft Annual Report and Accounts and Quality Report for the year ended 31st March 2013 at its meeting on 30th April 2013 and the final Audited Accounts and Quality Report at its subsequent meeting on 23rd May 2013 and formally recommended to the Board of Directors that the Accounts be approved at the Board meeting also held on 23rd May 2013. The initial draft of the Annual Report and Quality Accounts for the year ending 31st March 2013 was discussed at the Committee meeting held on 5th February 2013. The continuing development and improvement of the Quality Accounts was also considered at a number of meetings and presentations made thereon by the External Auditors.

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

Internal Control and Risk Management Systems

Throughout the year the Committee has received regular reports from both Internal and External Auditors in relation to the adequacy of the systems of internal control and also received regular reports from the **Associate** Director of Corporate Affairs and Governance on the robustness of risk management and governance arrangements throughout the Trust. Specifically, the Committee gained assurance by reviewing the Governance Briefing Report, **Standing Orders and Delegated Powers of Authority, the reporting Framework for the Trust's new committees, the Procurement Assurance Report,** Divisional Risk Registers, the Corporate Risk Register and the Board Assurance Framework. The Trust Annual Governance Statement was considered at the meeting held on 30th April 2013 and was recommended to the Board for approval.

External Audit

The Committee has reviewed the work and findings of the External Auditors by:-

- Discussing and agreeing the scope and cost of the audit detailed in the Annual Plan for 2013/14.
- Considering the extent of co-ordination with, and reliance on, Internal Audit.
- Consideration of mechanisms regarding self-assessment of the Audit Committee's effectiveness.
- Consideration of a number of accounting treatments under IFRS and the impact thereon in relation to the Annual Accounts.
- Presentations on Quality Update and Commercial Assurance.
- Consideration of matters in relation to Fraud Responsibilities and Raising Awareness.
- Receiving and considering the Annual Audit Letter at its meeting on 23rd May 2013 which was presented to the Board of Directors at its meeting also on 23rd May 2013.
- **The accounting treatment of Charitable Funds and their relationship with the Trust's accounts**
- Receiving and considering reports in relation to going concern matters, the position in relation to the Trust breach situation with Monitor (which was satisfactorily resolved upon de-escalation from significant breach on 21st May 2012) and on the matter of Integration of Community Services with effect from 1st April 2013. Members of the Audit Committee have also met in private with External Audit representatives so as to allow discussion of matters in the absence of executive officers.

Internal Audit

With effect from 1st October 2012 the Trust appointed new internal auditors having been serviced for a considerable time by Audit North West. Formal tendering procedures took place and the contract was awarded to KPMG LLP.

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

- Discussing and agreeing the nature and scope of the Annual Internal Audit Plan.
- Receiving and considering progress against the plan presented by the Chief Internal Auditor and Internal Audit Manager.
- Receiving reports on the Assurance Framework, Risk Management System and Care Quality Commission Quality and Safety Standards. At its meetings on 30th April 2013 and 23rd May 2013, the Committee received the Head of Internal Audit Opinion which gave "significant assurance" that there was a generally sound system of internal control for the year ended 31st March 2014.

The Committee also met in private with Internal Audit representatives so as to allow discussion of matters in the absence of Executive Officers.

Other Matters

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

- The Trust's approach to procurement and its Annual Procurement Plan.
- **Storage and Disposal of Personal data**
- The 2012/13 Audit Committee Annual Report and matters arising.
- Local Counter Fraud Specialist Reports and Annual Report, together with a formal review of the Local Counter Fraud Service.
- The Role of the Audit Committee itself, particularly in the light of the Trust's revised Committee structure and membership, responsibilities, ways of working.and delegations.
- Progress of the implementation of the Trust electronic rostering system.
- Progress on the review of Managed Equipment Services.
- Quality Governance and latest trends in Quality Reporting.
- The working of the PMO regarding QuIPP **or CIP**.
- The Trust's approach to waivers to standing orders and the finalisation of a revised approval system.
- **The actions taken to reduce the level of overpayments made to staff.**
- The implications for the Trust of the Bribery Act.
- Updates on current legal issues.
- The continuous review of training and development needs for Audit Committee members and attendance at relevant courses.
- The identification and agreement of matters for consideration by the Board.
- Further information regarding financial risks, including QuIPP **or CIP** and liquidity is detailed in Section 4.4 of the Annual Governance Statement

Conclusion

2013/14 has been another year of progress and change. The Trust's governance arrangements were substantially re-designed with a view to making accountability or actions sharper and to reduce duplication of committee and Board effort. The Board has begun to meet in public for the first time. There has been significant turnover at Executive level, which has meant a certain amount of discontinuity. June 2013 saw the Keogh review team "inspect" the Trust's performance in caring for patients as well as its wider performance in serving its communities on the Fylde Coast and other parts of Lancashire. The Trust was one of fourteen reviewed and one of the two Trusts not put into special measures as a result. A detailed improvement action plan was adopted as a consequence of the review and was largely implemented over the remainder of the year.

Looking Ahead

The Committee will be looking at how the new governance arrangements settle down and will offer constructive advice where necessary. Pressure will continue to improve the experience of and outcomes for patients and growing demand for services is likely in the year ahead. The Trust's finances remain in a healthy but delicate state and good resource management will be essential. The Committee will play its part in promoting service review and improvement, together with greater integration of services and value for money. At all times these will need to be done to the highest standards and within the agreed policies of the Trust. The year ahead therefore looks challenging and I take this opportunity to thank my fellow Audit Committee Members for their help and assistance during the year covered by this report.

Signed

Jim Edney
Audit Committee Chairman

21st May 2014

Remuneration Committee Report Judith Oates/Neil Seddon

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

Membership of the Remuneration Committee is as follows:-

Mr Doug Garrett – Chairman of the Committee
Mr Ian Johnson
Mr Paul Olive (until 31st May 2013)
Mr Tony Shaw
81Mrs Karen Crowshaw
Mr Alan Roff
Mr Jim Edney (from 1st June 2013)
Mrs Michele Ibbs (from 1st September 2013)
Miss Judith Oates/Mrs Nicky Ingham – Secretary

Seven meetings of the Committee took place during 2013/14 as follows: - 24th April 2013, 29th May 2013, 26th June 2013, 31st July 2013, 25th September 2012, 30th October 2013 and 16th December 2012 with attendance as follows:-

Committee Members (7)	Number of Meetings (7)
Mr Doug Garrett (Chairman)	6
Mr Ian Johnson	7
Mr Tony Shaw	7
Mrs Karen Crowshaw	7
Mr Alan Roff	7
Mr Paul Olive (until 31st May 2013)	1
Mr Jim Edney (from 1st June 2013)	5
Mrs Michele Ibbs (from 1st September 2013)	3
Mrs Janet Benson – Secretary (April 2013)	1
Miss Judith Oates – Secretary (May/June/July 2013)	3
Mr Richie Siziba – Secretary (September/October 2013)	2
Mrs Nicky Ingham – Secretary (December 2013)	1

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

The Committee undertakes its duties by reference to national guidance, pay awards made to other staff groups through national awards and by obtaining intelligence from independent specialists in pay and labour market research. Any increments to pay would be subject to satisfactory performance, evidenced by performance appraisal and monitoring and evaluation through the Chairman or Chief Executive.

At the meeting in April 2013, the Committee agreed that, in line with national pay uplifts for the nationally agreed staff groups, a 1% increase would be applied to Directors and other senior posts that are reviewed by the Committee.

During the course of the year, the Committee has also formally ratified the appointment of Mrs Nicky Ingham as the Director of Workforce & OD and Mr Tim Bennett as the Director of Finance.

All Executive Directors are on permanent contracts. Notice and termination payments are made in accordance with the provisions set out in the standard NHS conditions of service and NHS pension scheme as applied to all staff. There were no early termination payments made in the year.

The following tables provide details of the remuneration and pension benefits for senior managers for the period 1st April 2013 to 31st March 2014. These tables are subject to audit review.

Signed: Date: 21st May 2014

Gary Doherty
Chief Executive

A) Remuneration

Name and title	2013/14						
	Salary & Fees (bands of £5,000)	Taxable benefits £'00	Annual Performance Related bonuses (bands of £5,000)	Long-trem performance-related bonuses (bands of £5,000)	Pension-related benefits (bands of £2,500)	Loss of Office (bands of £5,000)	Total (bands of £5,000)
I Johnson - Chairman	45 - 50						45 - 50
G Doherty - Chief Executive (from 01/04/13)	160 - 165				252.5 - 250		415 - 420
T Bennett - Director of Finance (from 25/11/13)	45 - 50				35 - 37.5		80 - 85
F Patel - Acting Director of Finance (to 24/11/13)	70 - 75				135 - 137.5		205 - 210
P Oliver - Director of Operations	110 - 115				(15) - (12.5)		95 - 100
M O'Donnell - Medical Director	215 - 220				2.5 - 5		220 - 225
M Thompson - Director of Nursing and Quality	110 - 115				5 - 7.5		115 - 120
W Swift - Managing Director of Community Development and Transformation	130 - 135				2.5 - 5		135 - 140
R Bell - Director of Facilities (to 22/11/13)	35 - 40				12.5 - 15	90 - 95	140 - 145
J Benson - Acting Director of Human Resources (to 30/06/13)	15 - 20						15 - 20
N Ingham - Director of Human Resources (from 01/11/2013)	40 - 45				40 - 42.5		85 - 90
PA Olive - Non Executive (to 31/05/13)	0 - 5						0 - 5
J Edney - Non Executive (from 01/06/13)	15 - 20						15 - 20
RA Shaw - Non Executive	10 - 15						10 - 15
K Crowshaw - Non Executive	10 - 15						10 - 15
D Garrett - Non Executive	10 - 15						10 - 15
A Roff - Non Executive	10 - 15						10 - 15
M Ibbs - Non Executive (from 01/09/13)	5 - 10						5 - 10

Name and title	2012/13						
	Salary & Fees (bands of £5,000)	Taxable benefits £'00	Annual Performance Related bonuses (bands of £5,000)	Long-trem performance-related bonuses (bands of £5,000)	Pension-related benefits (bands of £2,500)	Loss of Office (bands of £5,000)	Total (bands of £5,000)
I Johnson - Chairman	45 - 50						45 - 50
A Kehoe - Chief Executive (to 04/11/12)	95 - 100				15 - 17.5		115 - 120
T Welch: Deputy Chief Executive (to 04/11/12) Acting Chief Executive (05/11/12 to 31/03/2013	135 - 140				25 - 27.5		160 - 165
F Patel - Acting Director of Finance (from 05/11/12)	35 - 40				25 - 27.5		60 - 65
P Oliver - Director of Operations	110 - 115				227.5 - 230		335 - 340
M O'Donnell - Medical Director	215 - 220				620 - 622.5		835 - 840
M Thompson - Director of Nursing and Quality	105 - 110				20 - 22.5		125 - 130
W Swift - Managing Director of Community Development and Transformation	130 - 135				5 - 7.5		135 - 140
R Bell - Director of Facilities	105 - 110				17.5 - 20		125 - 130
N Grimshaw - Director of Human Resources (to 31/03/12)	80 - 85				(22.5) -(25)		55 - 60
J Benson - Acting Director of Human Resources (from 01/01/2013)	20 - 25						20 - 25
PA Olive - Non Executive	15 - 20						15 - 20
MG Faulkner - Non Executive (to 17/12/12)	5 - 10						5 - 10
RA Shaw - Non Executive	10 - 15						10 - 15
K Crowshaw - Non Executive	10 - 15						10 - 15
D Garrett - Non Executive	10 - 15						10 - 15
A Roff - Non Executive	10 - 15						10 - 15

The remuneration report table as above has been prepared in line with 2013/14 ARM for FT's. The 2013/14 guidance requires new basis for calculation of pension related benefits. As a result prior year comparatives have been restated in line with new guidance.

The basis of calculation for pension related benefits is in line with section 7.62 of the ARM, and follows the 'HMRC method' which is derived from the Finance Act 2004 and modified by Statutory Instrument 2013/1981. The calculation required is:

$$Pension\ Benefit\ Increase = \big((20 \times PE) + LSE\big) - \big((20 \times PB) + LSB\big) - EC$$

Where:

PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year;

PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year;

LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year;

LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year; and,

EC is the employee's contribution paid during the year.

In summary the new basis of calculation as above, shows the pension accrued in year multiplied by a factor of 20. This has resulted in large pension related benefits as shown in the remuneration report table as above.

The pension related benefits are especially large for new directors in post in year, these being the Chief Executive, Director of Finance and the Director of HR, who have received pay increases in year in line with their new office.

No directors or senior managers of the Trust have received non cash benefits as part of their remuneration package in 2013/14.
During 2013/14 compensation payments of £92,155 were paid to R Bell for loss of office.
No executive directors of the Trust hold external non-executive director appointments.

Pension Benefits - Values subject to audit review

Salary and Pension Entitlements of Senior Managers

B) Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2500)	Total accrued pension at age 60 at 31st March 2014 (bands of £5000)	Real increase in pension lump sum at age 60 (bands of £2500)	Lump sum at age 60 related to accrued pension at 31st March 2014 (bands of £5000)	Cash Equivalent Transfer Value at 1st A 201pril3	Cash Equivalent Transfer Value at 31st March 2014	Real Increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
G Doherty - Chief Executive (from 01/04/2013)	10 - 12.5	40 - 45	35 - 37.5	125 - 130	425	625	191
T Bennett - Director of Finance (from 25/11/2013)	0 - 2.5	45 - 50	0 - 2.5	135 - 140	708	775	18
F Patel - Acting Finance Director (from 05/11/2012 to 30/01/2014)	2.5 - 5	15 - 20	12.5 - 15	55 - 60	160	251	57
M O'Donnell - Medical Director	0 - 2.5	80 - 85	2.5 - 5	240 - 245	1,668	1,782	78
W Swift - Managing Director of Community Development and Transformation	0 - 2.5	55 - 60	2.5 - 5.0	170 - 175	1,177	1,261	58
P Oliver - Director of Operations	0 - 2.5	35 - 40	0 - 2.5	110 - 115	626	820	179
M Thompson - Director of Nursing and Quality	0 - 2.5	35 - 40	2.5 - 5	115 - 120	591	635	32
N Ingham - Director of Human Resources (from 01/11/2013)	0 - 2.5	20 - 25	2.5 - 5	60 - 70	253	296	16
R Bell - Director of Facilities (to 22/11/2013)	0 - 2.5	5 - 10	0 - 2.5	0 - 5	117	140	13

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

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

Real increase in CETV - this reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

In his budget of 22 June 2010 the Chancellor announced that the uprating (annual increase) of public sector pensions would change from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI) with effect from April 2011. As a result the Government Actuaries Department undertook a review of all transfers factors.

Executive Director Expenses

C) **Executive Director Expenses**

Name and title	Apr 2013 (£)	May 2013 (£)	June 2013 (£)	July 2013 (£)	Aug 2013 (£)	Sep-13 (£)	Oct 2013 (£)	Nov 2013 (£)	Dec 2013 (£)	Jan 2014 (£)	Feb 2014 (£)	Mar 2014 (£)
G Doherty Chief Executive from 01/14/2013						7.00	41.52	45.67	66.39	8.40	8.81	
F Patel Acting Finance Director to 24/11/2013	4.80		49.84				12.00	9.70				
T Bennett Finance Director from 25/11/2013										21.83	46.32	
M O'Donnell Medical Director*	10.69	10.70	10.69	10.69	10.69	10.69	10.69	10.69	10.69	10.69	10.69	10.69
P Oliver Director of Operations			74.98						129.25			
M Thompson Director of Nursing and Quality							155.61	185.98	125.65		80.97	
J Benson Acting Director of HR to 30/06/2013	196.97		53.73									
N Ingham Director of HR from 01/11/2013									22.10		136.75	
W Swift Managing Director of Community Development and Transformation												
R Bell Director of Clinical Support and Facilities Management to 22/11/2013												

Reporting related to the Review of Tax Arrangements of Public Sector Appointees

*Expense claims for M O'Donnell are for telephone allowances.
All other claims relate to travel expense claims.

Off-Payroll Engagements

As part of the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23rd May 2012, Foundation Trusts are required to publish information in relation to the number of off-payroll engagements.

Table 1: For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than 6 months

No. of existing engagements as of 31 March 2014	1
Of which:	
No. that have since come onto the Organisation's payroll	0
Of which:	
No. that have since been re-negotiated/re-engaged to include to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No. that have come to an end	1
Total	1

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014, for more than £220 per day and that last for longer than 6 months

No. of new engagements	0
Of which:	
No. of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	0
Of which:	
No. for whom assurance has been accepted and received	0
No. for whom assurance has been accepted and not received	0
No. that have been terminated as a result of assurance not being received	0
Total	0

Nominations Committee

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

Membership of the Nominations Committee:-

Mr Ian Johnson – Trust Chairman (Chairman)
Mr Peter Askew – Elected Governor (Wyre Constituency)
Mr Eric Allcock – Elected Governor (Blackpool Constituency) (until September 2013)
Mrs Jean Taylor – Appointed Governor (UCLAN)

There have been two meetings of the Nominations Committee during 2013/14.

The Nominations Committee has the following responsibilities:-

Recruitment and Appointment of Non-Executive Directors:-

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

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

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

Performance Management and Appraisal:-

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

Board Recruitment:-

- The recruitment process to appoint one replacement Non-Executive Director and one additional Non-Executive Director was undertaken by an external company in conjunction with the Nominations Committee. Jim Edney and Michele Ibbs were appointed and took up post on the 1st June 2013 and 1st September 2013 respectively.
- The recruitment process for an additional Non-Executive Director with a clinical background will take place in 2014/15.

Annex A – Quality Accounts - David Holden / Carol Powell

To be inserted

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 incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support 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 the Quality Report is not inconsistent with internal and external sources of information including:

  - Board minutes and papers for the period April 2013 – April 2014 May and June 2014 are not yet available;
  - Papers relating to Quality reported to the Board over the period April 2013 to June 2014;
  - Feedback from the commissioners - Blackpool Clinical Commissioning Group and Fylde and Wyre Clinical Commissioning Group – dated xx/05/2014;
  - Feedback from Governors dated 12/05/2014, and xxxxxx;
  - Feedback from Local Healthwatch organisations - Local Healthwatch Lancashire dated xx/04/2014;
  - Feeback from Local Healthwatch organisations – Local Healthwatch Blackpool dated 12.05.2014
  - Feedback from the Blackpool Council's Health Scrutiny Committee dated 13.05.2014
  - The Trusts Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xx/04/2014;
  - The latest 2013 national patient survey published February 2013;
  - The latest 2013 national staff survey published February 2014;
  - The Head of Internal Audits annual opinion over the Trust's control environment approved 30/04/2014;
  - Care Quality Commission quality and risk profiles dated 31.05.2013, 30.06.2013 and 31.07.2013;
  - The CQC Intelligent Monitoring Report dated 21.10.2013, 13.03.2014.

- 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: 22nd May 2014

Chairman:
Ian Johnson

Date: 22nd May 2014

Chief Executive:
Gary Doherty

Annex C: External Auditor's Limited Assurance Report on the Contents of the Quality Report PwC

(2 pages)

(2 pages)

Annex D: A Statement of the Chief Executive's responsibilities as the Accounting Officer

Statement of the Chief Executive's responsibilities as the Accounting Officer of Blackpool Teaching Hospitals NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed Blackpool Teaching Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Blackpool Teaching Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements, and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities are set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum.*

Signed: Date: 21st May 2014

Gary Doherty
Chief Executive

Annex E: Annual Governance Statement 2013/14 David Holden/Carol Powell

ANNUAL GOVERNANCE STATEMENT 2013/14

BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST

1. Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

2. The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Blackpool Teaching Hospital NHS Foundation Trust (the Trust), to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place for the Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

3. Capacity to Handle Risk

3.1 Leadership

As Accounting Officer, I have overall accountability and responsibility for ensuring that there are effective risk management and integrated governance systems in place within the Trust and for meeting all statutory requirements and adhering to guidance issued by Monitor in respect of governance and risk management. I lead the Risk Management process as Chair of the Trust's Risk Committee, which meets on a bi-monthly basis. The Risk Committee has its membership drawn from the Directors within the Trust. The Chairman of the Trust is also in attendance. The Risk Committee oversees all risk management activity and ensures the correct strategy is adopted for managing risk; controls are present and effective; and action plans are robust for those risks which remain intolerant. The Risk Committee also comprised the Deputy Director of Corporate Affairs and Governance, Senior Managers and specialist advisors who routinely attend each meeting. In the last year, the Board Committee Structure was reviewed and the internal auditors KPMG, found significant assurance. This review saw the establishment of separate committees for the management of Risk and Quality in the Trust. The Committee structure will be reviewed again this year internally to ensure that it is efficient and effective and is continuing to meet the needs of the organisation. These reviews ensure the committees structure is working at its optimum, prevent duplication of work and ensure there are clear lines of responsibility and accountability to the Trust Board, Council of Governors and our regulatory bodies as required.

The Trust has reviewed and updated the Risk Management Strategy which clearly describes the roles and responsibilities of individual Executive Directors specifically and generally and is reviewed and endorsed by the Board of Directors annually. The Risk Management Strategy applies to all employees and requires an active lead from managers at all levels to ensure risk management is a fundamental part of the total approach to quality, safety, corporate and clinical governance, performance management and assurance. There is a clearly defined structure for the management and ownership of risk through the development of the Board Assurance Framework and Corporate Risk Register.

A lead Executive Director has been identified for each principal risk defined within the Board Assurance Framework and Corporate Risk Register and each risk is linked to the Care Quality Commission Quality and Safety Standards. These 'high level' risks within the Board Assurance Framework and Corporate Risk register are subject to ongoing review by the Risk Committee and the Board of Directors on a quarterly basis.

The Board of Directors has overall responsibility for setting the strategic direction of the Trust and managing the risks in delivering that strategy. All committees with risk management responsibilities have reporting lines to the Board. Some aspects of risk are delegated to the Executive Directors:

- The Director of Strategy/Deputy Chief Executive is responsible for Strategy, including the Estate Management and Fire Safety. The Deputy Chief Executive is the Senior Information Risk Owner (SIRO) and as has overall responsibility for Information Governance risk.
- The Finance Director provides the strategic lead for financial risk, Capital Programme Management and the effective coordination of financial controls throughout the Trust;
- The Medical Director (jointly with the Director of Nursing and Quality) is responsible to the Board for Clinical Risk Management and is the professional risk lead for all Doctors within the Trust. The Medical Director is also the Executive Lead responsible for health and safety, is the Caldicott Guardian and therefore responsible for information governance risk in relation to patient information.
- The Director of Nursing and Quality has shared responsibility for Clinical Risk Management with the Medical Director and is the professional risk lead for Nurses, Midwives and Allied Health Professionals within the Trust. The Director of Nursing and Quality is the Executive Lead responsible for infection prevention and is also responsible for "soft" facilities management. The Director of Nursing and Quality is supported by the Deputy Director of Corporate Affairs and Governance who is responsible for reporting to the Board of Directors on the development and progress of the Risk Management Strategy and for ensuring that the strategy is implemented and evaluated effectively;
- The Director of Operations is responsible for developing risk based operational Key Performance Indicators and for monitoring performance and reporting to the Board on a monthly basis;
- The Director of Workforce and Organisational Development is responsible for workforce planning, staffing issues, education and training;
- The Deputy Director of Corporate Affairs and Governance is the management lead responsible for ensuring a fully integrated and joined up system of risk and control management is in place and embedded on behalf of the Board; and
- All Divisional Directors, Heads of Departments, Associate Directors of Nursing, and ward/departmental managers have delegated responsibility for the management of risk in their areas. Risk is integral to their day-to-day management responsibilities. It is also a requirement that each individual division produces a divisional/directorate risk register, which is consistent and mirrors the Trust's Corporate Risk Register requirements and is in line with the Risk Management Strategy;

Governors have an important role to play and are responsible for providing leadership in order to operate effectively, represent the interests of members and influence the strategic direction of the Trust. The Council of Governors is responsible for holding the non-executive directors, individually and collectively, to account for the performance of the board of directors This is attained for example by Governors attending and observing committees of the Board, attending Board meetings in public and meeting with the Chairman, Chief Executive and Committee Chairs as well as at meetings of the Council of Governors.

3.2 Training

Staff are trained or equipped to manage risk in a way appropriate to their authority and duties. The Trust has in place an induction programme for new employees, which includes awareness of the Trust's Risk Management Strategy. Risk management is a dedicated session on the Corporate Mandatory Training Programme and each Division and Corporate Directorate has a responsibility to develop specific departmental local induction programmes, which includes awareness of the Division/Directorate Risk Management Strategy. In addition, training is also provided to relevant staff on risk assessment, incident reporting and incident investigation. The Trust has in place a mandatory training programme and the Board has set out the minimum requirements for staff training required to control key risks and includes risk management processes such as health and safety, manual handling, resuscitation, infection prevention, safeguarding patients, blood transfusion and information governance. A comprehensive training needs analysis has been kept under review which sets out the training requirements for all members of staff and includes the frequency of training in each case. Trust Board members have participated in bespoke risk management training.

To ensure the successful implementation and maintenance of the Trust's approach to risk management, staff at all levels are appropriately trained in risk assessment, incident reporting and root cause analysis training. The Trust uses an integrated electronic risk management system, known as Ulysses which is used to record and manage incidents and risk registers both at Corporate and Divisional level. The system allows for the recording and assessment of risks using a generic scoring matrix. The risk management leads within each Division and Corporate Directorate are responsible for coordinating the ongoing review and management of risks identified, collated, reported and reviewed locally through the Trust Governance structures.

All members of staff have responsibility for participation in the risk management system through awareness of risk assessments which have been carried out in their place of work and to compliance with any control measures

introduced by these risk assessments. The Trust recognises the importance of supporting staff and the risk management team act as a support and mentor to staff who are undertaking risk assessments and managing risk as part of their role.

The overarching performance management system within the Trust ensures that controls are in place to identify and manage any risks to the delivery of key performance targets. This process is utilised as a further assurance mechanism to maintain an effective system of internal control.

Employees, contractors and agency staff are required to report all adverse incidents and concerns. The Trust supports a learning culture, ensuring that an objective investigation or review is carried out to continually learn from incidents, only assigning 'blame' to individuals where it is clear that policies and procedures have not been appropriately followed.

The Learning from Incidents and Risks Committee meets on a bi-monthly basis to ensure concerns identified from incidents, complaints and claims, are investigated to ensure that lessons are learned and as a method of improvement and sharing good practice. The Trust fosters an environment where individuals are treated in a fair and just way, and where lessons are learned rather than blame being attributed.

The Trust seeks to learn from good practice and will investigate any serious incidents, complaints and serious untoward incidents requiring investigation via the Serious Incident Review and Action Team. The findings are reviewed by the Action Team to ensure learning points are implemented. Assurance is gained by presenting an overview of the investigation reports to the Trust's Quality Committee, the Learning from Incidents and Risks Committee and the Board of Directors. Any learning points for staff when things go wrong are shared via Divisional governance systems and published via the Staff Lessons Learned Newsletter and via the Risk Management Website and the Knowledge Management Website for all staff to access.

In addition to the Trust reviewing all internally driven investigation reports, the Trust also adopts an open approach to the learning derived from third party investigations and audits, and/or external reports. During 2013/14, the Trust has taken on board recommendations from a number of external reports including ongoing work in relation to the Francis report on Mid Staffordshire NHS Foundation Trust.

In June 2013 the Trust had a visit from a team under the direction of Bruce Keogh. We welcomed this opportunity to demonstrate the quality of care provided by the organisation and to highlight many areas of improvement being undertaken. This visit linked well with our ongoing work to improve service quality and reduce mortality, which has seen average standardised mortality ratios for the Trust decreasing since July 2012. .

The Trust has committed itself to improving the nurse and doctor to patient ratios over coming years and is spending over £1m new monies this year to reduce the number and severity of incidents that could result in patient harms and ensure high standards of clinical care are maintained.

The Trust actively seeks to share learning points with other health organisations, and pays regard to external guidance issued. Accordingly, the Trust will undertake a gap analyses and adjust systems and processes as appropriate in line with best practice.

4. The Risk and Control Framework

4.1 Key Elements of the Risk Management Strategy

The Risk Management Strategy is validated by the Risk Committee and approved by the Board of Directors. It covers all risks and is subject to an annual review to ensure it remains appropriate and current. The Risk Management Strategy assigns responsibility for the ownership, identification and management of risks to all individuals at all levels in order to ensure that risks which cannot be managed locally are escalated through the organisation. The process populates the Board Assurance Framework and Corporate Risk Register, to form a systematic record of all identified risks. The control measures, designed to mitigate and minimise identified risks, are recorded within the Board Assurance Framework and Corporate Risk Register.

Risks are identified from risk assessments and from the analysis of untoward incidents. The Risk Management Strategy is referenced to a series of related risk management documents, for example, Patient Safety Strategy, Untoward Incident and Serious Incident Reporting Procedure. The Risk Management Strategy is available to all staff via the Document Library on the Trust Intranet.

The Trust's vision and values, (which have recently been reviewed and will now be ratified by the Board) identify the accepted culture within the organisation; these are linked to the corporate objectives and therefore support the risk management framework. The Trust has developed a risk appetite maturity matrix. This is a very useful tool in aiding our thinking on risk, our risk tolerance and our corporate decision making. This is a simple approach

to quantifying risk in order to define qualitative measures of consequences and likelihood. This allows construction of a Risk Matrix, which can be used as the basis of identifying acceptable and unacceptable risk.

4.2 Key Elements of the Quality Governance Arrangements

Strategy
Patient safety, clinical effectiveness and patient experience, alongside improving efficiency, drive the Board's strategic framework, which identifies key elements in the quality of care it delivers to its patients and provides the basis for annual objective setting. The potential risks to patient safety, clinical effectiveness or patient experience are identified and escalated to the Board in accordance with the process outlined in section 4.1 above.

Capabilities and Culture
The Board of Directors has ensured it has the necessary leadership, skills and knowledge to deliver on all aspects of the quality agenda. In addition, the Board has put in place a clinical leadership model which puts senior medical and nursing colleagues at the heart of decision-making and management. Our culture continues to develop the 'Blackpool Way' now re-launched and renamed "the Trust Way", in relation to the way we do things around here', with our new core values which places people at the centre of all that we do in addition to compassion, excellence and positivity.

Processes and Structure
Accountability for patient safety, clinical effectiveness and patient experience and improved efficiency are set out within the job descriptions and objectives of the Executive Team, senior leaders and staff. All policies and procedures clearly set out roles and responsibilities for all colleagues involved in the delivery of patient care. The Board actively seeks feedback from patients, members, governors and other stakeholders in the pursuit of excellence and as part of the continuous improvement cycle. Executive Directors routinely participate in patient safety walkabouts in clinical areas to engage with frontline teams, patients and visitors, and to evaluate the safety, clinical effectiveness and experience of care for patients.

The Board commences a significant number of formal meetings with a patient story, reflecting on positive and negative experiences of patients using our services. The Board of Directors monitor quality by reviewing the Compliance Assurance Monitoring Report and the Assurance Report on a monthly basis. Safety, quality and patient experience are paramount in the proceedings of the senior corporate committees; namely the: Risk Committee, Quality Committee, and the Audit Committee.

Information reported to the Board, regarding performance against nationally mandated targets, is collated from the dataset submitted to the Department of Health. Likewise data to support compliance with locally commissioned services and targets is reported to the Board from the dataset provided to commissioners.

Measurement
Information relating to patient safety, clinical effectiveness and patient experience is analysed and scrutinised by the Board on a monthly basis, and steps are taken to assure the robustness of data as part of the internal and external audit programmes. The information within the monthly Compliance Assurance Monitoring Report and Assurance Reports are used to evaluate and drive accountability for performance and delivery.

4.3 How Risks to Data Security are Being Managed

The Health Informatics Committee (HIC) is responsible for all aspects of Information Management, Information Governance and Information Communications Technology throughout the Trust known collectively as Information Management; this includes the identification and management of information and data security risks. The HIC is chaired by the Deputy Chief Executive who is also the nominated Board Lead for Information Governance and the Senior Information Risk Owner (SIRO) for the Trust.

The reporting and investigation of incidents is an integral part of all employees' duties. It applies to ALL staff and all untoward events and near misses. Information Security Incidents are known as an 'Information Governance related Serious Incident Requiring Investigation' (IG SIRI). As a guide this includes any incident which involves actual or potential failure to meet the requirements of the Data Protection Act 1998 and/or the Common Law of Confidentiality.

Using information about the context, scale and sensitivity of what has occurred IG SIRI's are categorised into one of the following levels:

0 - Near miss/non-event.
1 - Confirmed IG SIRI but no need to report to ICO, DH and other central bodies.
2 - Confirmed IG SIRI that must be reported to ICO, DH and other central bodies.

During 2013/14 the Trust has incurred no incidents classified as an IG SIRI severity level 2. Should an incident of this level take place a detailed report would be included in the Trust's Annual Report.

Incidents classified at severity level 1 are aggregated and reported in the table below.

Summary Of Level 1 Personal Data Related Incidents In 2013-14		
Category	Breach Type	Total
A	Corruption or inability to recover electronic data	2
B	Disclosed in Error	20
C	Lost in Transit	6
D	Lost or stolen hardware	4
E	Lost or stolen paperwork	15
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	1
J	Unauthorised access/disclosure	13
K	Other	4

4.4 Organisations Key Risks

The key organisational risks for the year were identified from the corporate strategic objectives for 2013/14, forming part of the Board Assurance Framework and included the following:

In-Year Risks 2012/13	Future Major and Significant Clinical Risks 2013/14
To provide patient centred care across integrated pathways with primary / community / secondary and social care	To provide patient centred care across integrated pathways with primary / community / secondary and social care
• To reduce Mortality Rates within the Trust • To reduce Patient Falls • To Reduce the Risk of Acquiring MRSA Bacteraemia • To Reduce the Risk of Acquiring Clostridium Difficile • To achieve CQUIN Local Contractual Measures • To implement actions from Keogh review • To continue to implement the action plan following the AQUA review	• To deliver safe and high quality care to medical patients through Winter • To reduce mortality rates within the Trust • To manage changes within the surgical vascular services at BTH • To manage targets within the Trust • To reduce patient falls • To reduce the risk of acquiring MRSA Bacteraemia • To reduce the risk of acquiring Clostridium Difficile • To achieve CQUIN Local Contractual Measures • To implement actions from Keogh review • To continue to implement the action plan following the AQUA review
To be financially sound and able to re-invest in future services	To be financially sound and able to re-invest in future services
• To Implement the Trust's electronic patient record • Cash Balances/The Organisation needs to deliver and increase Liquidity to meet Monitor's Compliance Framework • Loss of income due to actual activity levels below plan as a result of demand management schemes • To maintain financial balance • To achieve QuIPP improvements • To reduce Fraud Within the Trust • To prevent Significant Breach of Authorisation	• To achieve QuIPP improvements • To implement Electronic Health Records (EDMS) • To deliver the cash balances the organisation needs to deliver and increase Liquidity to meet Monitor's Compliance Framework • To prevent significant breach of Provider Licence Conditions • To manage the loss of income due to actual activity levels below plan as a result of demand management schemes • To reduce fraud within the Trust
To deliver consistent best practice NHS care which is evidence based	To deliver consistent best practice NHS care which is evidence based
• To achieve Monitor's Compliance Framework performance measures • To prevent the Deterioration of Quality & Safety Standards of Patient Care in line with the Francis Report • To maintain CNST Level 1 and 2 • To embed Clinical Audit Activity process within divisions to support clinical improvement. • To Maintain NHSLA Risk Management Standards General Assessment – Level 3 • Cardiothoracic Surgical Services • To comply with Health and Safety regulations	• To achieve Monitor's Compliance Framework performance measures • To fully roil out ward based Pharmacists • To ensure appropriate levels of anaesthetic cover when patient's condition deteriorates out of hours • To maintain and improve quality and safety standards of patient care in line with the Francis Report • To embed clinical audit activity process within divisions to support clinical improvement. • To maintain NHSLA Risk Management Standards General Assessment – Level 3 • Cardiothoracic Surgical Services • To comply with Health and Safety regulations • To maintain CNST Level 1 and 2
To support and develop a workforce that is appropriately skilled and flexible in order to achieve the new models of working	To support and develop a workforce that is appropriately skilled and flexible in order to achieve the new models of working

• To Attract, Develop & Retain a Highly Skilled Workforce • To reduce the Shortage of Junior and Middle Grade Doctors • Ineffective Roll out and use of E-Rostering system • To Ensure Effective Attendance Sickness and Absence • To Achieve Mandatory Training Compliance	• To achieve Mandatory Training Compliance • To retain a safe and sufficient workforce • To reduce the level of vacancies of junior and middle grade doctors • To effectively roll out and use of E-Rostering system • To attract, develop and retain a highly skilled workforce • To ensure effective attendance sickness and absence

The above risks have been risk assessed and managed within impact scores validated by the Board of Directors. In the preceding 12 months, the Trust has taken effective action and reduced the overall risk of significant harm in the following areas:

- Improvement of maternity patient's experience
- Improvement in patient feedback in some areas of National Cancer Patient Survey
- Management of old Anaesthetic Machines
- Delays in imaging for Inpatients, Out Patients and GP Fast Track Patients
- Maintenance of Medical Devices within the Trust
- Closure of Rossall Hospital

Mitigating actions against a number of potential significant in-year risks 2013/14 are detailed in Section 7 of the Annual Governance Statement. Outcomes of each risk remain under constant review and are assessed by reviewing progress with measurable targets, and auditing compliance with national and local standards/regulations. Mitigating actions and outcomes are monitored as a minimum on a quarterly basis by the reporting committees identified in the risk management strategy. Escalation and de-escalation of risks is dependent upon progress to achieve outcomes.

4.5 How Risk Management is Embedded in the Activity of the NHS Foundation Trust

Risk Management is embedded in the activity of the organisation through Induction Training, regular Risk Management Training and ad-hoc training when need is identified. Staff are openly encouraged to report incidents and near misses through the monthly drop-in training sessions and through the corporate and mandatory training. The Trust encourages reporting within an open and fair culture, where reporting is congratulated and individuals are not blamed or penalised if they speak out. An Untoward Incident and Serious Incident reporting system is in place and incidents are entered onto a database for analysis. Root cause analysis is undertaken and all identified changes in practice are implemented.

Risk Management is embedded within the Trust through key committees identified in the Corporate Governance Structure and consists of clinical and non-clinical committees, which report to the Risk Committee on a bi-monthly basis.

The security of staff, service users, carers, relatives, visitors and property is a key Trust priority. The delivery of high levels of safety and security is critical to the delivery of the highest possible standards of clinical care and Blackpool Teaching Hospitals NHS Foundation Trust is committed to improving the environment and sense of overall personal security for those who access our services and for those who provide those services.

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

Wherever possible the Trust seeks to minimise risk by deterrence, all security related incident reports are reviewed by the LSMSs on a weekly basis and investigations instigated as appropriate and if required a review undertaken of any security measures in place for effectiveness.

The Trust employs a security team for the Blackpool Victoria Hospital site. The team are trained to a high standard and form an integral part of the Trusts deterrence strategy.

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

We are committed to ensuring that Trust staff are properly protected and appropriate training is recognised, as a key factor Conflict Resolution and Breakaway Training and Security Awareness Training is offered to all front line staff and is included as part of the Corporate Induction

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

The Trust CCTV working group continues to oversee and develop the Closed Circuit Television (CCTV) monitoring system, for the Blackpool Victoria, Clifton and Fleetwood sites. . There have been some new camera instillations during the 2013/14 period which were highlighted as gaps by the CCTV Working group and they cover what would be considered critical assets to the Trust. The CCTV improvement enhanced throughout a number of premises is anticipated this will enhance the chance of criminals being caught and act as a visual deterrence to people mindful of committing criminal offences. The security room both monitor and control some 150 cameras

Security audits have been introduced within the Trust by the Local Security Management Specialists,(LSMS) where visits to individual departments are conducted so security/safety issues can be addressed and the L.S.M.S can work with the department to produce its own individual Lockdown action card.

The Trust has a zero-tolerance approach to fraud and the Counter Fraud service is provided by Audit North West. This helps to embed and tackle fraud and potential fraud in several ways:

- developing an anti-fraud culture across the Trust's workforce;
- fraud proofing of all of our policies and procedures;
- conducting fraud detection exercises into areas of risk;
- investigating any allegations of suspected fraud; and
- obtaining, where possible, appropriate sanctions and redress.

Each Division has undertaken a self assessment and completed a fraud risk assessment which is monitored on a local level and existing controls continue to mitigate the risk.

The Audit Committee is a committee of the Board of Directors and provides independent assurance on aspects of governance, risk management and internal controls. The Risk Committee links with the Audit Committee, Quality Committee and reports directly to the Board of Directors.

The Trust has been carrying out Equality Impact Assessments (EIA) since 2007. Since their inception within the Trust all policies, procedures, guidelines, schemes, strategies etc have to have a completed EIA attached before being sent to the relevant committee for discussion and signing off. Likewise completion of an EIA is expected when there is a new service to be implemented, a change to a service or cessation of a service along with the relevant consultation and engagement with service users. Where an adverse impact is identified during the completion of the initial assessment, a full EIA is carried out. This involves consulting and engaging with people who represent protected characteristic groups and other groups if required to do so.

An action plan is drawn up after completing the full assessment which details the actions to be taken, along with a time frame, to eliminate or reduce as far as possible any adverse impact. A copy of the action plan is sent to the Trust's Equality Diversity and Human Rights Steering Group for monitoring on its progress.

Equality and Diversity training is part of the Trust's Induction Programme and the Trust's overall mandatory training programme.

4.6 Elements of the Assurance Framework

The Board Assurance Framework has been fully reviewed during 2013/14. The Assurance Framework:

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

- Covers the Care Quality Commission essential Quality and Safety Standards on which the Trust has registered with the CQC with no conditions during 2013/14.

The Risk Committee considers high/significant risks and if appropriate, recommends their inclusion on the Corporate Risk Register and/or Board Assurance Framework. This is presented to the Board of Directors for formal ratification.

Risk prioritisation and action planning is informed by the Trust's corporate objectives which have been derived from internal and external sources of risk identified from national requirements and guidance, complaints, claims, incident reports and Internal Audit findings. This also includes any other sources of risk derived from Ward, Departmental, Directorate and Divisional risk assessments, which feed up to Divisional and Corporate level management. Action plans are developed for unresolved risks.

Lead Executive Directors and Lead Managers are identified to address the gaps in control and assurance and are responsible for developing action plans to address the gaps. The Board Assurance Framework serves to assure the Board of Directors that the Trust is addressing its risks systematically. The action plan arising from each risk serves as a work plan for the Trust through the Lead Managers to ensure mitigation against risks and closure of any gaps in control or assurance.

The 'elements' of the Board Assurance Framework are monitored and reviewed on a bi-monthly basis by the Risk Committee and the Audit Committee followed by the Board of Directors. This demonstrates that the document is live and continuous and provides evidence to support the Annual Governance Statement.

The Finance Director and the Deputy Director of Corporate Affairs and Governance are members of the Risk Committee and provide Governance and Risk Management assurance to the Audit Committee at each of its meetings, thus ensuring an integrated risk management approach.

The Trust manages gaps in assurance by way of the Audit Committee who will review these gaps and assess the required assurances to review systems and processes.

4.7 How Public Stakeholders are Involved in Managing Risks Which Impact on Them

The Governance Framework requires the Trust to involve both patients and public stakeholders in the Governance agenda. This has been achieved through engagement with the Trust membership and Governors, NHS Blackpool, NHS North Lancashire, Blackpool Overview and Scrutiny Committee, Lancashire Overview and Scrutiny Committee, Blackpool Local Safeguarding Children's Board, Blackpool Vulnerable Adults Board, Learning Disability Partnership Board and Local Involvement Networks (LINk), now Healthwatch. The Trust has a Patient and Public Involvement Strategy in place and this has been continuously implemented throughout 2013/14. This is now a core component of the Trust Membership Strategy. Public Stakeholders are consulted with regard to any future service developments and changes in service development.

Patient feedback is actively solicited through the monthly local in-patient survey and patient feedback is reviewed on an ongoing basis with summary reports reviewed regularly by the Board. The Chief Executive regularly holds public "Question Time" sessions where any member of the public can attend and raise any issue they would like to have addressed.

The Trust has engaged with Staff and Public Governors to provide them with assurance that the risks across the organisation are being managed and mitigated. The Trust has worked with Deloitte LLP, an independent Management Company, to undertake a review of the effectiveness of the Governors in preparation for the new Health and Social Care Act Legislation and the Trust is working with the Governors to help them fulfil in their role.

Issues raised through the Trust's Risk Management processes that impact on partner organisations, for example, Lancashire Care NHS Foundation Trust would be discussed at the appropriate forum in order that appropriate action can be agreed.

An established communications framework is in place in the form of a Major Incident Plan, and cross-community emergency planning arrangements are in place.

4.8 Disclosure of Registration Requirements

The NHS Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

Announced visit to Blackpool Teaching Hospitals NHS Foundation Trust by the Care Quality Commission (CQC)

In January 2014, Blackpool Teaching Hospitals acute services at Victoria Hospital, Clifton Hospital and Fleetwood Hospital were inspected as part of the Care Quality Commission's new national programme of inspections. This inspection was 6 months after the Keogh visit and subsequent report and action plan. The CQC inspected acute services covering; Accident and Emergency, Medical Care, Surgery, Intensive/critical care, Maternity and family planning, Children's care, End of Life Care and Outpatients. The CQC focussed on five areas of inspection. These were: Are services safe, effective, caring, responsive to peoples needs and are they well-led.

The CQC's final report, published on 2 April, 2014 gave an overall rating to the Trust of "requires improvement" with the following ratings for each of the 5 key inspection questions:

Are acute services at this Trust safe?	Requires Improvement
Are acute services at this Trust effective?	Requires Improvement
Are acute services at this Trust caring?	Good
Are acute services at this Trust responsive?	Requires Improvement
Are acute services at this Trust well-led?	Requires Improvement

Of the 68 individual ratings given 42 were good, 2 were outstanding, 22 were requires improvement and 2 areas were deemed inadequate. Maternity Services were rated as 'inadequate' due to the ongoing review of PPH cases that had resulted in a hysterectomy, 5 cases in a 6 month period. The expected range for our Trust is 2 cases per year. The RCOG are due to undertake their case review on 30th April and the CQC wish to receive a copy of this report and to agree with the Trust a date for re-inspection of the Maternity Service.

Copies of the CQC reports and the high level action plan have been provided in the Board papers. Following the Quality Summit on the 28th March it was agreed to formulate one quality improvement action plan following the CQC visit. The new CQC action plan and monitoring dashboard incorporates the main areas of continued focus from the Keogh Action plan e.g. monitoring mortality reduction, patient experience, incident reporting and staffing. The high level CQC action plan has been agreed with Commissioners and shared with Monitor. A detailed draft action plan has been developed and this has also been shared with Commissioners. The final action plan is due to be returned to the CQC by 30th April 2014.

An action plan is currently being produced to ensure all matters requiring improvement will be attained. This plan will be agreed by the Trust Board and with our commissioners and with Monitor and will be implemented in 2014/15.

Unannounced Visit – Cardiac Directorate and the Trust's Complaints Service

On 11th June 2013 the Care Quality Commission carried out an unannounced visit to Blackpool Teaching Hospitals NHS Foundation Trust and reviewed the following standards:

Outcome 1: Respecting and Involving People Who Use Services
Outcome 2: Consent to Care and Treatment
Outcome 4: Care and Welfare of People Who Use Services
Outcome 16: Assessing and Monitoring the Quality of Service Provision
Outcome 17: Complaints

Following this visit the final report provided overall positive feedback, however the Trust was deemed to have not met the standard in respect of Outcome 17: Complaints, with moderate impact on patients using this service being identified.

Based on the final report the Trust developed an action plan and commenced implementation of the recommendations to address the areas for improvement detailed above. The Trust has demonstrated compliance with Outcome 17. This has been achieved by the following:

The Trust's Operation Procedure – Patient Relations Department (Corp/Proc/403) has been updated with regards to the investigation timescales to ensure they are manageable and fit for purpose. This has been undertaken in conjunction with a Non Executive Director. The Trust has also reviewed the Safeguard electronic system to ensure flexibility in date recording.

If a complaint is delayed a holding letter is sent to the complainant and a date identified of when the Division will have the final response mailed out to the complainant.

A Red Alert was developed by the Director of Nursing and Quality and the Medical Director. The Alert was sent out to all Ward Managers to present to staff at handover for a period of one week. An e-mail was also sent all Consultants regarding the contents of the red alert.

The completed action plan and progress report detailed above has been submitted to the Care Quality Commission in October 2013 following approval by the Board.

Unannounced Follow up Visit – Complaints Service
The Care Quality Commission carried out a second unannounced follow up visit on 26th November 2013 to review of the Trust's compliance against Outcome 17. The Trust was able to evidence that they were taking the improvement of complaints management very seriously and was found to be meeting the standard fully.

4.9 Compliance with the NHS Pension Scheme Regulations

As an employer with staff entitled to membership of the NHS Pension Scheme control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules and regulations, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

4.10 Compliance with Equality, Diversity and Human Rights Legislation

Control measures are in place to ensure that all Trust's obligations under equality, diversity and human rights legislation are complied with. This is evidenced by the annual review during the year of the Single Equality Scheme at the Equality and Diversity and Human Right Steering Committee which reports to the Clinical Governance Committee. This is also evidenced by demonstrating that all procedural documents incorporate an equality impact assessment prior to ratification by the relevant committee.

The Trust has adopted the national NHS Employers toolkit known as the Equality Delivery System to assist the Trust in meeting the legal requirements of the Equality Act 2010 and the Human Rights Act 1998. This involves carrying out self assessments and public consultation grading events on any work around equality and diversity to ensure a more inclusive approach to the access of services and service provision.

4.11 Compliance with Climate Adaptation Requirements under the Climate Change Act 2008

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5 Review of Economy, Efficiency and Effectiveness of the Use of Resources

As at 31 March 2014 the Trust's governance risk rating status, published on Monitor's website is "Green"..

The Trust achieved its planned delivery of a Continuity of Service Rating (CoS) of 3 at the 31st March 2014.

The Trust is meeting Monitor's quarterly monitoring requirements on an ongoing basis.

The Trust has arrangements in place for setting objectives and targets on a strategic and annual basis and during 2013/14 the Trust has consolidated and developed a number of systems and processes to help deliver an improvement in the financial performance which includes the following, namely: -

- Heads of Department Budget presentations to a group of Executive Directors and Non Executive Directors; incorporating: -
    - Department SWOT analysis;
    - Providing more care in the community;
    - QuIPP ideas;
    - Department activity plan;
    - Key deliverables;
    - Clinical and quality priorities;
    - Key risks and mitigations.

- Approval of the annual budgets by the Board of Directors.
- Monthly Finance and Business Monitoring Committee to ensure Directors meet their respective financial targets reporting to the Board.
- Monthly Divisional Performance Meetings attended by the Executive Team to ensure that Divisions meet the required level of performance for key areas.
- Monthly Cash Committee is actively continuing with measures to further improve cash balances which reports to the Finance and Business Monitoring Committee. The Cash Committee has minimised the risk of the Trust

using the Working Capital Facility. The measures taken include creditor stretch, improvements in receivables processes and improvements to cash forecasting.

- The Trust has in place a Programme Management Office to scrutinise CIP planning and delivery. In addition, the Trust is utilising external support to identify areas of improvement and develop / implement action plans to deliver the required efficiency.
- In light of the Francis Report on Mid Staffordshire Hospitals and the Trust being identified as having high mortality rates, the Trust was selected as part of the review by a national advisory group set up by NHS Medical Director, Sir Bruce Keogh into 14 hospitals which had higher than expected mortality rates. Further details are outlined in section 7. The review took place from the 17th June 2013. Sir Bruce Keogh published his report summarising the findings and actions the Trust needed to take. From this, the Trust produced an action plan based on the findings of the Keogh review, and monitored and has now successfully implemented the vast majority of the action plan matters. Those actions which require ongoing improvement, including the Trust's objective to continue to reduce mortality rates will be combined with the new action plan which will be formulated following the CQC visit in January, 2014.
- The Divisions play an active part in ongoing review of financial performance including Cost Improvement Requirements / Quality, Innovation, Productivity and Prevention (QuIPP) delivery.
- Monthly reporting to the Board of Directors on key performance indicators covering Finance activity; Quality and Safety activity and Human Resource targets.
- Weekly reporting to the Executive Team on key influences on the Trust's financial position including activity on quality and safety performance and workforce indicators.

The Trust also participates in initiatives to ensure value for money, for example: -

- Value for money is an important component of the Internal and External Audit plans that provide assurance to the Trust regarding processes that are in place to ensure the effective use of resources.
- In-year cost pressures are rigorously reviewed and challenged, and mitigating strategies are considered.
- The Trust subscribes to a national benchmarking organisation (CHKS). This provides comparative information analysis on patient activity and clinical indicators. This informs the risk management process and identifies where improvements can be made.
- The Trust has a standard assessment process for future business plans to ensure value for money and to ensure that full appraisal processes are employed when considering the effect on the organisation Procedures are in place to ensure all strategic decisions are considered by the Board of Directors.

6. Annual Quality Report

The Trust's Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of Annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The Trust has built on the extensive work undertaken to develop the Quality Account and has drawn on the various guidance published in-year in relation to the Quality Account. We developed our vision, values and priorities through wide involvement and in consultation with patients, staff, external stakeholders and Governors. The consultation of the Quality Account was launched and included a number of presentations made to the Council of Governors on Quality Accounts, a workshop session with representatives from the Council of Governors and Local Healthwatch (previously known as LINk) as well as members of the public. In addition a website was developed to obtain the views of the public regarding the quality accounts priorities for 2012/13. Through this engagement, the Trust was able to ensure the areas chosen provided a balanced view of the organisation's priorities for 2013/2014. In the preparation of the Quality Account, the Trust appointed a Quality Account Project Lead to develop the Quality Account, reporting direct to the Director of Nursing and Quality, and a Quality Account Steering Group was established. A formal review process was established, involving the submission of our initial draft Quality Report to our external stakeholders (Commissioners, Overview and Scrutiny Committees and Healthwatch). The Quality Account drafts were formally reviewed through the Trust's governance arrangements, formal Executive Directors' meeting and the Board of Directors. The Trust set 2013/14 priorities for improvement for clinical effectiveness, quality of the patient experience and patient safety. Priorities were developed to embed and monitor quality improvement processes, set against the needs of our patients in the delivery of our services.

The Board of Directors can confirm that they have met the necessary requirements under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare its Quality Accounts for the financial year 2013/14. Steps have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data. These steps cover the following areas as detailed below:

- **Governance and Leadership**

The quality improvement system is led directly by the Board of Directors which also exercises its governance responsibilities through monitoring and review of the Trust's quality performance. The Healthcare Governance Committee reporting directly to the Board leads the quality improvement strategy and reviews quality improvement projects on a regular basis.

- **Policies**
  Key policies for quality improvement are in place and these are linked to risk management and clinical governance policies. Trust data quality policies and procedures score highly on the national Information Governance Toolkit and all evidence is delivered and audited. Data quality reports are developed and submitted through the Health Informatics Committee, Performance Board and through to the Trust Board. Data quality staff are in post with relevant job descriptions whose remit is to provide training, advice and review and (where applicable) correct anomalies.

- **Systems and Processes**
  The Board of Directors ensures that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery. The Board regularly reviews the performance of the Trust in these areas against regulatory requirements and approved plans and objectives.

- **People and Skills**
  The 'Blackpool Way', now renamed the "Trust Way", outlines and reinforces the expected behaviour across the Trust and actively encourages and supports employees to gain the skills and qualifications that will support their future employability and meet the needs of the organisation. Locally the focus in 2013/14 was to continue developing managers in coaching and leadership skills particularly for those colleagues who lead our clinical teams to ensure that all staff are safe to practice and to care for our patients.

  The Learning and Development Team continues to provide skills support through widening access to education for staff in the workforce. The purpose is to ensure that all staff are skilled, competent and able to make a full contribution to the success of the organisation.

- **Data Use and Reporting**
  The Trust is provided with external assurance on a selection of the quality data identified within the Quality Report which was taken from national data submissions, CHKS and national patient survey results, Local Inpatient Survey results and Information Governance Toolkit results. Local internal assurance is also provided via the analysis of data following local internally led audits in relation to nursing care indicators, analysis of data following incidents in relation to medication errors and slips, trips and falls incidents for patients. The quality and safety metrics are also reported monthly to the Board through the business monitoring report and the quality and safety report.

  The Trust has a fully controlled process for the provision of external information with control checks throughout the process. Formal sign off procedures and key performance indicators on data are submitted through the Information Management Department.

  Data reporting is validated by internal and external control systems involving Clinical Audit, the Audit Commission and Senior Manager and Executive Director reviews.

The Trust has reviewed its objectives and re-emphasised its commitment to quality, with the aim of achieving excellence in everything it does. Its aspirations for quality improvement in 2013/14 were to:

- Improve our hospital standardised mortality rate;
- Conform to best practice by fully implementing Advancing Quality, 100,000 Lives and Saving Lives interventions;
- Reduce avoidable harms; and
- Improve the patient experience.

The Trust has maintained progress to deliver top 10% performance for clinical quality and has strengthened its performance management structure in relation to delivering the Care Quality Commission (CQC) quality and safety standards. The Trust believes quality should be supported at every level of the organisation and has ensured that all Divisions have implemented the actions required to meet the quality standards. Monitoring was overseen through a number of committees and forums.

The Board of Directors at the Trust can confirm it has the appropriate mechanisms in place to prepare, approve and publish its Quality Report for 2013/14. The Board of Directors is satisfied that the Quality Report provides a balanced view and the appropriate controls are in place to ensure accuracy of data and a true reflection of overall quality within the organisation.

7. Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their Management Letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In describing the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, I have detailed below some examples of the work undertaken and the role of the Board of Directors, the Audit Committee, Quality Committee, Clinical Audit, Internal Audit and External Audit in this process. My review has been informed by:

- The self-assessment of the maintenance of compliance against NHSLA Level 3 Risk Management Standards status that provided assurance on controls.

- The self-assessment of the maintenance of compliance against CNST Maternity Level 2.

- Self-assessment of the Trust's performance against the Key Lines of Enquiry for Auditors Local Evaluation standards and the progress of this review was considered by the Audit Committee throughout the current year.

- The Clinical Quality Department facilitates the participation in projects and monitoring of reports that result from national clinical audits. In response to the audit findings, the Clinical Audit Group monitors the actions taken to improve the patient safety and quality outcomes and an assurance report is provided to the Audit Committee and the Board of Directors.

- Internal Audit reviewed the Board Assurance Framework and the effectiveness of the overall system of internal control as part of the Internal Audit Annual Plan which is agreed by the Chief Executive and the Audit Committee.

The Head of Internal Audit Opinion gave an overall Significant Assurance opinion on the system of internal control for 2013/14. Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Internal Audit provided an overall significant assurance opinion for 2013/14. This conclusion was formed following the completion of 5 core reviews, of which two received moderate assurance and three received significant assurance.

A further 11 strategic reviews were also completed. Two reviews, in relation to procurement and business planning processes, received limited assurance opinions. The Trust identified these two areas for review based on known risks. Our findings are not indicative of significant issues with the system of internal control within the Trust and have therefore no impacted upon our significant assurance opinion.

Actions have been agreed to address recommendations raised in the year with the aim to improve the systems of control. Management have already implemented or are in the process of implementing these actions in order to improve systems of internal control in the areas identified. The Audit Committee monitors the implementation of the action plans and progress against the recommendations made in order to be provided with assurance that improvements are made

- The Trust maintained registration with the CQC without compliance conditions for 2013/14.

- The Trust's assessment of 82% compliance (Satisfactory) with the Information Governance Toolkit standards for 2013/14 (version 11) demonstrates a high level of compliance with the requirements set.

- The Annual Risk Management Report and the Quality and Safety Report, which evidence action on all aspects of governance including, risk management.

- The Board Assurance Framework itself provides the Trust with evidence of the effectiveness of the system of internal controls that manage the risks to the organisation. The Board of Directors also monitor and review the effectiveness of the Board Assurance Framework on a quarterly basis. Internal Audit provided a

Significant Assurance opinion on the Board Assurance process. As the Vision, Aims and objectives of the Trust are updated, so too is the BAF.

- The Board of Directors, Risk Committee, Audit Committee, Executive Directors Meeting and the Quality Committee have advised me on the implications of the result of my review of the effectiveness of the system of internal control. These committees also advise outside agencies and myself on serious untoward events.

- All of the relevant committees within the Corporate Governance Structure have a clear timetable of meetings and a clear reporting structure to allow issues to be raised.

- The Quality Committee manages and reviews the Board Assurance Framework in conjunction with Executive Directors. The minutes of the Quality Committee are presented to the Board of Directors. The Quality Committee produce an annual Risk Management report, which is presented to the Audit Committee followed by the Board of Directors and this provides assurance on controls.

- The Audit Committee review the establishment and maintenance of an effective system of Integrated Governance, Risk Management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the overall Trust objectives. The Audit Committee review the Board Assurance Framework on a quarterly basis.

- The Trust has a robust process for ensuring recommendations made in assurance reports are implemented on a timely basis.

- Comments made by External Auditors (to be added here as appropriate)

As at 31st March 2014, the Trust had the following potential significant risks identified which are currently being mitigated, although in 2013/14 they could have a direct bearing on compliance with the terms of Authorisation, CQC registration or the achievement of corporate objectives should the mitigation plans be ineffective:

- In relation to clinical sustainability and quality risk and ensuring the reduction in Hospital Standardised Mortality Index (Dr Foster) and the Summary Hospital Mortality Indicators, the Trust has embarked on an intensive plan for reducing mortality both in hospital and within 30 days of discharge. 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.

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

  The Trust has shown a 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 has a mortality action plan and progress is monitored by the Mortality Board and the Board of Directors on a monthly basis to ensure improvements are made. As at March 2014 the Trust has delivered the planned reduction in its SHMI rate, and is now within the expected range for a Trust of our size and complexity.

- In light of the Francis Report on Mid Staffordshire Hospitals and the Trust being identified as having high mortality rates, the Trust was selected as part of the review by a national advisory group set up by NHS Medical Director, Sir Bruce Keogh into 14 hospitals which had higher than expected mortality rates. Further details are outlined in section 7. The review took place from the 17th June 2013. Sir Bruce Keogh published his report summarising the findings and actions the Trust needed to take. From this, the Trust produced an action plan based on the findings of the Keogh review, and monitored and has now successfully implemented the vast majority of the action plan matters. Those actions which required ongoing improvement, including the Trust's objective to continue to reduce mortality rates will be combined with the new CQC inspection action plan which will be formulated following the CQC visit in January, 2014.

- As reported elsewhere in this statement, the Care Quality Commission inspected the Trust in January, 2014 and gave the Trust a rating of "requires improvement".

- The Trust achieved the Clostridium Difficile targets during 2013/14. To mitigate the risk of breaching the Trust's infection prevention targets, 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 mitigation 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.

- Towards the end of the 2013/14 financial year, the Trust had one "never event". At the time of writing this report, this incident is being investigated and a full report will be produced in the near future.

- In relation to the financial performance and the economic downturn risk, the Trust achieved a Continuity of Service Rating (CoS) of 3 in 2013/14. In response to the potential stabilisation or fall in NHS income, and potential failure of CCG demand management schemes we identified a risk in respect of CCG affordability and this risk was adequately mitigated in 2013/14. A satisfactory outcome was achieved with a level-3 CoS rating which, under Monitor's Compliance Framework, indicates sound financial performance.

- In relation to the Transforming Community Services risk, the Trust took on the provider arm of NHS Blackpool and part of NHS North Lancashire as at 1st April 2012. Performance of integration was monitored through achievement of actions in the Post Transaction Action Plan by the Transformation Programme Board. Strategic issues are addressed through formal and informal reports to the Board. The Pre Transaction Action Plan and Benefits Realisation Plan was monitored and signed off by the Board in April 2012. The New 'Families' and Community Adults/Long Term Conditions Divisions has been formally integrated into the organisation in April 2013. Work is ongoing on pathway redesign and improved service modelling. Close working relationships have been established with the local Clinical Commissioning Groups, Local Authorities and the National Commissioning Board to identify and implement service development, improvements and new models of care, as identified through the Strategic Framework. Friends and Family Test is being undertaken, Patient Experience Revolution project instigated, Ward Audits and Patient Led Assessment of Care Environment (PLACE) are undertaken.

- In relation to failing to implement ALERT as the Trust's full electronic patient record, the Trust has reviewed its strategic approach to the development and implementation of electronic health records across the local health community. The Trust recognises that it must ensure that electronic health records are readily accessible across all healthcare services and geographic settings, including GPs, community services, acute services and tertiary services, and can be updated by relevant healthcare professionals across these services. Given this, the Trust's forward strategy will be one that is based on the integration of existing systems, along with the use of multiple specialist systems, with all systems being used across the Trust's range of geographic settings and linked via interoperability.

  The Trust has engaged with ALERT Life Sciences Computing, and the parties have mutually agreed to a change in scope of the ALERT® deployment in order to support the Trust's revised way of working. It has been agreed that the Trust will continue to use the ALERT® solution in the A&E Department at the Trust and in a selected number of outpatient services including Senior Review Clinic, the Colposcopy Outpatients Service and the Paediatric Diabetes Outpatients Service. The Trust will be engaging with third party suppliers, for both clinical systems that are currently in use and proposed new clinical systems, in order to ensure that the Trust achieves its aim of electronic health records. The Trust has reconfigured its Executive team to create a Board level post of Director of Information, which it hopes to recruit to in 2014/15.

8. Conclusion

My review of the effectiveness of the systems of internal control has taken account of the work of the Executive Management Team within the organisation, which has responsibility for the development and maintenance of the internal control framework within their discreet portfolios. In line with the guidance on the definition of the significant internal control issues, I have not identified any significant control issues.

Signed: Date: 21st May 2014

Gary Doherty
Chief Executive

Annex F: Independent Auditor's Report To The Council of Governors

Peter Chambers, PwC

Annex G: Accounts for the Period 1st April 2013 to 31st March 2014

FOREWORD TO THE ACCOUNTS

BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST

These accounts for the period ended 31st March 2014 have previously been prepared by Blackpool Teaching Hospitals NHS Foundation Trust in accordance with Schedule 7, Sections 24 and 25 of the National Health Services Act 2006 in the form which Monitor (the Independent Regulator of foundation trusts) has directed.

Signed: Date: 21st May 2014

Gary Doherty
Chief Executive

Notice of the Trust's Members and Annual Public Meeting Judith Oates

The Annual Members and Public Meeting of the Blackpool Teaching Hospitals NHS Foundation Trust will be held on Monday, 22nd September 2014 at 6.00 pm.

Further copies of the Annual Report and Accounts for the period 1st April 2013 to 31st March 2014 can be obtained by writing to:

Miss Judith Oates
Foundation Trust Secretary
Blackpool Teaching Hospitals NHS Foundation Trust
Trust Headquarters
Blackpool Victoria Hospital
Whinney Heys Road
Blackpool
FY3 8NR

Alternatively the document can be downloaded from our website www.bfwhospitals.nhs.uk

If you would like to make comments on our Annual Report or would like any further information, please write to:

Mr Gary Doherty
Chief Executive
Blackpool Teaching Hospitals NHS Foundation Trust
Trust Headquarters
Blackpool Victoria Hospital
Whinney Heys Road
Blackpool
FY3 8NR

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Quality Account
2013 - 2014

Clinical Effectiveness of Care

Quality of the Patient Experience

Patient Safety

Quality Account

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If you require any further information about the 2013/14 Quality Account please contact: The Corporate Affairs Team on 01253 655520 or email Judith Oates at judith.oates@bfwhospitals.nhs.uk

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 fourth 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 2013/14 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 2013/14 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 91% reduction in incidents of clostridium difficile over the last six years and 89% in Methicillin-Resistant Staphylococcus Aureus (MRSA) when compared to 2007/08. 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 and the Trust's Maternity Substance Misuse team was recognised nationally for winning the Women's Health category at the National Care Integration Awards for its Integrated Care Pathway for Pregnant Women who misuse substances. The team has developed and improved the care and support given to pregnant women who misuse substances and this good practice has been recognised both inside and outside the Trust.

We have continued to make progress on reducing mortality rates and this is something the Trust is totally committed to achieving. During the past 12 months our Summary Hospital – Level Mortality Indicator (SHMI) and Risk Adjusted Mortality Index RAMI) figures have reduced significantly and we confidently expect the data to be within the expected range by April 2014. On all (HSMR) mortality metrics the Trust's relative risk has reduced year-on-year following a number of operational and clinical quality initiatives which have now resulted in substantial improvements in mortality figures. Our Better Care Now scheme has developed a number of clinical pathways that impact most on mortality and morbidity figures and are focusing particularly on the first 24-36 hours of patient care to standardise and improve the treatments they receive and this is providing excellent results.

The Trust has also invested more than £1.5M in clinical staff with more than 180 qualified nurses and more than 40 doctors joining the organisation.

We have also been undertaking intensive work to deliver life-saving care within the community and developed a number of initiatives to provide care outside the hospital setting in particular for the frail elderly and those with long term conditions.

For example we are now able to offer intravenous therapy treatments in the home or community setting which allow long-term recipients of intravenous drugs to be allowed home from a hospital ward to continue their treatment.

Our Rapid Response Plus multi-disciplinary team, which is able to respond within two hours to an urgent health or social care need which does not require immediate hospitalisation, is also a great example of providing fast and efficient care in a safe and controlled way.

The Trust is also piloting a dedicated team working with 15 care homes across Blackpool. The team has worked with care home staff and other professionals to develop individual care plans for each resident which ensure they always receive appropriate treatment when needing medical intervention.

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 2014/15 aim to build on the progress we have made as well as new improvement targets in relation to patient care. In 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 2013 – 31st March 2014 is a balanced and accurate account of the quality of services we provide.

Gary Doherty
Chief Executive

Date: 22nd May 2014

Part 2: Our Quality Achievements

In this section the Trust's performance in 2013/14 is reviewed and compared to the priorities that were published in the Trust's Quality Account in 2012/13. Priorities for improving the quality of services in 2014/15 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 2013/14 against Priorities in 2012/13 Quality Account

This section tells you about some of the quality initiatives we progressed during 2013/14 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 2012/13 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 Trust Priorities

Key	Target Achieved/ On Plan	Close to Target	Behind Plan
			

Priority 1: Clinical Effectiveness of Care	2011/12	2012/13	2013/14	Actual Target 2013/14	Expected Score 2013/14
Reduce premature mortality from the major causes of death - Reduce 'preventable' mortality by reducing the Trust's Hospital Mortality Rates / Summary Hospital Mortality Indicators				< 1.18	Provisional 1.16 Results due October 2014
- The value and banding of the Summary Hospital-Level Mortality Indicator (SHMI) for the Trust (See section 2.3.7 Core Clinical Indicators for results)	Not reported in 2011/12			1	1
- The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. (See section 2.3.7 Core Clinical Indicators for results)	Not reported in 2011/12			18.90%	10.57%
North West Advancing Quality initiative that seeks compliance with best practice to improve patient experience in seven clinical areas:	**2011/12**	**2012/13**	**2013/14**	**CQS Target 2012/13**	**Result Achieved 2012/13**
– Acute Myocardial Infarction			Data not available until Sept 2014	95%	98.54%
– Hip and Knee Surgery				95%	95.54%
– Coronary Artery Bypass Graft Surgery				95%	98.19%
– Heart Failure				82.84%	91.14%
– Community Acquired Pneumonia				87.39%	90.77%
- Stroke				90% / 50%	89.34% /57.74%

Table 1: Performance Against Trust Priorities					
Priority 1: Clinical Effectiveness of Care (Continued)	**2011/12**	**2012/13**	**2013/14**	**Actual Performance 2013/14**	**Expected Score 2013/14**
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 2011/12			90%	68%
Medical Care Indicators used to assess and measure standards of clinical care and patient experience				82%	95%
Nursing Care Indicators used to assess and measure standards of clinical care and patient experience				Acute 95% ALTC 58% Trust 87%	95%
Improving outcomes from planned procedures by Improving Patient Reported Outcomes Measure (PROMs) scores for the following elective procedures:		Provisional data			
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 to hospital (for the same condition) within 28 days of discharge (See section 2.3.7 Core Clinical Indicators for results)	Not reported in 2011/12	12.04		16+ -16.77%	Not available at this time
		10.73		< 16 - 16.77%	Not available at this time
Priority 2: Quality of the Patient Experience	**2011/12**	**2012/13**	**2013/14**	**2013/14**	**2013/14**
Improve hospitals' responsiveness to inpatients' personal needs by improving the CQC National Inpatient Survey results in the following five areas:				**National Picker average**	**BTHFT actual**
– Were you involved as much as you wanted to be in decisions about your care and treatment?				88%	87% said definitely or to some extent
– Did you find someone on the hospital staff to talk to about your worries and fears?				44%	79% said definitely or to some extent
– Were you given enough privacy when discussing your condition or treatment?				91%	91.1% said always/ sometimes
– Did a member of staff tell you about medication side effects to watch for when you went home?				45%	59% 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?				89%	81.9% said yes
Improve staff survey results in the following area:				**National average**	**BTHFT actual**
– Percentage of staff who would recommend their friends or family needing care	Not reported in 2011/12			To be the Best 20% of Trusts	Not yet reporting
– Report on Friend and Family Test and achieve above national target	Not reported in 2011/12	Not reported in 2011/12		To be above national average	Not yet reporting
Improving the experience of care for people at the end of their lives:	**2011/12**	**2012/13**	**2013/14**	**2013/14**	**2013/14**
– Seeking patients and carers views to improve End of Life Care				Patient views to be sought	Patient questionnaire in place
– 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	Identification of preferences for future care
Patient Led Assessment of the Care Environment (PLACE) Survey				**Actual 2013/14**	**Expected Score 2013/14**
– *To improve PLACE* survey results/standards				Excellent	Excellent
Priority 3: Patient Safety	**2011/12**	**2012/13**	**2013/14**	**Actual 2013/14**	**Expected Score 2013/14**
Achieve 95% Harm Free care to our patients by 2016 through the following strands of work:					
Risk-assessment for Thrombo-Embolism (VTE) - Improve the percentage of admitted patients who were risk- assessed for VTE; and - Compare the national average for the above percentage - (See section 2.3.7 Core Clinical Indicators for results)	97. 50%	99.40%		96%	99.5%
- Achieve a 10% reduction on the previous year in all VTE				10%	49.5%

Table 1: Performance Against Trust Priorities	2011/12	2012/13	2013/14	Actual Performance 2013/14	Expected Score 2013/14
Rates of Clostridium Difficile and MRSA - Reduce the incidence of Clostridium Difficile infection rates in the Trust as reflected by national targets				29	26
- Reduce the incidence of MRSA infection rates in the Trust as reflected by national targets				0	1
Reported Patient Safety Incidents - To monitor the rate of patient safety incidents and reduce the percentage resulting in severe harm or death				12	18 16% increase
– Reduce the incidence of inpatient Falls by 30% resulting in moderate or major harm				25	39
– Reduce the incidence of Medication Errors by 50% resulting in moderate or major harm				17	15
- Reduce the incidence of new hospital acquired pressure ulcers stage 2 by 30%, stage 3 by 40% and stage 4 by 100%; and -				Stage 2 – 30%	25%
				Stage 3-40%	60%
				Stage 4 -100%	100%
- reduce stage 2, 3 and 4 community acquired pressure ulcers by 10%				Stage 2 -10%	12%
				Stage 3-10%	59%
				Stage 4 -10%	0%
- Overall reduction in Hospital Acquired pressure Ulcers -				33%	33%
- Introduce the Think Glucose Programme	Not reported in 2011/12	Not reported in 2011/12		Introduce Programme	Introduce Programme

2.2 Selected Priorities for Quality Improvement in 2014/15

This section tells you about how we prioritised our quality improvements for 2014/15. 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 2014/15

The Board of Directors has developed an organisational Strategic Framework which underpins the quality programme set out in this Quality Account for 2013/14. 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 2014/15

The Trusts priorities for 2014/15 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 2014/15 with our Clinical Commissioning Groups, Blackpool Healthwatch, 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 2014/15 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 2014/15 which set out the high-level national outcomes that the NHS should be aiming to improve. The priorities focus on 3 key elements in the quality of care. These are:

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

Four additional quality improvement priorities have also been selected by the Board of Directors as a priority in 2014/15 and are detailed in Table 2 in bold italics.

Table 2: Priorities for Quality Improvement			
National Level NHS Outcomes Framework (DH 2014/15) Quality Domain(s)	**Trust Level**	**Key Elements in the Quality of Care**	**Description of Priority Indicators for Quality Improvement 2014/15**
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	Our strategic aim is 100% compliance with agreed pathways by 2016 through the following strands of work: - **Sepsis** - ***Pneumonia*** - ***Stroke*** - ***Cardiac Chest Pain*** - ***Acute Kidney Injury*** North West Advancing Quality initiative that seeks compliance with best practice to improve patient outcomes in **eigh**t clinical pathway programmes: - Acute Myocardial Infarction - Hip and Knee Surgery - Coronary Artery bypass graft surgery - Heart Failure - Pneumonia - Stroke - Patient Experience Measures - ***Acute Kidney Injury***
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 2014 DH) - The percentage of patients' of all ages and genders (aged 0 to14) 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			
National Level NHS Outcomes Framework 2013/14 Domains of Quality	**Trust Level**	**Key Elements in the Quality of Care**	**Description of Priority Indicators for Quality Improvement 2014/15**
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.
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 Thrombo-Embolism (VTE)* - *Improve the p*ercentage 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 *r*esulted in severe harm or death - Reduce the incidence of Falls resulting in patient harm by 30% at low, minor moderate and serious impact levels - Reduce the incidence of medication errors resulting in moderate or severe harm by 30% - Reduce the incidence of new hospital acquired pressure ulcers stage 2 by 50%, stage 3 by 100% and stage 4 by 100%; and - reduce stage 2, 3 and 4 community acquired pressure ulcers by 30%
			Continue to introduce the plan 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, and a number of committees within the Board Committee Structure. 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 2014/15

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 2014/15. 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 quality improvement priority used in 2013/14. Although this will continue to be monitored by the relevant committee's detailed below, this will not be reported in the 2014/15 Quality Accounts:

- The one priority removed is in relation to improving Patient Led assessments of the Care Environment (PLACE) as the Trust constantly achieves high standards, and this will be continued to be monitored at the PLACE 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 2014/15

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 2014/15 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 2014/15 to our staff, patients and the public via the 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, patient harms, 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 2013/14 the Blackpool Teaching Hospitals NHS Foundation Trust provided and/or subcontracted 49 relevant Health 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 relevant Health services.

The income generated by the relevant Health services reviewed in 2013/14 represents 88 per cent of the total income generated from the provision of relevant Health services by the Blackpool Teaching Hospitals NHS Foundation Trust for 2013/14.

The quality aspirations and objectives outlined for 2013/14 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 enables 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

The informal patient safety walkabout visits undertaken by the Executive Directors on a weekly basis and the formal patient safety walkabouts visit, undertaken by Executive Directors and 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 2013/14, 46 national clinical audits and 3 national confidential enquiries covered relevant Health services that Blackpool Teaching Hospitals NHS Foundation Trust provides.

During 2013/14 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 for which it was eligible. These 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 during 2013/14, and for which data collection was completed during 2013/14, 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 2013/14					
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 intensive 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	✓	✓	1448/1598	91%
7	Heart Failure Audit	✓	✓	334	115%
8	NHFD: hip fracture	✓	**X Not required for 13/14 QA**		
9	TARN: severe trauma	✓	✓	158	100%
10	Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	358	100%
11	National Audit of Dementia: dementia care	**NA**	**X Not required for 13/14 QA**		
12	British Thoracic Society: National Bronchiectasis Audit	**NA**	**BTS Not running this period 2013/14**		
13	RCP: National Care of the Dying Audit	**NA**	**X Not required for 13/14 QA**		
14	National comparative audit of blood transfusion in adult cardiac surgery	✓	✓	309	100%
15	Coronary angioplasty	✓	✓	**Awaiting confirmation**	
16	Oesophago-gastric cancer (National O-G Cancer Audit)	✓	✓	130	100%
17	CCAD: Adult Carotid interventions	✓	✓	1223	100%
18	CCAD :Heart rhythm management (pacing and implantable cardiac defibrillators (ICDS)	✓	✓	861	100%
19	CCAD: Congenital Heart Disease Paediatric Cardiac surgery	✓	✓	5	100%
20	Adult cardiac surgery: CABG and valvular surgery	✓	✓	1223	100%
22	NBOCAP: bowel cancer	✓	✓	219	100%
23	NLCA: lung cancer	✓	✓	293	100%
24	RCP: Audit to assess and improve service for people with inflammatory bowel disease	✓	✓	9/100	9%
25	Adult community acquired pneumonia (British Thoracic Society)	**NA**	**BTS Not running this period 2013/14**		
26	Emergency use of oxygen (British Thoracic Society)	✓	✓	29	100%
27	Renal colic (College of Emergency Medicine)	**NA**	**X Not required for 13/14 QA**		
28	Non-invasive ventilation - adults (British Thoracic Society)	**NA**	**BTS Not running this period 2013/14**		

Table 3 List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2013/14					
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**
29	Potential donor audit (NHS Blood & Transplant)	**NA**	**X Not required for 13/14 QA**	326	100%
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)	**NA**	**X Not required for 13/14 QA**		
33	Adult asthma (British Thoracic Society)	**NA**	**BTS Not running this period 2013/14**		
34	Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	✓	✓	108	100%
35	Diabetes (Paediatric) (NPDA)	✓	✓	69	100%
36	National Review of Asthma Deaths (NRAD)	✓	✓	1	100%
37	Pain database	✓		Awaiting Confirmation	
38	Fractured neck of femur	**NA**	**X Not required for 13/14 QA**		
39	Elective surgery (National PROMs Programme)	✓	✓	**NA**	67.7
41	Epilepsy 12 audit (Childhood Epilepsy)	✓	**NA**	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)"	✓	✓	43	100%
43	Paediatric asthma (British Thoracic Society)	✓	✓	22	100%
44	Paediatric fever (College of Emergency Medicine)	**NA**	**X Not required for 13/14 QA**		
45	Paediatric intensive care (PICANet)	**Not eligible at this Trust**	**X**		
46	Paediatric pneumonia (British Thoracic Society)	✓	✓	10	100%
47	National audit of seizure management in Hospitals	✓	✓	30	100%
48	National emergency laparotomy audit (NELA)	✓	✓	54	100%
49	Paracetamol overdose (care provided in Emergency Departments - College of Emergency Medicine)	✓	✓	**Awaiting confirmation**	
50	Pleural procedures	**Not eligible at this Trust**	**X**		

Table 3 List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2013/14					
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**
51	Severe sepsis & septic shock (College of Emergency Medicine)	✓	**Suspended due to Sepsis Pathway March 14**		
52	Vital signs	**NA**	**X Not required for 13/14 QA**		
53	Intra thoracic transplantation (NHSVT UK transplant registry)	**Not eligible at this Trust**	**x**		
54	Liver transplantation (NHSVT UK transplant Registry)	**Not eligible at this Trust**	**x**		
55	Prostate Cancer	**NA**	**X Not required for 13/14 QA**		
56	COPD Discharge Audit	**NA**	**X Not required for 13/14 QA**		
57	National COPD Audit Programme (RCP)	✓		**Awaiting confirmation**	
58	Paediatric Bronchiectasis	✓	✓	**Awaiting confirmation**	
59	Renal Registry	**Not eligible at this Trust**	**x**		
60	Renal transplantation (NHSVT Transplant Registry)	**Not eligible at this Trust**	**x**		
61	Rheumatoid and early inflammatory arthritis	✓	✓	**Awaiting confirmation**	
62	Learning disabilities/feasibility study	**Not eligible at this Trust**	**X**		
63	Mental health clinical outcome review programme NCEPOD into suicide and homicide with people with mental illness	**Not eligible at this Trust**	**x**		
64	National audit of psychological therapies	**Not eligible at this Trust**	**x**		
65	National audit of schizophrenia	**Not eligible at this Trust**	**x**		
66	Prescribing observatory for mental health	**Not eligible at this Trust**	**x**		
67	Falls and fragility fractures audit programme	✓		**Awaiting confirmation**	
68	National audit of memory clinics	**Not eligible at this Trust**	**X**		
69	Parkinson's Disease (Nationals Parkinson's audit)	**NA**	**X Not required for 13/14 QA**		
70	Familial Hypercholesterolaemia (National clinical audit management of FH)	**NA**	**X Not required for 13/14 QA**		

Table 3 List of National Clinical Audits in which Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate during 2013/14					
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**
71	National audit of intermediate care	**NA**	**X Not required for 13/14 QA**		
72	National health promotion in hospitals audit	**NA**	**X Not required for 13/14 QA**		
73	Patient transport (National kidney care audit)	**Not eligible at this Trust**	**X**		
74	**Fitting childcare in emergency departments**	**NA**	**X Not required for 13/14 QA**		
75	**Mental health care in emergency departments**	**NA**	**X Not required for 13/14 QA**		
76	Older people care in emergency departments	**NA**	**X Not required for 13/14 QA**		
77	**Speciality rehabilitation for patients with complex needs**	**NA**	**X Not required for 13/14 QA**		
78	**Child health clinical outcome review programme (CHR/UK)**	**NA**	**X Not required for 13/14 QA**		
78	**Heavy menstrual bleeding**	**NA**	**X Not required for 13/14 QA**		
79	**Paediatric Asthma audit**	✓	✓	**Awaiting confirmation**	
80	**Pain management (College of emergency medicine)**	**NA**	**X Not required for 13/14 QA**		

✓ **-** Eligible to participate or actively participating

NA – Eligible to participate however not required for QA (Data collection dependent upon individual audit) or stage of audit with managing body for this time period

Not eligible at this Trust – The service to which this service relates to is not undertaken within the Trust

Table 4: List of National Confidential Enquires that Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2013/14.					
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	Tracheostomy Care Study	Yes	Yes	17	100%

2	Lower Limb Amputation Study	Yes	Yes	7 Data collection not due to complete at time of report	100%
3	Gastro Intestinal Haemorrhage Study	Yes	Yes	Data collection not due to complete at time of repor	100%
4	Alcohol Related Liver Disease	Yes	Yes	7	100%
Data source: Clinical Audit Programme and final reports. This data is governed by standard national definitions					

The reports of 2 National Clinical Audits (Confidential Enquiries) were reviewed by the provider in 2013/14 and Blackpool Teaching Hospitals NHS Foundation Trust intends to take or has taken the following actions to improve the quality of healthcare 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.**
Sub Arachnoid Haemorrage Study – Report issued Nov 2013 Managing the Flow? A review of the care received by patients who were diagnosed with an aneurysmal subarachnoid haemorrhage.	All patients presenting with acute severe headache in a secondary care hospital should have a thorough neurological examination performed and documented. • All patients presenting to the emergency department with acute severe headache have a GCS recorded in the observations section of the electronic patient record by the initial assessment nurse. Documentation of full neurological assessment by a doctor is recorded in the hospital notes • A full audit of all patients admitted with a suspected sun arachnoid haemorrage will be part of a clinical audit undertaken by the Lead Consultant to determine neurological assessment in A&E A CT- scan should be performed immediately in this group of patients as defined by *the 'National Clinical Guideline for Stroke'.* • The Trust provides 24 hr CT scanning In hours, • The PACS system at Blackpool Teaching Hospitals NHS Trust is linked directly to the PACS system at Central Lancashire Teaching Hospitals NHS Trust. The images are therefore immediately available for review by the neurosurgical on call at Royal Preston Hospital prior to transfer. The nationally-agreed standard *('National Clinical Guideline for Stroke'*) of securing ruptured aneurysms within 48 hours should be met consistently and comprehensively by healthcare professionals who treat this group of patients. This will require providers to assess the service they deliver and move towards a seven-day-service. • Neurosurgical services at Royal Preston Hospital conveniently located within15 minutes of a "blue light" ambulance transfer. • Critical care support is provided for transfer of patients intubated or with airway concerns. Organ donor policy in place within the Trust with appointed Specialist Nurse – Organ Donation (BVH)
Alcohol Related Liver Disease Study Report issued June 2013 Measuring the Units A review of patients who died with alcohol-related liver disease	• The Trust has appointed a multi disciplinary Alcohol Care Team that is led by a Consultant. • The Alcohol Specialist Nurse Service offers a 7 day service. • Policies are in place re the identification and management of alcohol misuse. • All patients are assessed on admission using an approved tool – (Audit – C) • Antibiotics and terlipressin are offered to all patients with a history of alcohol abuse and gastro intestinal haemorrhage until the results of endoscopy are reviewed. • Escalation of care is actively pursued based on renal function of individuals and need.
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 2013/14, 90 % (215) of audits were completed or are running according to schedule for completion. The number of audits being monitored by the Clinical Audit Department is 53 % (127). This includes all audits that have not been fully completed at end of Q4.

The reports of 113 local clinical audits were reviewed by the provider in 2013/14 and 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 2013/14 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.**
Ventilatory Associated Pneumonia (VAP) care bundles in ICU	CC1202 - Daily Ward Round Chart to check VAP / CPIS scores have been completed Bedside Nurses to complete VAP bundle on ICU day chart
Management of basal cell carcinoma with topical immiquimod	DER1101 The use of immiquimod in treatment of BCC will be constantly monitored.
Secondary prevention of Osteoporosis in patients with low trauma fracture neck of femur	GM092 - Size A4 flow chart developed. Discharge check list developed. Regular education to junior doctors ongoing.
Audit of diagnosis and management of inflammatory arthritis against NICE guidance	GM1032 - No change to MDT referral & assessment as better than regional ones but continuing to monitor. Recruitment of 2 specialist nurses underway for specific Early Arthritis Clinic incorporating urgent new patient slots & monthly follow up for newly diagnosed patients according to agreed protocols.
Drug errors in adult patients with diabetes	GM1118 - Plan to take up the 'Think Glucose' campaign is underway. Plans to make a separate insulin prescription with electronic prescribing tool can only be implemented when Vision is active.
30 day mortality and 8 day complications	GM1217 Patient leaflet has been updated. Coding problems have been addressed. Feedback process has been introduced for contact clinicians.
Colonic Biopsies for chronic diarrhoea	GM1210 - Action plan implemented. Ongoing education and information disseminated to all colonoscopists.
BTS National Emergency Oxygen Audit 2011 Continued from 12/13	GM1218 - Ongoing education of junior doctors, ward staff, and other Allied Health Professionals in drug chart inspection and importance of oxygen prescription. Oxygen therapy to be part of ward level indicators.
National Care of the Dying Acute Hospitals Audit (NCDAH) Interim audit Continued from 12/13	GM1219 - Continued rolling programme of training on all EOLC tools. Increased ward based training on LCP, communication, symptom management and best EOLC. Unable to implement recommendation of changing questions on NCI as request for this has been rejected at this time.
Adult Community Acquired Pneumonia Continued from 12/13	GM1226 - New pathway and checklist developed with real time feedback / accountability for performance. Education and communication on pathway ongoing. Information available on intranet.
Mortality review in the acute medical unit at BVH	GM1303 Continual education to improve documentation on AMU noting times, dates and clinician performing review.
Management of acute upper gastrointestinal haemorrhage (AUGH)	GM1306 - Early referral/discussion with Gastroenterologist/SpR of all acute upper gastrointestinal haemorrhage patients. AMU and A&E staff notified. Rockall/ Blatchford score to be a mandatory field in endoscopy e-request agreed with Vision & Alert.
Re-Audit of patient casenotes who have undergone peripheral blood stem cell transplantation	GM1307 - Introduction of orange casenote stickers to ensure all notes are returned to transplant coordinator for completion of casenotes.
Re-audit Assessment of compliance with NICE CG50 in Acutely ill patients in hospital	CC1204 - Ongoing education of nursing and medical staff regarding the need to use new POTTS charts and remove old versions. Monitor compliance with observation recording via NCI and spot checks by Matrons Full audit of 2222 calls to be undertaken in 2013
Audit of management of paediatric postoperative pain management	AN1207 - Discussed with ENT Surgeons who do not support the use of topical local anaesthetics for paediatric tonsillectomies.
Adequacy of medical records in Cardiothoracic surgical inpatients	CAR1203 - ITU round sheet introduced and in use. Medical staff more diligent to patient identifier details date and time.
The management of central venous catheter in surgical and medical wards	GS1206 Training to all staff at all levels in relation to completed daily reviews of patients being undertaken according to CVC care bundle and clear documentation on indication and on-going needs. Training to all health care professionals, junior doctors and nurses involved in the insertion and maintenance of cvc regarding central line associated infection.

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.**
NW Regional Bladder Cancer Audit	GS1204 Regular TRUS biopsy sessions introduced with extra sessions to accommodate peaks in demand. New standard letter introduced showing procedural steps. Fast track system developed for prostatic biopsies. Appointment of a further Consultant. All Consultants now have clinic slots reserved for giving positive results to cancer patients. Procedural operation note agreed that specifically requires the number of cores to be documented. Patients suitable for trials to be discussed at MDT and outcome of discussion to be documented.
DSE guided revascularisation	CAR1302 - Ongoing education/presentation to raise awareness of current ESC guidelines.
VTE prophylaxis in patients undergoing elective urological procedures	GS1302 Changes have been made to trust policy to reflect prescribing Dalteparin. Junior doctors advised in the increase in frequency of prescribing Dalteparin.
Diagnostic investigations in heart failure	CAR1306 - Ongoing education to doctors to refer all clinical suspicions of heart failure without requirement of an echo and echoes should include assessment of left ventricular diastolic function where possible.
Monitoring VTE prophylaxis in urology patients	GS1005 All surgical patients to have VTE assessment on admission Anaesthetists to consider regional anaesthesia to reduce risk of VTE Patients to be offered thromboprophylaxis to reduce VTE risk Minimise hospitalisation by considering minimal invasive procedures
Timeframe between listing for the laser treatment in Diabetic Retinopathy	OP1103 - New specific diabetic retinopathy clinic to be set up. Awaiting appointment of new consultant to oversee all ophthalmic diabetic patients.
Compliance with inpatient chart clinical verification audit	PH1215 Ensure all pharmacists obtain and have access to up to date standards
NPSA Alert - Loading Dose Audit	PH1214 - Trust policies to be amended to include critical care area procedures. Continue to educate newly qualified doctors to ensure awareness of importance of stopping the loading dose and continuing with maintenance dose. Warfarin posters on display throughout hospital to clarify policy. Disseminate policy to all nursing and medical staff.
Reducing harm from omitted and delayed medicines in hospital/ The correct use of omission codes	PH1211 Supply a critical drugs list to each ward, step by step easy to follow flow chart on how to obtain medication and the list of omission codes and what appropriate action needs to be taken to be placed in the drugs trolley on each ward.
Re-audit of Pharmaceutical Procurement Services	PH1212 - SOP116 has been reviews, policies covering how to deal with suppliers, reps and waste management have been written. Procedure for dealing with breaches of minimum and maximum specified temperatures and records reviewed. A documented training programme has been incorporated into training and competency records. A training record is now available for all staff working in procurement.
Clinical handover of care of neonates	CH1306 - Raise awareness of Baby transfer notification within Women's unit. Updated Baby Transfer Notification form to provide signature. Raise awareness of Baby transfer notification within Women's Unit.
Discharge of babies from the Neonatal unit	OB1217 - Review of discharge plan: Health Visitor Liaison only to be phoned if Neonatal Nursing Unit discharge occurs at weekend. Otherwise Health Visitor Liaison will visit for discharge information during the week.
Venous thromboembolism (VTE)	OB1220 - Risk assessments for every woman to be completed. Women identified as intermediate or high risk of VTE following risk assessment by the obstetrician must be informed to carry out assessment and develop a management plan. Documentation reflects the advice and care provided.
Discharge	OB1221 - Comprehensive discharge documentation developed that includes antenatal record, discharge advice, prescription as required and post discharge care of mother and baby.
Handover of care	OB1222 - SBAR communication tool promoted for use of transfer of handover and care inter department. SBAR sticker proforma now includes information from the obstetrician St3 and the anaesthetist which details plan of care recorded in birth record.
Management of postpartum haemorrhage	OB1212 - Update current guideline to include pathway. Consider consultant baton bleep and inclusion 2222.
Obesity in Pregnancy	OB1210 - Improve communication with GP & Community Midwives regarding Folic Acid and Vitamin D. Improve documentation. Ongoing training.
North West Diabetes Pregnancy Audit	OB1207 - replaced by OB1302 ongoing audit
Actions noted in Health Action Plans; audit of record of action completion	C013 Provide Mandatory Training to Clinicians; Feedback to team managers and Clinicians; Evidence of meeting KPI's
Health Promotion in Hospitals	CG1213 - Results cascaded to relevant trust members, committees and external

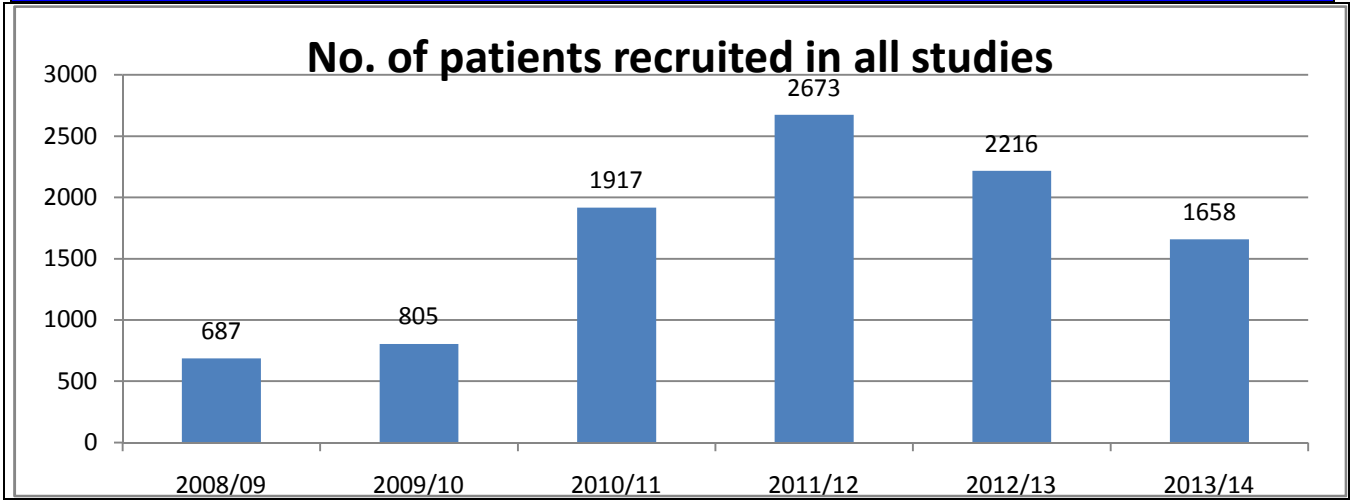
	organisations. Ongoing training of staff in brief interventions for alcohol and tobacco use. Ongoing half day training in obesity.

2.3.3 Participation in Clinical Research in 2013/14

The number of patients receiving relevant health services provided or sub-contracted by Blackpool Teaching Hospitals NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 1,658*, identified in Graph 1, of which the number of patients recruited to National Institute of Health Research (NIHR) Portfolio Studies is 1,592*. This figure was less than the number recruited in 2012/13 due to a number of high recruiting studies closing during 2013/14.

* It should be noted that 2013/14 NIHR Portfolio Study data is not signed off nationally until 30th June 2014. We therefore estimate the total patient recruitment total to be higher than currently reported (as at 31st March 2014).

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

Participation in clinical research demonstrates Blackpool Teaching Hospitals NHS Foundation Trust's commitment to improving the quality of care offered and to making our contribution to wider health improvement. Our clinical staff remain 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 140 clinical research studies during 2013/14. There were over 80 clinical staff participating in research approved by a research ethics committee at Blackpool Teaching Hospitals NHS Foundation Trust during 2013/14. 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 2014.

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	No. of patients recruited 2013/14
Age and Ageing	0	0	0	10	17
Cancer	111	140	419	303	197
Cardiovascular	223	275	449	549	353
Critical Care	25	963	359	8	6
Dementias and Neurodegenerative Diseases	5	11	6	0	9

Dermatology	0	21	10	9	23
Diabetes	0	6	150	702	307
Genetics and Congenital Dis	0	0	171	177	29
Health Services Research	2	7	133	4	2
Infection	3	24	6	26	42
Injuries and Emergencies	0	14	4	101	47
Meds for Children	30	43	24	15	6
Musculoskeletal	31	18	1	9	11
Neurological	0	0	0	0	6
Ophthalmology	0	1	0	0	22
Oral and Gastrointestinal	67	106	67	52	85
Paediatric	0	20	223	160	128
Paediatrics (non medicines)	10	10	32	66	11
Renal and Urogenital	114	90	0	0	0
Reproductive Health	88	54	41	35	26
Respiratory	13	19	22	20	20
Stroke	83	94	116	44	33

In addition, over the last three 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

A proportion of Blackpool Teaching Hospitals NHS Foundation Trust's income in 2013/14 was conditional on 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 relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2013/14 and for the following 12 month period are available online at: http://www.bfwh.nhs.uk/about/performance/

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.

The total planned monetary value of income of CQUIN in 2013/14 conditional upon achieving quality improvement and innovation goals is £ 7,678,469; however, it is estimated that the Trust will achieve a monetary total value of £ 7,301,025 for the associated payment in 2013/14.

The main areas of risk are the Dementia (Screening, Assessment & Referral), Patient Experience and AQ (CABG, Stroke and Heart Failure), CQUIN themes; however performance against these measures will not be confirmed until August 2014.

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 2013/14.

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 areas during 2013/14. The Care Quality Commission has undertaken two visits during 2013/14 in relation to an unannounced visit in June 2013 and unannounced follow up visit in November 2013 to review the Trust's Complaints Service.

Unannounced Visit – Cardiac Directorate and Trust Complaints Service

On 11th June 2013 the Care Quality Commission carried out an unannounced visit to Blackpool Teaching Hospitals NHS Foundation Trust and reviewed the following standards:

Outcome 1: Respecting and Involving People Who Use Services
Outcome 2: Consent to Care and Treatment
Outcome 4: Care and Welfare of People Who Use Services
Outcome 16: Assessing and Monitoring the Quality of Service Provision
Outcome 17: Complaints

Following this visit the final report provided overall positive feedback, however the Trust was deemed to have not met the standard in respect of Outcome 17: Complaints, with moderate impact on patients using this service being identified.

Based on the final report the Trust developed an action plan and commenced implementation of the recommendations to address the areas for improvement detailed above. The Trust has demonstrated compliance with Outcome 17. This has been achieved by the following:

The Trust's Operation Procedure – Patient Relations Department (Corp/Proc/403) has been updated with regards to the investigation timescales to ensure they are manageable and fit for purpose. This has been undertaken in conjunction with a Non Executive Director. The Trust has also reviewed the Safeguard electronic system to ensure flexibility in date recording.

If a complaint is delayed a holding letter is sent to the complainant and a date identified of when the Division will have the final response mailed out to the complainant.

A Red Alert was developed by the Director of Nursing and Quality and the Medical Director. The Alert was sent out to all Ward Managers to present to staff at handover for a period of one week. An e-mail was also sent all Consultants regarding the contents of the red alert.

The completed action plan and progress report detailed above has been submitted to the Care Quality Commission in October 2013 following approval by the Board.

Unannounced Follow up Visit – Complaints Service

The Care Quality Commission carried out a second unannounced follow up visit on 26th November 2013 to review of the Trust's compliance against Outcome 17. The Trust was able to evidence that they were taking the improvement of complaints management very seriously and was found to be meeting the standard fully.

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Chief Inspector of Hospitals inspection Visit

Announced visit to Blackpool Teaching Hospitals NHS Foundation Trust by the Care Quality Commission (CQC)

In January 2014, Blackpool Teaching Hospitals acute services at Victoria Hospital, Clifton Hospital and Fleetwood Hospital were inspected as part of the Care Quality Commission's new national programme of inspections. This inspection was 6 months after the Keogh visit and subsequent report and action plan. The CQC inspected acute services covering; Accident and Emergency, Medical Care, Surgery, Intensive/critical care, Maternity and family planning, Children's care, End of Life Care and Outpatients. The CQC focused on five areas of inspection. These were: Are services safe, effective, caring, responsive to peoples needs and are they well-led.

The CQC's final report, published on 2 April, 2014 gave an overall rating to the Trust of "requires improvement" with the following ratings for each of the 5 key inspection questions:

Are acute services at this Trust safe?	Requires Improvement
Are acute services at this Trust effective?	Requires Improvement
Are acute services at this Trust caring?	Good
Are acute services at this Trust responsive?	Requires Improvement
Are acute services at this Trust well-led?	Requires Improvement

Of the 68 individual ratings given 42 were good, 2 were outstanding, 22 were requires improvement and 2 areas were deemed inadequate. Maternity Services were rated as 'inadequate' due to the ongoing review of PPH cases that had resulted in a hysterectomy, 5 cases in a 6 month period. The expected range for our Trust is 2 cases per year. The RCOG undertook their case review on 30th April and the CQC wish to receive a copy of this report and to agree with the Trust a date for re-inspection of the Maternity Service.

Following the Quality Summit on the 28th March it was agreed to formulate one quality improvement action plan following the CQC visit. The new CQC action plan and monitoring dashboard incorporates the main areas of continued focus from the Keogh Action plan e.g. monitoring mortality reduction, patient experience, incident reporting and staffing. The high level CQC action plan has been agreed with Commissioners and shared with Monitor. A detailed draft action plan has been developed and this has also been shared with Commissioners. The final action plan was returned to the CQC by 30th April 2014.

An action plan is currently being produced to ensure all matters requiring improvement will be attained. This plan will be agreed by the Trust Board and with our commissioners and with Monitor and will be implemented in 2014/15.

2.3.6 Information on the Quality of Data

Good quality information and data are 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, service 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 2013/14 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:
- 99.5% for Admitted Patient Care;
- 99.7% for Outpatient Care; and
- 98.6% for Accident and Emergency Care.

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

** based on provisional April 2013- February 2014 SUS data at the month 11 inclusion date

Information Governance Assessment Report 2013/14

Blackpool Teaching Hospitals NHS Foundation Trust's Information Governance Assessment Report overall score for 2013/14 was 82% and was graded Satisfactory (Green).
For 2013/14 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 2014/15 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 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 6.7%. 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	6.0%
Secondary Diagnoses Incorrect	9.4%
Primary Procedures Incorrect	4.5%
Secondary Procedures Incorrect	46.2%
Data source: External audit carried out by an approved auditor through the Audit Commission. This data is governed by standard national definitions	

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:
  - Establish a method of capturing pressure ulcers information
  - Remove the facility from the system to add and remove codes from any staff other than coding staff and other essential users

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 – To Update		
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.

2.3.7 Core Quality Indicators

From 2013/14 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 2013.

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 2012 to September 2013	117	100	118	63	0.86%	1.19%	14.09%	0.00%
July 2012 to June 2013	116	100	116	63	0.88%	1.23%	13.93%	0.00%
July 2011 to June 2012	126	100	126	71	0.92%	1.09%	15.51%	0.00%

**Internally calculated data suggests the Trust's SHMI score on next release will be 110.9
*The palliative care indicator is a contextual indicator

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
	2011/12	405	0.089	0.087	0.143	-0.002
	2010/11	369	0.052	0.085	0.156	-0.02
Groin Hernia	2009/10	360	0.06	0.082	0.136	0.011

**Provisional scores for 2012/13 show Trust position as 0.089 to be verified in September 2014

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
	2011/12	269	0.366	0.413	0.499	0.306
	2010/11	238	0.267	0.405	0.503	0.264
Hip Replacement	2009/10	236	0.353	0.411	0.514	0.287

**Provisional scores for 2012/13 show Trust position as 0.366 to be verified in September 2014

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
	2011/12	322	0.297	0.303	0.385	0.181
	2010/11	323	0.231	0.298	0.407	0.176
Knee Replacement	2009/10	251	0.279	0.294	0.386	0.172

**Provisional scores for 2012/13 show Trust position as 0.297 to be verified in September 2014

	Year	Eligible episodes	Average health gain	National average health gain	National Highest	National Lowest
	2011/12	443	0.097	0.095	0.167	0.049
	2010/11	377	0.005	0.091	0.155	-0.007
Varicose Vein	2009/10	341	0.058	0.094	0.15	-0.002

**Provisional scores for 2012/13 show Trust position as 0.097 to be verified in September 2014

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 2011-12 (April 2011 - March 2012) and Provisional PROMs Data 2012-2013 (April 2012 - March 2013) shows an improvement against the national scores, but reviewing the negative scores, the Trust has improved on previous data.

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:

Enhance our relationships with the provider, Capita, and work with clinicians essentially across the

orthopaedic speciality to enhance the patients reported outcomes and provide greater information to clinicians on their 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,

Re-admitted 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	2013/14	2012/13	2011/12	England Average
0 to 15; and	10.70	10.40	8.80	N/A
16 or over,	6.70	6.30	6.51	N/A

**Latest readmission percentages for 2013/14 show the Trust rate as – 7.00. However the English Average is not available until December 2014.

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
2012/13	65.6	68.1	84.4	57.4
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

- Developing training to assist team leaders to maximise and sustain the capacity and capability of individual team members.
- Developing a more robust Patient Relations Service and continuing to analyse concerns and complaint data to inform service improvement.
- Developing processes to gain more qualitative and quantitative feedback from patients.
- Planning services around the patient by working with the Trust's Patient Panel and local patient

participation groups.
- Enhancing communication and providing treatment specific information to patients if appropriate, calling upon specialist nurses to assess patient's individual concerns around specific disease pathways.
- Encouraging patients to discuss any concerns they may have with staff at the time so they feel assured about their care plan.

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

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	63	63	98	35
2013	65	65	94	40
2014	72	67	100	12

The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:
- Increased activity and demand on some services seeing an increase in hospitals admissions and pressures on discharges
- Staffing levels and agency and locum use, with some staff being moved from their own work area to cover staffing shortfalls
- Levels of sickness in some areas, increased levels of work related stress which also adds to the pressure on other staff to come to work despite not feeling well
- High levels of negative press reporting linked to patient mortality statistical reporting and regulatory reviews
- Levels of staff morale, pressure and conflicting demands placed on staff

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve the standard of care provided by this organisation by undertaking the following actions:
- Significant investment has been made in nurse and doctor staffing including increased levels of international recruitments and widening access secondments to increase supply of staff
- Better Care Now project to develop best evidence based care and pathways in key priority areas such as stroke, sepsis, pneumonia and cardiac chest pain
- Roll out of Targeted Support initiative that includes Patient Experience Revolution training aimed at helping staff to be at their best more of the time and improve their resilience and wellbeing as well as compassionate care – metrics link the numbers of staff trained and increased patient satisfaction levels
- TalkSafe project continues to be implemented with training for clinical staff to have conversations about safe and unsafe acts to help embed a safety culture through increased awareness and personal responsibility
- Development and launch of the Trust values to help support a culture of compassionate care
- Continued investment in our quality assured health and wellbeing services including therapies, mindfulness, fitness programmes, and in-house physiotherapist, etc.
- Increased visibility of the senior managers and leaders of the organisation including out of hours
- Review of the Whistleblowing Policy to make it easier for staff to raise a concern
- Recognition events taking place in each division to share good practice taking place across the Trust
- Investors In People (IIP) Gold interim review in preparation for a full reaccreditation
- Pilot of Aston University Team Based Working Pilot, with a research base that predicts that effective and high performing team will improve patient outcomes and reduce mortality

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 2013/14	99.81%	96%	100.00%	77.7%
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 2012 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 2014.

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:

- A senior clinician and a senior nurse have been identified to provide leadership to facilitate ongoing improvements in compliance with trust processes and consequently improvements in patient care with regards VTE. The National Institute for Health and Clinical Excellence Venous Thrombo-Embolism guideline (CG 92) has been incorporated into easy to follow risk assessment forms across various specialties and is 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.
- Since December 2013, the clinical audit department have collected real time VTE data 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).

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
2012/13	10.4	16.1	30.8	0
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% 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 26 cases of Clostridium Difficile Infection (CDI) attributed to the Acute Trust between April 2013 and March 2014, in comparison to 28 for the period April 2012 to March 2013, demonstrating a reduction of 7%. The Trust was required to achieve a trajectory of 29, a reduction of 24%, based on the 38 incidences of Clostridium Difficile between October 2011 and September 2012 by March 2014. 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.

Please note that the data supplied by HSCIC is provisional.

	Incidents				Resulting in Severe Harm or Death			
Period	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)
01/04/2013 to 30/09/2013	1.98	N/A	N/A	N/A	0.347	N/A	N/A	N/A
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 four 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 Serious Untoward Incident's in order to mitigate the risk of reoccurrence, these lessons are fedback to staff within the Divisions through training, ward meetings, SUI reports being uploaded onto the Risk Management site of the Intranet, the bi-monthly LIRC Committee meetings and the Trust wide monthly "lessons learned" newsletter.
- Engagement with the patient and their relatives is very important to the Trust to embed an open and honest culture, and to the patient and their family as a healing tool. Patients and relatives are informed when an incident has occurred and that an investigation is to be undertaken. They are also offered feedback in relation to the investigation findings.

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 attention upon them. We would however, like to highlight the following projects as key priorities for 2013/14:

3.1 An Overview of the Quality of Care Based on Performance in 2013/14 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 2012/13 report and none of these priorities changed in 2013/14 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 four additional priorities for quality improvement for monitoring in 2013/14 in relation to improving patient pathways with our service users. The additional priority has been identified and included and monitored during the reporting period 2013/14 for the following reasons detailed below:

Improving Patient Pathways in: –

- **Pneumonia**
- **Sepsis**
- **Stroke**
- **Cardiac Chest pain**
- **Acute Kidney Injury**

The Better Care Now project - pathways stream, was launched in August 2013 and links our quality and safety initiatives under one umbrella. It has 3 workstreams:

- Pathways
- Waits
- Staffing

It has been proven that the use of clinical pathways supports standardised management and delivery of patient care, improves patient outcomes, and can contribute to a reduction in mortality, hospital complications and length of stay.

The pathways identified and developed to date are for conditions that impact most on our mortality and morbidity. Five pathways have been implemented to date and a work plan for 2014/15 agreed to address other high mortality areas.

Data is collected real time and fed back to clinicians and teams to allow immediate improvements to be made. All pathways have seen an improvement in compliance with the mission critical points of the pathways, and there has been a downward trend in mortality for pneumonia, sepsis and stroke. `

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 the pathway of care with all our service users and are very focussed on providing clearer information and improving the pathway of care with all our service users.

100 Day Pathway Campaign

The Fylde Coast Scheduled Care vision is committed to introducing end-to-end pathways for specific conditions to maximise convenience and safety for patients and overall efficiency. Over 20 local pathways relating to the high demand procedures undertaken by the hospital in 2012 in areas such as general surgery, gynaecology and orthopaedics were launched in December 2013. These not only provide clear guidance to GP's, Practice Nurses, Consultants and other clinical staff but have been made available for patients on the Fylde Coast to access through the Trust's web site so they can see the care they can expect to receive.

Enhanced Recovery Pathways

Enhanced Recovery is an approach to elective surgery based on the principles that patients are in the optimal condition for treatment, have different care during their operation and experience optimal post-operative rehabilitation. A number of patient pathways have been developed and are in use in Gynaecology, Cardiology, Orthopaedics and Urology. As well as a reduction in length of stay these pathways improve communication between clinical staff and patients by providing them with a recovery diary to update daily on their recovery.

3.2 Performance Against Key National Priority Indicators And Thresholds

The NHS Outcomes Framework for 2013/14 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 2013/14. This includes performance against the relevant indicators and performance thresholds set out in the Risk Assessment Framework 2013/14 which can be accessed via the following link: http://www.monitor-nhsft.gov.uk/sites/default/files/publications/RAF_Update_AppC_1April14.pdf

Monitor uses a limited set of national measures of access and outcome objectives as part of their assessment of governance at NHS Foundation Trusts. Monitor uses performance against these indicators as a trigger to detect potential governance issues.

NHS Foundation Trusts failing to meet at least four of these requirements at any given time, or failing the same requirement for at least three quarters, will trigger a governance concern, potentially leading to investigation and enforcement action. Except where otherwise stated, any trust commissioned to provide services will be subject to the relevant governance indicators associated with those services.

Part 3, Section 3.2 and detailed in table 11 sets out the relevant indicators and performance thresholds outlined in Appendix A of Monitors Risk Assessment Framework. Unless stated in the supporting notes, these are monitored on a quarterly basis. Please note: where any of these indicators have already been reported on in Part 2 of the quality report, in accordance with the Quality Accounts Regulations, they will not be repeated here. Only the additional indicators which have not already been reported in part 2 will be reported here to avoid duplication of reporting.

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 of Directors each month and is based on national definitions and reflects data submitted to the Department of Health via Unify and other national databases.

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 2010/11	Trust Self Assessment 2011/12	Trust Self Assessment 2012/13	Trust Self Assessment 2013/14
All Cancers: one month diagnosis to treatment:				
First Treatment (target >= 96%)	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%	Achieved: Q1 98.9% Q2 98.9% Q3 99.8% Q4 99.3%
Subsequent Treatment – Drugs (Target >=98%)	Achieved	Achieved Q1 100% Q2 100% Q3 99.3% Q4 99.3%	Achieved Q1 100%, Q2 100%, Q3 99.2%, Q4 98.6%	Achieved: Q1 99.2% Q2 100% Q3 100% Q4 100%
Subsequent Treatment – Surgery (Target >=94%)	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%	Achieved: Q1 100% Q2 98.7% Q3 96.3% Q4 97.3%
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 Q190.8% Q2 87.2% Q3 92.3% Q4 87%	Achieved Q1 85.1%, Q2 89.5%, Q3 85.5%, Q4 83%	Achieved: Q1 86.6% Q2 89.4% Q3 85.2% Q4 86.6%

Table 11: Performance against Relevant Key National Priority Indicators and Thresholds (Continued)				
Quality Standard	**Trust Self Assessment 2010/11**	**Trust Self Assessment 2011/12**	**Trust Self Assessment 2012/13**	**Trust Self Assessment 2013/14**
62 day general (target >=85%) Including Rare Cancers	Not applicable	Not applicable	Not applicable	Achieved: Q1 86.8% Q2 89.4% Q3 85.4% Q4 86.7%
62 day screening (target >=90%)	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%	Achieved: Q1 89.1% Q2 91.7% Q3 90.1% Q4 94.7%
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%	Achieved: Q1 85.4% Q2 95.9% Q3 93.6% Q4 92.6%
Breast Symptoms – 2wk wait (Target 93%)	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%	Achieved: Q1 94% Q2 94.8% Q3 96.7% Q4 93%
Reperfusion – Primary PCI	Achieved	Achieved	Achieved	Achieved
Delayed Transfers of Care (target <3.5%)	Achieved	Achieved	Achieved	Achieved
Percentage of Operations Cancelled (target 0.8%)	Achieved 0.6%	Achieved 0.56%	Achieved 0.45%	Under Achieved 0.92%
Percentage of Operations not treated within 28 days (target 0%)	Achieved 0%	Achieved 0%	Achieved 0%	Achieved 0%
National In-Patient Experience Survey	Achieved	Under-achieved	Under-achieved	Achieved
Quality of Stroke Care	Achieved	No longer measured	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	3.70 (Highest best 20% nationally)
18 week Referral to Treatment (Admitted Pathway) (target >=90%)	Achieved 94.08%	Achieved 91.89%	Achieved 94.66%	Achieved 92.02%
18 week referral to treatment Open Pathways (Target >+92%)	Not Applicable	Not Applicable	Achieved 94.37%	Achieved 94.78%
18 week Referral to Treatment (Non-Admitted Pathways [including Audiology]) (Target >=95%)	Achieved 96.46%	Achieved 95.76%	Achieved 97.51%	Achieved 96.78%
18 week Referral to Treatment (non admitted pathways) 95th percentile (target 18.3 weeks)	Not Applicable	Achieved	No longer measured	No longer measured
18 week Referral to Treatment (admitted pathways) 95th percentile (target 23 weeks)	Not Applicable	Achieved	No longer measured	No longer measured
Incidence of MRSA	4 (target <=3)	2 (target <=3)	3 (target <=3)	1 (target 0)
Incidence of Clostridium Difficile	101 (target <=152)	53 (target <=86)	28 (target <=51)	26 (target <=29)
Mixed Sex Accommodation (Target 0)	2 breaches	5 breaches	12 breaches	15 breaches
Total time in A&E (target 95% of patients to be admitted, transferred or discharged within 4hrs)	Achieved 97.69%	Achieved 95.93%	Achieved 96.61%	Not updated on National website as yet
Total time in A&E (95th percentile) (Target 240 minutes)	Not applicable	Under-achieved	Under-achieved	Under-achieved
Total time to initial assessment (95th percentile) (Target 15 minutes)	Not applicable	Under-achieved	Under-achieved	Under-achieved
Time to treatment decision (median) (Target 60 minutes)	Not applicable	Under-achieved	Achieved	Under-achieved

Table 11: Performance against Relevant Key National Priority Indicators and Thresholds (Continued)				
Quality Standard	**Trust Self Assessment 2010/11**	**Trust Self Assessment 2011/12**	**Trust Self Assessment 2012/13**	**Trust Self Assessment 2013/14**
Unplanned re-attendance (Target 5%)	Not applicable	Achieved	Achieved	Not updated on National website as yet
Left without being seen (Target 5%)	Not applicable	Achieved	Achieved	Not updated on National website as yet
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	Under-achieved 26.99%	24.59%	24.56%	23.2%
Breast-feeding initiation rates target (average rate within 48 hrs)	Under-achieved 63.14%	60.47%	56.35%	65.7%
Emergency Preparedness	**	**	**	**
Where needed the criteria for the above indicators has been included in the Glossary of Terms				

** The Pandemic Influenza Plan (Version 8) was reviewed in April 2014 and ratified by the Board of Directors.

This document defines the key pandemic influenza management systems and responsibilities of staff**. The suite of emergency plans are all to be reviewed in early 2014 due to the release of new national guidance in November 2013 and the Emergency Preparedness, Resilience and Response Core Standards being issued which have been reviewed and are to be approved by the Trust Board in January 2014.

The Major Incident Plan (Version 6) and Decontamination Plan (Version 5) were reviewed in March 2014 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 regional major incident exercise was hosted by NHS England in October 2013 with all NHS organisations in Lancashire taking part.

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 March 2013. Beneath the Trust Business Continuity Plan are 9 Corporate, 19 CSFM, 3 Scheduled Care, 4 Unscheduled Care, 26 Adults and 8 Families Business Continuity Plans (total 69) with operational information on alternative options to deliver their services.

The Emergency Planning Manager and Local Security Management Specialist continue to undertake group training sessions for the seventy eight 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.

The Emergency Planning Manager and Local Security Management Specialist also deliver quarterly lockdown and silver command activation exercises for on call staff to rehearse their roles.

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 2013/14 was above peer average; however for readmissions following non-elective admissions the Trust was above peer average as shown in Table 12. Work continues to improve the performance of patients readmitted following an elective procedure.

Table 12: 28 Day Readmissions						
Indicator	**Trust 2011/12**	**Peer 2011/12**	**Trust 2012/13**	**Peer 2012/13**	**Trust 2013/14**	**Peer 2013/14**
All Admissions	6.9%	6.9%	6.4%	6.8%	6.8%	6.6%
Non-elective	11.5%	10.8%	10.8%	10.7%	11.2%	10.4%
Elective	2.9%	3.2%	3.3%	3.1%	3.2%	3.1%
Data source: CHKS Quality and Patient Safety Tool. This data is not governed by standard national definitions						

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

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 2013/14 and the year end figure was 86.50% (excluding Rare Cancers) The annual performance was adjusted to 87.1% when the Rare Cancers were included. 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 2013 to 31st March 2014 we received 3794 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 506 this includes 395 written complaints registered via the Trust and 32 Community formal complaints. There were also 79 verbal complaints made. The numbers of formal complaints received shows an overall increase of 49 cases compared to the previous year as shown in the Table 13 below.

Table 13: Complaints

Date - Financial Year	Complaints
2013/2014	**506 Total** (439 Trust + 67 Community)
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:

- Treatment Issues 263
- Communication 42
- Staff Attitude 56
- Waiting Times 48
- Administration 51

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 2013/14**,** 63 meetings were held in order to resolve a complaint in a more timely manner (9 after a final response and 54 before a final response), a 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. Following recommendations in the Keogh Report, the Trust holds a monthly Complaint Review Panel to discuss 'upheld' formal complaints. The panel address if the divisions complaints have been managed in line with agreed timeframe, investigated thoroughly and proportionally and the response is appropriate. Evidence is reviewed and lessons learned discussed to discover emerging themes and trends arising from complaint investigations. The panel will also review complainants that are deemed vexatious and agree a suitable response.

Once local resolution has been exhausted the complainant has the right to contact the Health Service Ombudsman for a review of the complaint. During 2013/14, 16 complaints were considered by the Ombudsman. Of these, the Ombudsman has decided 'no further investigation' is required, 2 have been reported as 'not upheld', one 'partially upheld' and 10 are still under consideration and classed as being '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 14 below shows the number of issues dealt with by the by PALS team over the last four years.

Table 14: Informal Complaints		
Date - Financial Year	**Number of Cases**	**Number of Issues**
2013/2014	2,284	4,307
2012/2013	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 212 cases in comparison to the previous year. Out of the 2,284 cases 2,182 have been resolved and 102 cases are ongoing or require final closure. The main themes that have emerged from the cases recorded are:

- Administration (476 issues)
- Staff Attitude (158 issues)
- Treatment Issues (466 issues)
- Waiting Times (449 issues)
- Communication (198 issues

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. Following recommendations in the Keogh Report, the Trust holds a monthly Complaint Review Panel to discuss 'upheld' formal complaints. The panel address if the divisions complaints have been managed in line with agreed timeframe, investigated thoroughly and proportionally and the response is appropriate. Evidence is reviewed and lessons learned discussed to discover emerging themes and trends arising from complaint investigations. The panel will also review complainants that are deemed vexatious and agree a suitable response.

3.4 Detailed Description of Performance on Quality in 2013/14 against Priorities in 2012/13 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 2013/14 against the 2012/13 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 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 SHMI.

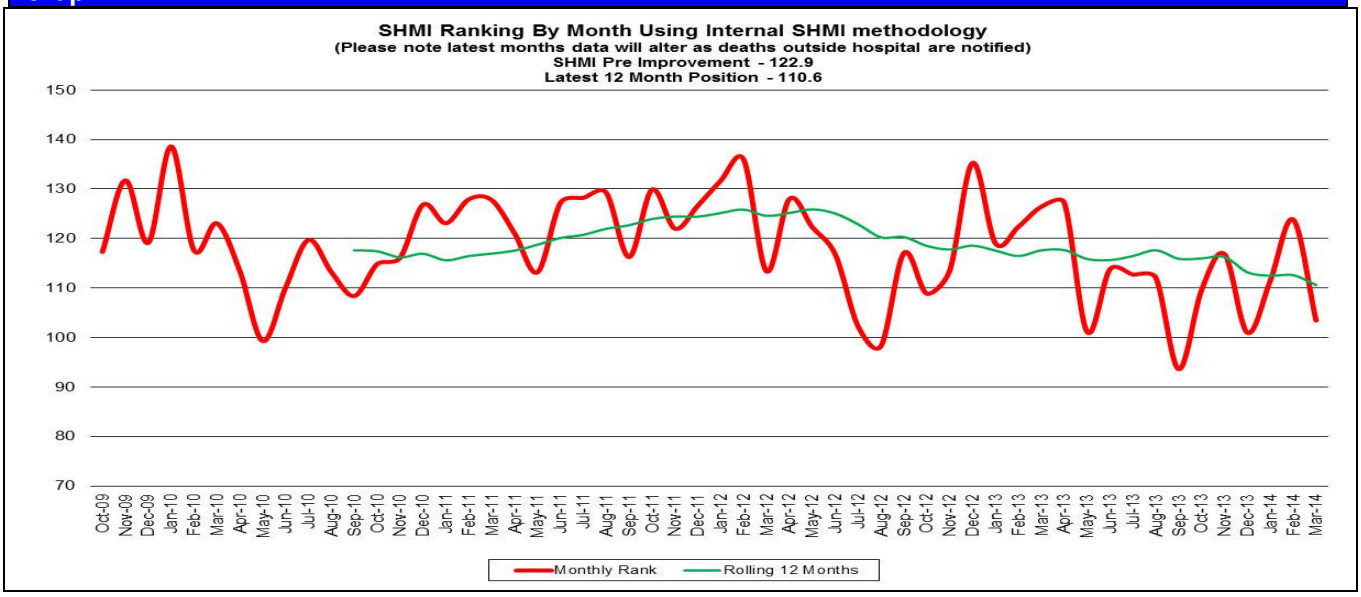
The Trust continues to be part of a North West Collaborative Programme for mortality reduction and has implemented programmes specifically around the care of patients with pneumonia and patients with severe sepsis. In addition to this work hospital mortality has been improved by the implementation of 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.

Blackpool Teaching Hospitals was one of the 14 Trusts identified for review by Sir Bruce Keogh as a persisting outlier on the national SHMI measure based on data from pre March 2012. The Trust welcomed this review and was one of only three organisations not placed in special measures following the review.

The Trust has also recently been inspected by the Care Quality Commision (CQC) where its work on reducing mortality and improving care pathways was commended.

These reviews have helped the organisation in creating a focused action plan for improving patient care.

Graph 2



Data source: HED data evaluation tool and Trust SHMI Calculation Tool. This data is governed by standard national definitions

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 over 12 points compared to the period from June 2010 to commencement of work.

Graph 3

Data source: Trust Patient Administration System (PAS). This data is governed by standard national definitions

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 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 15. 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

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 patient experience. Approximately 3,000 patients a year will benefit from this programme.

Table 15
Commissioning for Quality and Innovation (CQUIN) and the respective Targets For The Trust

Scheme	Threshold	Collection Period
Acute Myocardial Infarction (Heart Attack)	88.08%	Discharges which occur between 1st April 2013 and 31st March 2014
Hip and Knee Replacement Surgery	83.17%	
Coronary Artery By-pass Graft (CABG)	95%	
Heart Failure	77.85%	
Community Acquired Pneumonia	64.58%	
Stroke	54%	
Patient Experience Measures (PEMs)	N/A	

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 15 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 2013/14 data cannot be published until Grant Thornton have completed their audit to validate the data, which is anticipated to be September/October 2014.

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 98.54% as shown in Table 16.

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 Ischemia 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 16				
Acute Myocardial Infarction (Heart Attack)	**Trust Performance**			
Measure	Oct 09 – Mar 10	Apr 10 – Mar 11	Apr 11 – Mar 12	**Apr 12 – Mar 13**
Aspirin at arrival	100.00%	100.00%	99.78%	99.65%
Aspirin prescribed at discharge	100.00%	100.00%	100.00%	99.74%
ACEI or ARB for LVSD	100.00%	100.00%	100.00%	98.91%
Adult smoking cessation advice/counselling	96.00%	96.61%	95.12%	96.73%
Beta Blocker prescribed at discharge	100.00%	98.79%	99.54%	99.01%
Beta Blocker at arrival				
Fibrinolytic therapy received within 30 minutes of hospital arrival				66.67%
Primary Coronary Intervention (PCI) received within 90 minutes of hospital arrival	100.00%	95.12%	91.50%	92.88%
Survival Index	99.00%	90.80%	96.52%	98.52%
Acute Myocardial Infarction (AMI) Composite Quality Score (CQS)	**99.62%**	**97.98%**	**98.17%**	**98.54%**
Top 25% CQS Threshold	99.04%			
Top 50% CQS Threshold	98.00%			
CQUIN Threshold	87.35%	95.00%	95.00%	95%
The Trust had to achieve the CQUIN Threshold of 95%. The Trust met the CQUIN Threshold – we scored 98.54% (green)				

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 98% 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 are compliant in this area. The Trusts performance is shown in Table 17.

Table 17				
Hip and Knee Replacement Surgery	**Trust Performance**			
Measure	Oct 09 – Mar 10	Apr 10 – Mar 11	Apr 11 – Mar 12	**Apr 12 – Mar 13**
Prophylactic antibiotic received within 1 hour prior to surgical incision	88.14%	97.96%	94.97%	93.13%
Prophylactic antibiotic selection for surgical patients	97.36%	99.59%	97.18%	91.06%
Prophylactic antibiotic discontinued within 24 hours after surgery end time	98.31%	96.64%	95.63%	97.13%
Recommended Venous Thrombo-Embolism prophylaxis ordered	99.66%	100.00 %	99.11%	98.73%
Received appropriate Venous Thrombo-Embolism (VTE) prophylaxis w/l 24 hrs prior to surgery to 24 hrs after surgery	99.66%	100.00 %	98.96%	98.73%
Readmission (28 Day) avoidance index	94.02%	92.50%	91.98%	94.78%
Hip and Knee Composite Quality Score (CQS)	**96.19%**	**97.78%**	**96.25%**	**95.54%**
Top 25% CQS Threshold	96.89%			
Top 50% CQS Threshold	94.27%			
CQUIN Threshold	75.67%	95.00%	95.00%	95.00%
The Trust had to achieve the CQUIN Threshold of 95%. The Trust met the CQUIN Threshold – we scored 95.54% (green).				

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. 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 98.19% as shown in Table 18.

Table 18				
Coronary Artery Bypass Graft Surgery	**Trust Performance**			
Measure	Oct 09 – Mar 10	Apr 10 – Mar 11	Apr 11 – Mar 12	**Apr 12 – Mar 13**
Aspirin prescribed at discharge	98.54%	98.68%	99.30%	100%
Prophylactic antibiotic received within 1 hr prior to surgical incision	87.89%	95.59%	99.68%	98.52%
Prophylactic antibiotic selection for surgical patients	94.88%	98.30%	99.68%	99.59%
Prophylactic antibiotic discontinued within 24 hrs after surgery end time	89.82%	93.62%	90.42%	94.52%
Coronary Artery Bypass Graft Composite Quality Score (CQS)	**92.73%**	**96.54%**	**97.23%**	**98.19%**
Top 25% CQS Threshold	97.75%			
Top 50% CQS Threshold	97.73%			
CQUIN Threshold	95.00%	95.00%	95.00%	95.00%
Year 3 - The Trust had to achieve the CQUIN Threshold of 95%. The Trust met the CQUIN Threshold – we scored 98.19% (green)				

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 91.14% as shown in Table 19.

Table 19				
Heart Failure	**Trust Performance**			
Measure	Oct 09 – Mar 10	Apr 10 – Mar 11	Apr 11 – Mar 12	**Apr 12 – Mar 13**
Discharge instructions	18.42%	34.43%	76.79%	81.01%
Evaluation of LVS function	84.62%	87.70%	96.40%	96.18%
ACEI or ARB for LVSD	81.37%	84.84%	92.88%	97.65%
Adult smoking cessation advice / counselling	53.85%	28.13%	76.79%	97.50%
Heart Failure Composite Quality Score (CQS)	**59.10%**	**65.94%**	**88.37%**	**91.14%**
Top 25% CQS Threshold	77.60%			
Top 50% CQS Threshold	72.19%			
CQUIN Threshold	65.34%	65.34%	75.08%	82.24%
The Trust had to achieve the CQUIN Threshold of 82.24%. The Trust met the CQUIN Threshold – we scored 91.14% (green)				

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 shows the Composite Quality Score (CQS) to be 90.77% as shown in Table 20.

Table 20				
Community Acquired Pneumonia	**Trust Performance**			
Measure	**Oct 09 – Mar 10**	**Apr 10 – Mar 11**	**Apr 11 – Mar 12**	**Apr 12 – Mar 13**
Oxygenation assessment	100.00 %	99.81%	100.00 %	100%
Blood Cultures performed in A&E prior to initial antibiotics received in hospital	41.60%	80.35%	77.82%	81.97%
Adult smoking cessation advice / counselling	39.62%	39.26%	50.00%	58.67%
Initial antibiotic received within 6 hrs of hospital arrival	64.94%	79.24%	83.60%	87.53%
Initial antibiotic selection for Community Acquired Pneumonia in immune-competent patients	97.32%	99.68%	100.00 %	99.48%
CURB-65 score			75.63%	87.25%
Community Acquired Pneumonia Composite Quality Score (CQS)	**76.28%**	**86.29%**	**85.74%**	**90.77**

Top 25% CQS Threshold	84.03%			
Top 50% CQS Threshold	82.24%			
CQUIN Threshold	78.41%	78.41%	84.81%	87.39%
The Trust had to achieve the CQUIN Threshold of 87.39%. The Trust met the CQUIN Threshold – we scored 90.77% (green)				

Stroke

Performance of Blackpool Teaching Hospitals NHS Foundation Trust shows the Composite Quality Score (CQS) to be 89.34% and Appropriate Care Score (ACS) as 57.74% as shown in Table 21.

Table 21			
Stroke (New Target Introduced October 2010)	**Trust Performance**		
Measure	(1.10.2010 – 31.3.2011)	(Apr 11 – Mar 12)	**Apr 12 – Mar 13**
Stroke Unit Admission	41.92%	74.19%	66.67%
Swallowing Screening	97.77%	97.96%	95.73%
Brain Scan	68.15%	84.41%	95.21%
Received Aspirin	90.71%	99.09%	96.32%
Physiotherapy Assessment	98.48%	96.69%	95.81%
Occupational Assessment	97.01%	95.47%	92.88%
Weighed	98.15%	98.49%	95.99%
Stroke Composite Quality Score (CQS)	**83.65%**	**92.07%**	**89.34%**
Stroke Appropriate Care Score (ACS)	**34.27%**	**68.11%**	**57.74%**
CQS - CQUIN Threshold	90%	90%	90%
ACS - CQUIN Threshold	50%	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%.			
Year 3 – The Trust achieved the ACS CQUIN target but failed the CQS CQUIN target.			

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

Dementia is a significant challenge for the NHS with it estimated that 25% of general hospital beds in the NHS are occupied by people with dementia, rising to 40% or even higher in certain groups such as elderly care wards or in people with hip fractures. The Dementia Project – Large Scale Change is led by two Associate Directors of Nursing and was introduced within the Trust to implement the Dementia Quality Standard and further raise awareness of dementia. The project is divided into five 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. The Dementia Advisory Board continues to meet regularly and significant improvement to all aspects of dementia care is demonstrated within each of the ongoing work -streams.

- A successful bid to the Blue Skies Charity fund has meant that plans have now been drawn up for the development of a memory walk. The location and members of a project team have been identified and discussions have taken place with local businesses and artists who have kindly donated picture boards and local artefacts. The memory walk will be fully operational by June 2014.
- Distraction/comfort boxes have been introduced to try to engage our patients more effectively. These boxes contain familiar everyday items such as buttons, clothes pegs, and a wide range of 'sensory' materials such as crinkly, furry fabrics or items with lights that flash and twinkle. The aim is to stimulate a range of senses and help staff to engage with the patients, whilst also helping to relieve the anxiety felt by patients in an unfamiliar setting.
- Development of a Dementia Pathway is now completed and the launch of this will coincide with "Dementia Awareness" week.
- The butterfly scheme has been re-launched this last month and work continues to ensure the principles of this approach is embedded within the organisation.
- Dementia Training and education continues to be improved. Opportunities for staff now include dementia awareness full day for all staff, Best Practice module in Dementia care, Level 3 course at UCLAN, Caring for people with Dementia, Delirium Awareness and risk assessment for junior doctors.
- Guidelines have been implemented for the prescription of antipsychotic medications.

A national target of 90% of patients admitted to hospital as an emergency aged over 75 years, will receive screening, assessment and onward referral for further memory assessment if indicated. 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 in 2012/13. Further improvements were made during quarter 4 of 2013/14 through the introduction of dedicated audit staff to collect data and feedback compliance real time. This has shown some improvement (17% in quarter), and it is envisaged that the Trust will build on this over the coming year, but the Trust did not meet the 90% national target overall as shown Table 22. 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 has been identified that further education is required to raise awareness of the importance in completing the assessments.

Table 22: Monthly Trust-wide performance. – Dementia Screening

Target 90%	Nov 12	March 2013	June 2013	September 2013	December 2013	April 2014
Screening Question	29%	73%	52%	57%	70%	59%
Assessment	39%	75%	61%	52%	71%	59%
Referral	0%	0%	0%	20%	0%	54%

Data source: Internal data system and data submitted to the Department of Health. This data is governed by standard national definitions. Please note: data has not been signed off for the April 2014 data or submitted to the Department of Heath

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 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.
- Practice Development Sisters offer additional training on dementia for clinical staff that will include content on how to complete the bundle particularly the Dementia Assessment.
- Since December 2013, clinical audit assistants have collected data and provided real time feedback to clinicians to identify areas where improvements can be made to patient care relating to dementia screening and care planning

Medical Care Indicators Used to Assess and Measure Standards of Clinical Care and Patient Experience

The framework for the medical care indicators was designed to support medical staff to understand how they deliver specific aspects of their care. As with the nursing care indicators, our overall aim when introducing these performance measures is to reduce harm and improve patient outcomes and experience. The metrics are visible and therefore by using this system we can ensure that accountability is firmly placed on the medical teams providing the bedside care.

The results are obtained from a monthly spot prevalence audit, and the Indicators are based on questions relating to medical documentation, antibiotic prescribing, DNARCPR, Consultant review and care planning, VTE risk assessment and mortality

Reports are circulated to identify the following:

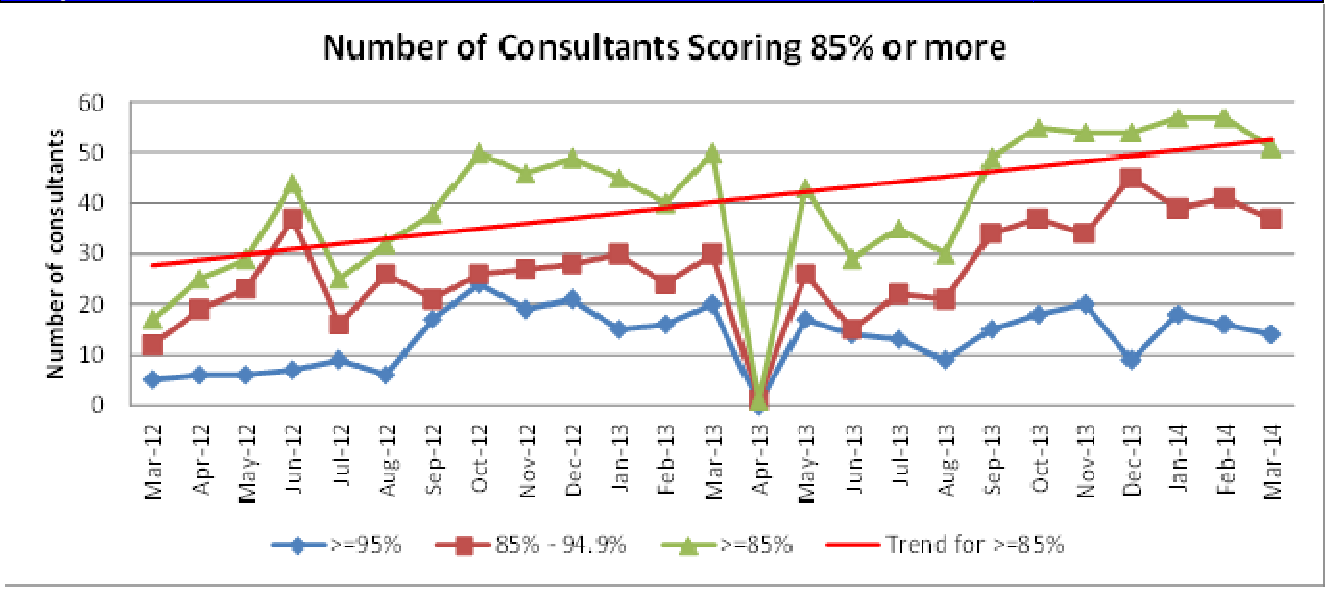
- Overall Trust Results
- Divisional Results
- Ward Level results
- Consultant level results

Between March 2012 and March 2014 the three month average number of consultants who achieved 85% compliance or better increased from 24 (Mar 12 to May 12) to 55 (Jan 14 to Mar 14) and the three month average number of consultants who achieved 95% compliance or better increased from 6 (Mar 12 to May 12) to 16 (Jan 14 to Mar 14)

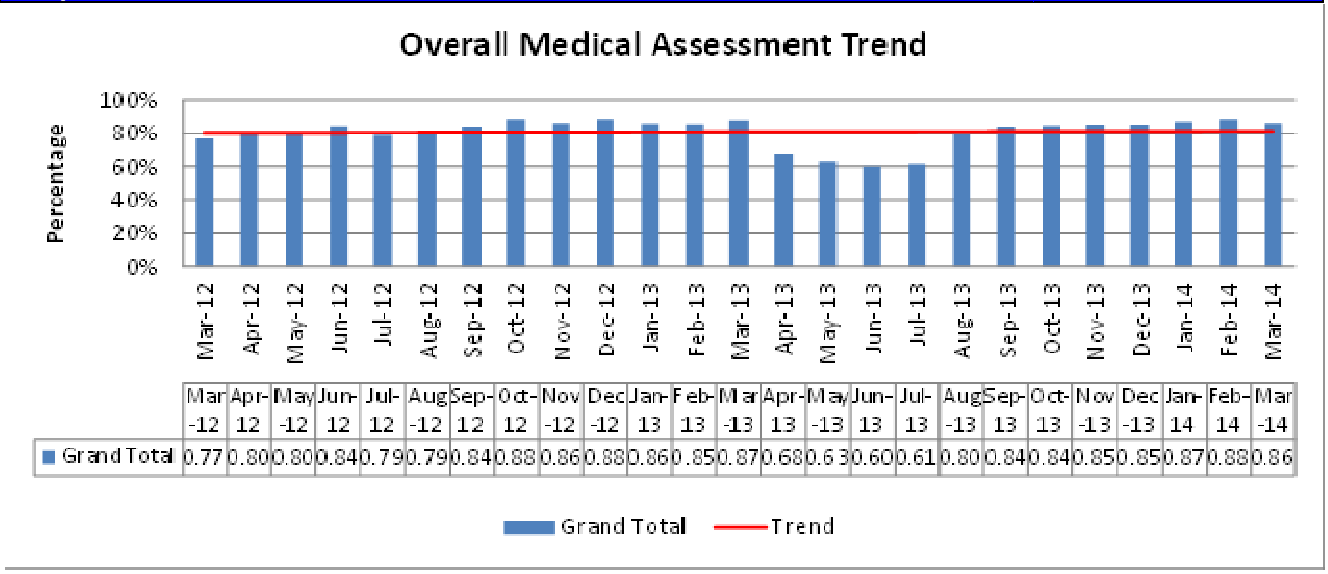
In April 2013 new criteria were added to the audit which led to the average consultant score falling from 87% to 68% and no consultants achieving a score for that month above 85%. By September 2013 the scores had recovered to the levels seen just prior to the introduction of the new criteria.

Graph 4 and Graph 5.The overall Medical Assessment Trend is shown in Graph 6.

Graph 4: Medical Care Indicators



Graph 5: Medical Care Indicators



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 **five** 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.

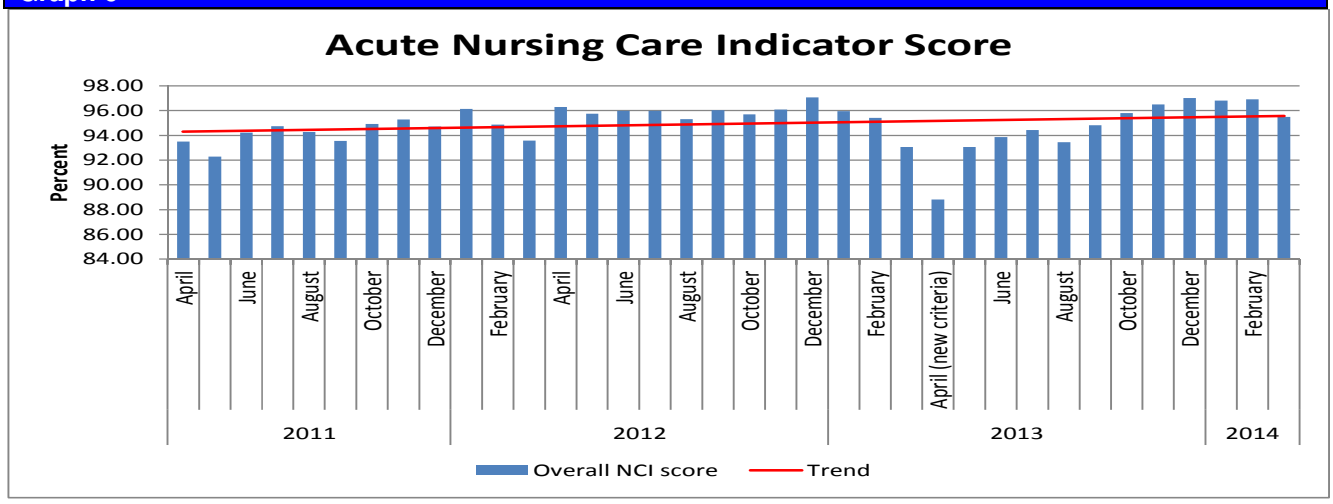
In the development of the Nursing Care Indicators, key themes for measurement were identified from complaints, the patients' survey, the Trust documentation audit, the benchmarks held within the essence of care benchmarking tool, and assessments against Trust nursing practice standards. Measurement of 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. In 2013 the criteria for all the indicators was reviewed and amended to reflect changing best practise. An additional indicator, 'Management of Patient property' was also added.

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
- Management of patient property

Graph 7 shows the overall Trust performance, expressed as an average percentage of all 11 nursing care indicators, for 2013/14. The variation in scores seen is the type expected in a normal process. The trend clearly shows an overall improvement over the year.

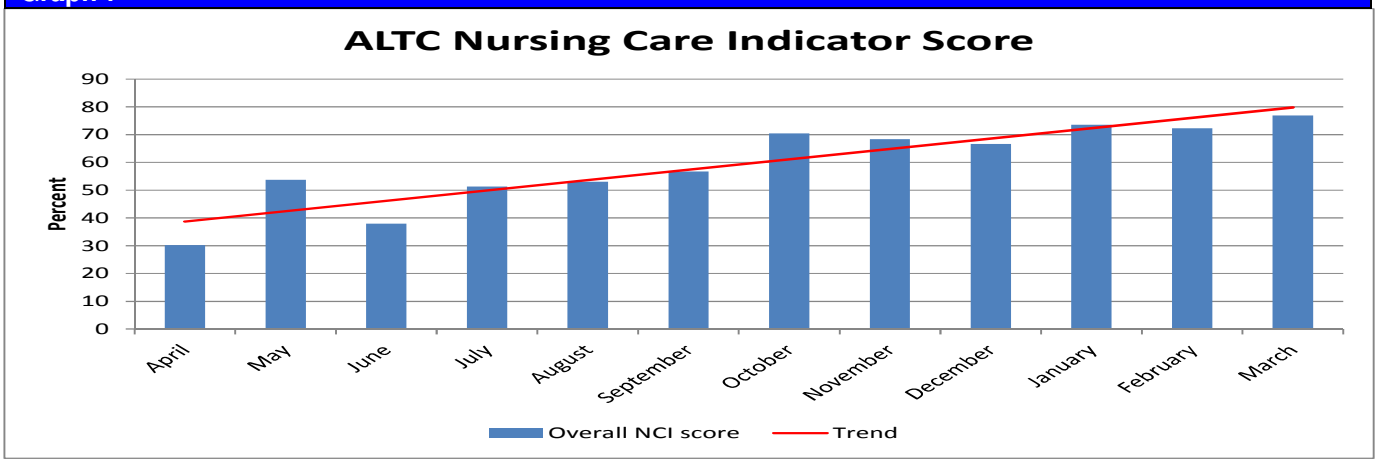
Graph 6



In April 2013, Nursing Care Indicators were introduced into the community setting. Five indicators are being measured:

- Nutritional Assessment
- Pain Management
- Falls Assessment
- Tissue Viability
- Care of the Dying Patient

Graph 7



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

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 23.

Table 23: Participation Rates	
Date	Participation rate (full year)
2011/2012	75.7%
2012/2013	73.7%
2013/2014	76.5%

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 2011 -12 (April 2011 - March 2012) and Provisional PROMs Data 2012-2013 (April 2012 - March 2013) is shown in Table 24. 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 2011/12 data to part year April to December 2012 data all scores have seen an increase in value.

Table 24:

Comparison between Blackpool Teaching Hospitals NHS Foundation Trust Provisional PROMs Data 2011 -12 (April 2011 - March 2012) and Provisional PROMs Data 2012 - 2013 (April 2012 - March 2013)

Comparison between Blackpool Teaching Hospitals NHS Foundation Trust Provisional PROMs Data 2011 -12 (April 2011 - March 2012) and Provisional PROMs Data 2012 - 2013 (April 2012 - March 2013)										
	Measure									
Percentage Improving	EQ-5D Index 2011-12	EQ-5D Index 2012-13	Variance		EQ-VAS 2011-12	EQ-VAS 2012-13	Variance		Condition Specific 2011-12	Condition Specific 2012-13	Variance
Groin Hernia	48.8%	44.8%	-4.0%		41.5%	39.0%	-2.5%		N/A	N/A	N/A
Hip Replacement	88.8%	86.0%	-2.8%		61.3%	65.4%	4.1%		96.8%	95.50%	-1.3%
Knee Replacement	80.1%	79.6%	-0.5%		60.3%	58.2%	-2.1%		95.3%	89.40%	-5.9%
Varicose Vein	54.9%	50.0%	-4.9%		49.0%	38.9%	-10.1%		80.4%	88.20%	7.8%

Comparison between Blackpool Teaching Hospitals NHS Foundation Trust Provisional PROMs Data 2011 -12 (April 2011 - March 2012) and Provisional PROMs Data 2012 - 2013 (April 2012 - March 2013)										
	Measure									
Percentage Getting Worse	EQ-5D Index 2011-12	EQ-5D Index 2012-13	Variance		EQ-VAS 2011-12	EQ-VAS 2012-13	Variance		Condition Specific 2011-12	Condition Specific 2012-13	Variance
Groin Hernia	14.0%	19.8%	5.8%		35.8%	42.6%	6.8%		N/A	N/A	N/A
Hip Replacement	7.0%	2.8%	-4.2%		28.5%	22.6%	-5.9%		2.6%	4.50%	1.9%
Knee Replacement	6.6%	10.8%	4.2%		30.5%	27.8%	-2.7%		3.7%	9.00%	5.3%
Varicose Vein	14.4%	11.6%	-2.8%		40.0%	47.8%	7.8%		19.6%	11.80%	-7.8%

Data source: Health and Social Care Information Centre (HSCIC). This data is governed by standard national definitions

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.

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 2013/14 was below peer average as shown in Table 25.

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 8.

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

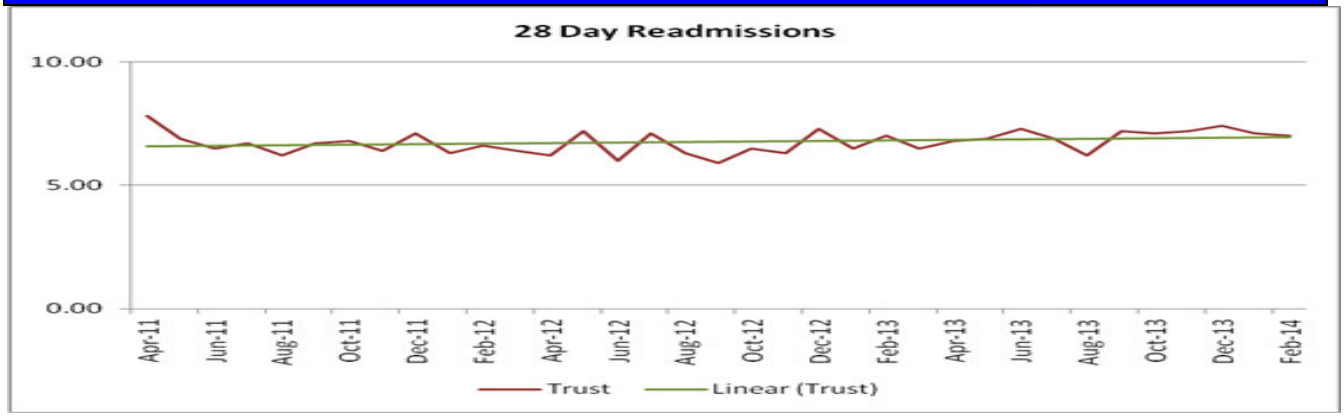
- A clinically led review of readmissions to identify implement actions required to reduce the number of avoidable admissions
- Joint work with Clinical Commissioning Groups to identify and implement health economy wide readmission avoidance schemes, including single point of access services to ensure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

Table 25: 28 Day Readmissions

Indicator	Trust 2011/12	Peer 2011/12	Trust 2012/13	Peer 2012/13	Trust 2013/14	Peer 2013/14
All Admissions	6.9%	6.9%	6.4%	6.8%	6.8%	6.6%
Non-elective	11.5%	10.8%	10.8%	10.7%	11.2%	10.4%
Elective	2.9%	3.2%	3.3%	3.1%	3.2%	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 2013/14.

Graph 8: 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 2013 and January 2014 a questionnaire was sent to 850 recent inpatients. 369 patients responded. Table 26 shows a comparison of data for five indicators from 2011 to 2014 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.

Table 26: Care Quality Commission National Inpatient Survey				
Indicator	**2011/12 Results**	**2012/13 Results**	**Comparison to last year's results**	**2013/14 Results**
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	↑	84.8% 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	↑	76.9% said yes often or yes sometimes
Were you given enough privacy when discussing your condition or treatment?	89.2% were always or sometimes	91.3% were always or sometimes	↓	89.9% 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	↑	57.4 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	↑	73.7% 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 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 is in the process of improving the score in relation to the question "Were you given enough privacy when discussing your condition or treatment?". The Patient Experience Team are conducting regular spot audits to identify areas where patients feel they are not given enough privacy, informing divisional leads of their findings so action can be taken in real time.

The clinical divisions are also 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 2012 and January 2013 a questionnaire was sent to 1996 staff. 938 staff responded. Table 27 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.

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 27: National Staff Survey Results		Comparison to last years results
Indicator	**2012 Result**	**2013 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	86% 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, Keogh and CQC reports as it deems necessary.

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. And can be accessed via the following link http://www.bfwh.nhs.uk/departments/comms/publications.asp#ann

Report on Friends and Family Test

The friends and family test (FFT) has been implemented within the inpatient areas and accident and emergency dept from 1st April 2013 and across Maternity Services from October 2013.

The test will provide us with a simple, easily understandable headline matric 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 matric and we will still need to supplement this with other methods of capturing, responding and understanding the patients experience data

Why the test is important for our patients
Patients will be able to use this information to make decisions about their care and also to challenge us in improving services as well as celebrating areas of good care.

Why the test is important for our staff
Sharing this data with staff will increase the transparency of our Trust and empower all levels of staff to target and carry out improvements. Along with tracking the test results staff will also be able to see where targeted improvements have been effective and sustained. Staff being engaged in this process will be key to its success and data collection.

Expected requirements for the Test
We use the test is to survey patients after they have experienced an episode of care, therefore participants are those adult patients at the point of discharge from acute inpatient care (with an overnight stay) and all patients who have attended A&E and from October 2013 this also included maternity services including ante natel, delivery, home birth and post natel care.

The aim of the test is to promote a responsive, patient led NHS. Ideally all patients in the target group should be given the opportunity to take part, so the Trust has been collecting data every day, not just on selected dates. We survey as many patients as possible as well as monitoring and reporting on the number of responses along with local reports.

The friends and family test is simple and centred around the one question, we also ask a small number of additional questions in order to gain a deeper understanding of our patient's experiences whilst in our care, a supplementary question is asked in order to get the detail and free text of what influenced their decision.

The Question that has to be asked is:

- How likely are you to recommend our (ward name/A&E Department) to friends and family if they needed similar care or treatment?

Respondents can respond by ticking:
- Extremely likely
- Likely
- Neither likely or unlikely
- Unlikely
- Extremely unlikely
- Don't know

The Trust is marked according to the net promoter score based on the Department of Health scoring methodology. Scores are calculated based on the following calculation:
- Proportion of respondents who would be extremely likely to recommend minus proportion of respondents who would not recommend (response categories neither likely nor unlikely, unlikely and extremely unlikely)

The net promoter score is marked from plus 100 to minus 100. The Trust scores and response rates are detailed in Table 28 below:

Table 28: Friends and Family Test

Month	Trust Overall score	Responses	Inpatient Response Rate	Emergency Department Response Rate	Maternity Response rates
April	72	453	19.7%	0.1%	Not surveyed
May	74	724	25.7%	1.5%	Not surveyed
June	76	877	32%	2.5%	Not surveyed
July	72	1021	37.7%	7.4%	Not surveyed
August	73	938	29.4%	4.1%	Not surveyed
September	76	814	25.60%	3.10%	Not surveyed
October	74	1128	30.70%	6.50%	9.7%
November	70	1521	41.2%	13.4%	8.6%
December	73	1816	44%	17.7%	9.8%
January 14	66	2005	43.4%	21.7%	7.9%
February 14	71	1611	41.8%	15.4%	12%
March 14	72	1636	37%	14.1%	19.45%

Data obtained from Health and Social Care Information Centre

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 and End of Life Teams are working closely with Trinity Hospice and representatives from community groups to promote quality in 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 Trust End of Life Care Team continues to promote the tools available to enable patients to have choices in where they are cared for at end of life. A local family have worked with the team to share their experience of choice and preferences for care at end of life. Their daughter participated in a poster campaign, which received television and radio coverage. The aim of the campaign is to encourage patients, carers and staff to have discussions about their wishes and choices. These posters were launched throughout the Trust in May 2013

and were again supported with media coverage. The Trust continues to support same day or next day rapid discharges for those patients who wish to be cared for outside hospital in their last few weeks of life.

Based on the national Route to Success 'How to' guide on Transforming end of life care in acute hospitals, a ward based training programme has been developed and 3 senior nurses appointed to the Transform Training Team. The aim of the Transform Project is to increase the quality of end of life care in the Trust for patients and their carers and promote earlier identification of end of life with the opportunity for advance care planning discussions, realistic treatment choices and reduced emergency admissions at end of life. It will enhance communication, documentation, training and patient choice to improve the overall journey and experience.

PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT (PLACE)

- **To Improve PLACE Survey Results/Standards**

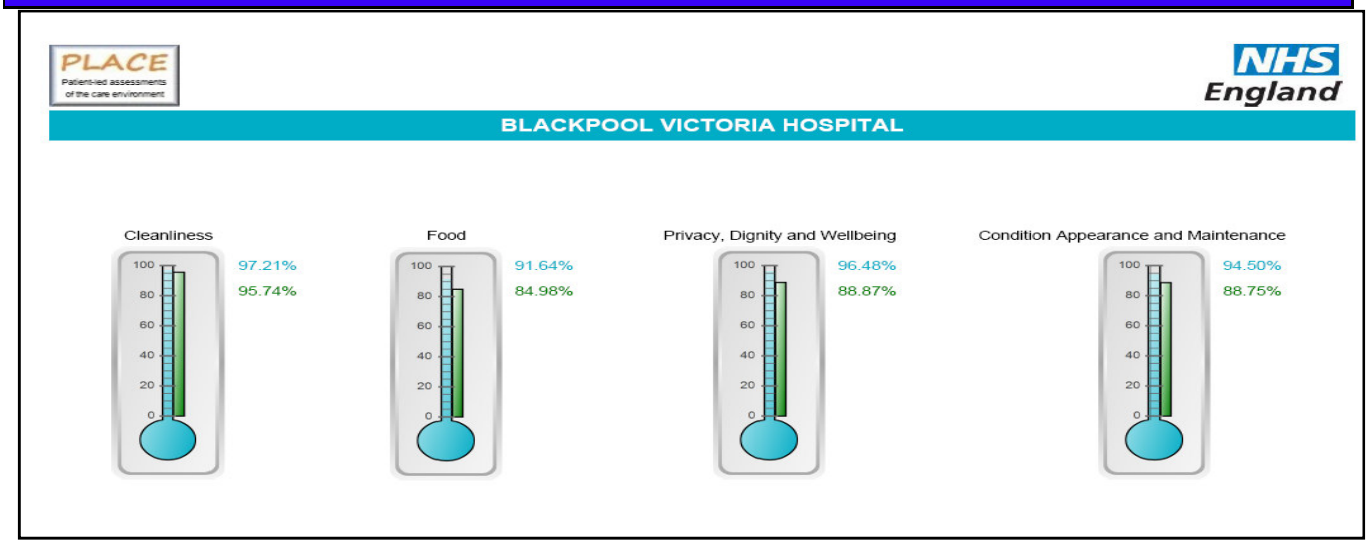
Our aim is to deliver the best environment for our patients to ensure that the patient experience exceeds the standards set by the National Patient Safety Agency. Providing a clean and safe environment for our patients is extremely important to the Trust. We monitor this through the Patient Led Assessments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

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

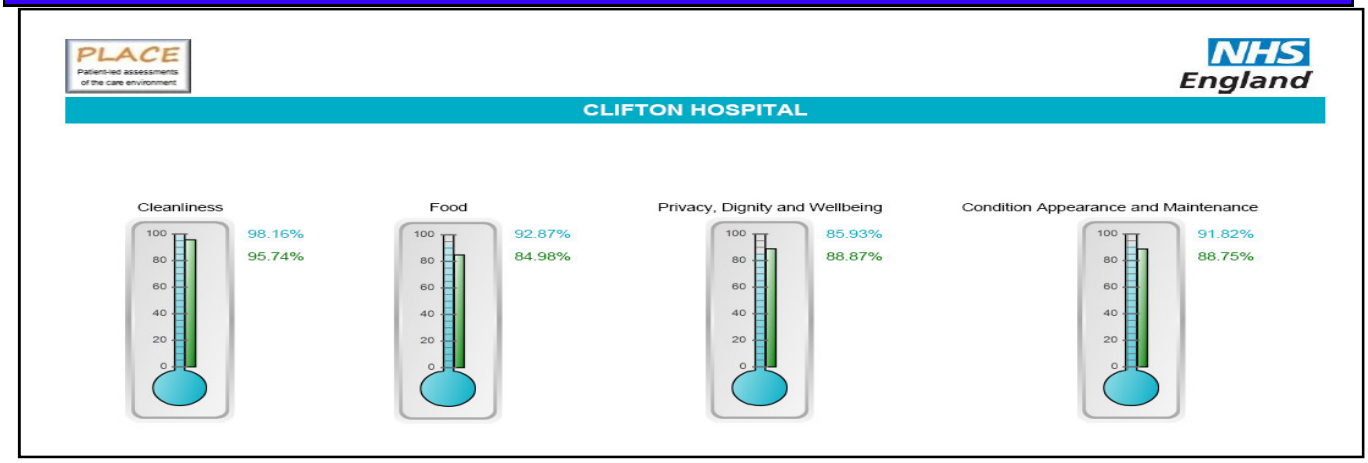
- Cleanliness
- Specific bathrooms/toilet cleanliness
- Catering Services
- Environment
- Infection Prevention
- Privacy and Dignity
- Access all external areas

The audit follows guidelines set by the National Patient Safety Agency and the results are publicised nationally on an annual basis. In 2013/14, PLACE audits were extremely encouraging across all hospital sites resulting in excellent standards achieved. The results in Graph 9 and Graph 10 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.

Graph 9: PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT (PLACE)



Graph 10: PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT (PLACE)



Key: Blue data indicates Trust scores, green data indicates National Average.

Data source: Local data from the Patient – Led Assessment Care Environment survey. This data is governed by standard national definitions set by the Health and Social Care Information Centre

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.

Achieve 95% Harm Free Care to Our Patients by 2016 through the following strands of work

Improve the Percentage of Admitted Patients Risk Assessed for Venous Thrombo-Embolism (VTE) -

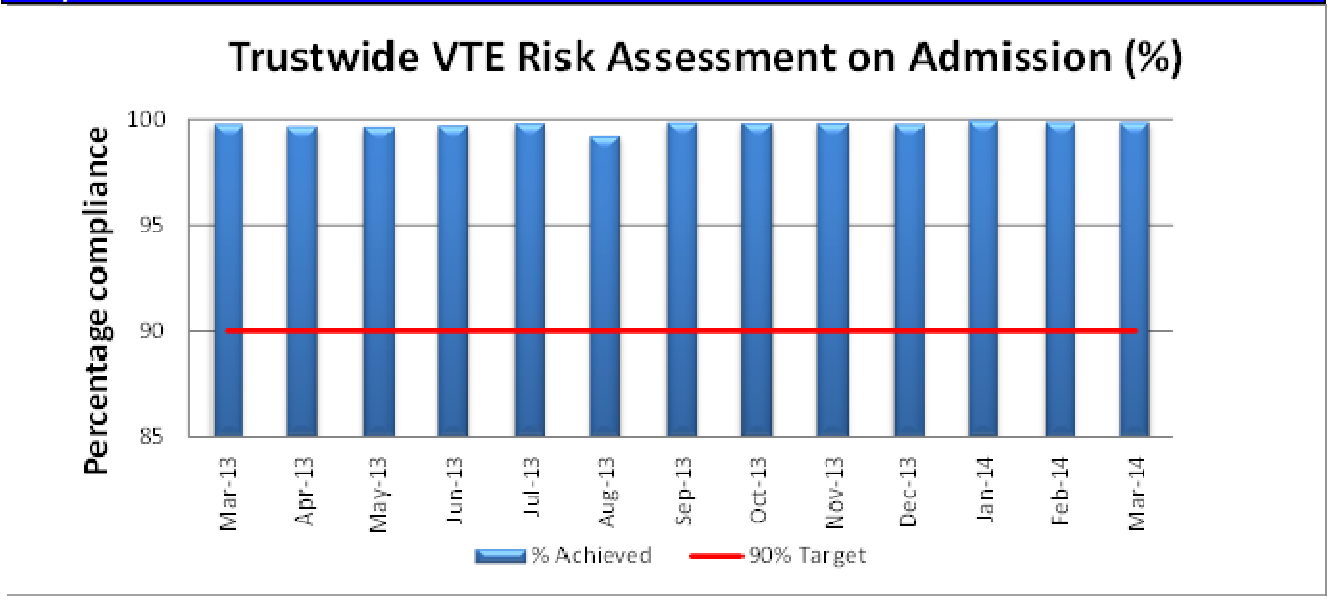
The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- 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 new 95% compliance indicator. We have been able to sustain previous improvement as shown by latest figures from March 2013 to 31st March 2014 as shown in graph 11.

The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this 95% percentage compliance indicator and so the quality of its services, by undertaking the following actions:

- A senior clinician and a senior nurse have been identified to provide leadership to facilitate ongoing improvements in compliance with trust processes and consequently improvements in patient care with regards VTE. The National Institute for Health and Clinical Excellence Venous Thrombo-Embolism guideline (CG 92) has been incorporated into easy to follow risk assessment forms across various specialties and is 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.
- Since December 2013, the clinical audit department have collected real time VTE data to give feedback to individual areas and address poor performance pro- actively.

Graph 11



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

- **Compare the VTE national average for the above percentages**
  - The average proportion of acute patients reported as having any type of VTE form the national Safety Thermometer (February 2013 to February 2014 inclusive) is 2.89%

- **Achieve a 10% reduction on the previous year in all VTE**

  In 2012/13, based on Safety Thermometer data, 563 out of 9030 hospital in-patients were reported as having a VTE. This represents a proportion of 6.23%. In 2013/14, 285 out of 9054 hospital in-patients were reported as having a VTE. This represents a proportion of 3.15%. The reduction in the proportion of patients reported as having a VTE from last year to this year is therefore 49.51%. The average proportion of acute patients reported as having any type of VTE form the national Safety Thermometer (February 2013 to February 2014 inclusive) is 2.89%

Reduce the Infection Rate of Clostridium Difficile and MRSA

Reduce 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 site

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:

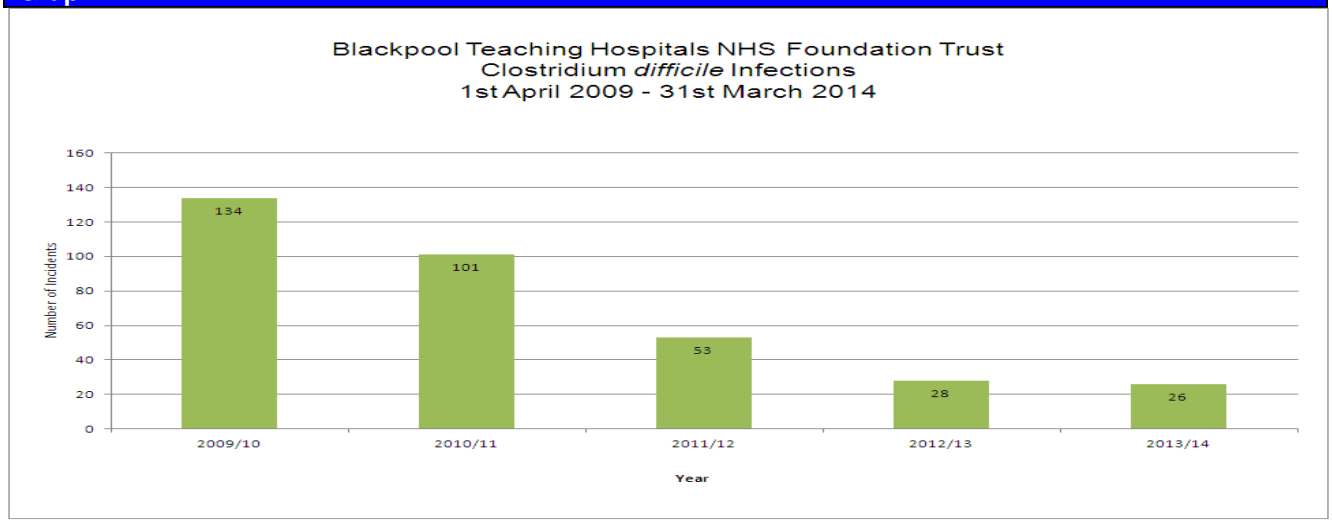
- Following the significant reductions in Clostridium Difficile Infection (91.95% for the last six years for the Acute Trust from 2007/2008) the Trust has continued to embed measures to reduce levels further within the organisation.

  There have been 26 cases of Clostridium Difficile Infection (CDI) attributed to the Acute Trust between April 2013 and March 2014, in comparison to 28 for the period April 2012 to March 2013, demonstrating a reduction of 7%. The Trust was required to achieve a trajectory of 29, due to the numbers achieved last year of 28 lower than the projected trajectory of 29 a reduction in the levels cannot be demonstrated from 2012-2013. Clostridium Difficile rates for April 2013-March 2014 as shown in Graph 12. 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. Effective Antibiotic Stewardship has had a significant impact on the rates of *C.difficile* and on trust antibiotic compliance rates. This is provided by regular ward rounds by the consultant microbiologist.
  ii. Introduction of probiotics drinks for patients considered to be at high risk for *C.difficile* by consultant microbiologists
  iii. Deconatmination of patient environment and equipment as and when possible by using hydrogen peroxide fogging system.
  iv. Ensuring cleaniliness of patient environment by ATP bioluminescence testing.
  v. Proactive management of GDH positive, who are likely colonised with *C.difficile* by the infection prevention team.
  vi. Continuing to raise awareness and leading by example;
  vii. Ongoing audits of compliance to ensure all infection prevention measures and control policies and procedures continue to be implemented, including in particular hand hygiene, environmental and decontamination standards; and
  viii. Training on all aspects of infection prevention continues to be delivered;
  ix. Outcomes were assessed by reviewing progress with the Clostridium Difficile target, and auditing compliance with national standards/regulations

Graph 12



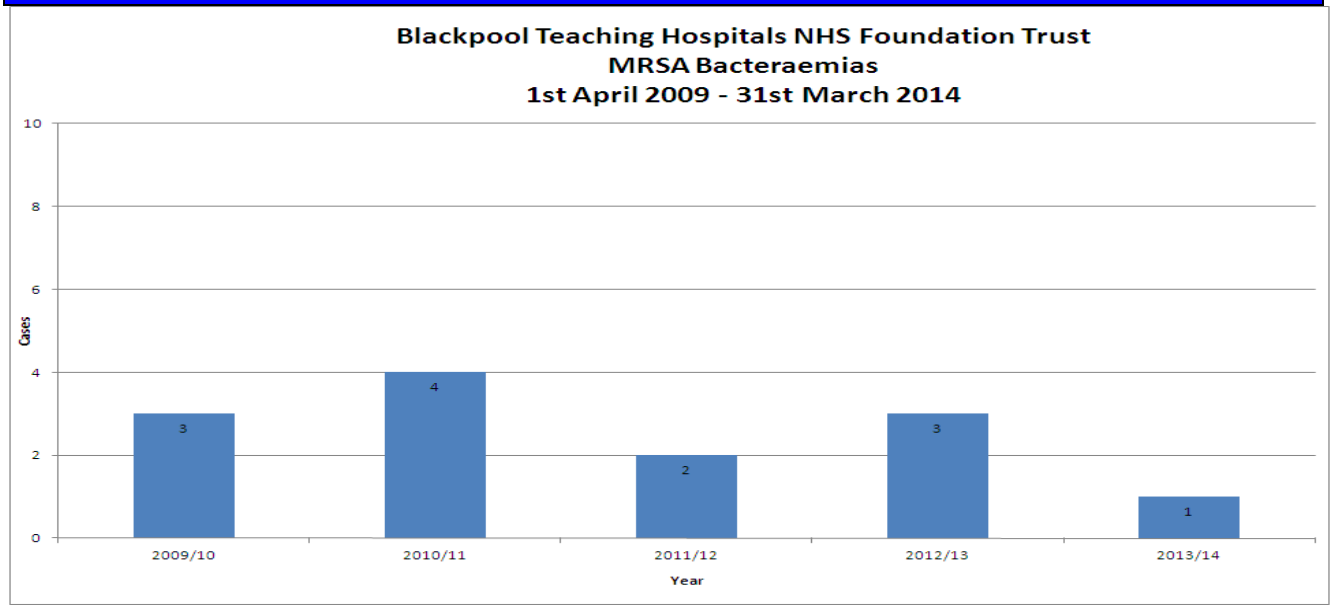
Data source: Department of Health M.E.S.S. This data is governed by standard national definitions

- **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 96.42% 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 9 and 10.

The delivery of the MRSA Bacteraemia target remains a clinical risk, in relation to Monitor's Compliance Framework which identifies an MRSA trajectory of 0 cases for the reporting period. The Trust has reported 1 case for this year, which is above trajectory and against Monitor's Compliance Framework target, as detailed in Graph 13 Information on how the criterion for this indicator has been calculated is detailed in the Glossary of Terms.

Graph 13



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

To Monitor the Rate of Patient Safety Incidents the Trust have reported per 1000 admissions and the proportion of Patient Safety Incidents the Trust has reported that resulted in Severe Harm or Death

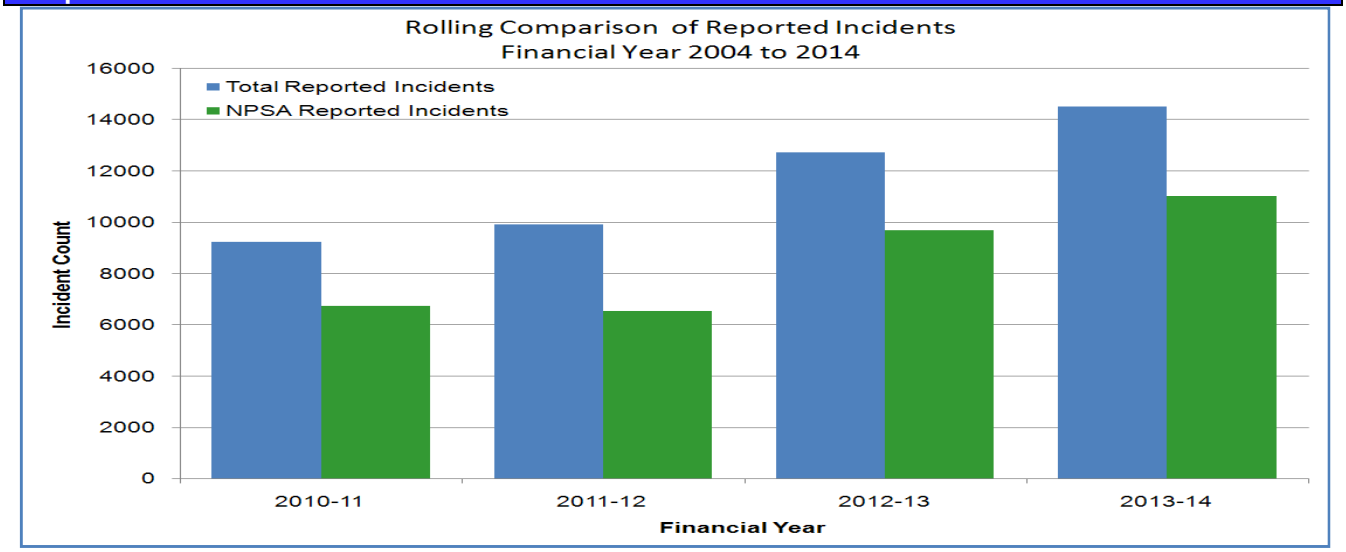
An analysis of patient safety incidents is undertaken by the Trust on a monthly basis. Incidents are coded based on the potential harm to the patient and on the actual harm to the patient. Incidents coded as severe involve any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving care in the Trust. Incidents resulting in death relate to those incidents where the incident directly resulted in the death of one or more persons receiving care in the Trust. Further information can be found in the Glossary of Terms

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 15). Patient Safety Incidents account for approximately 76% of all reported untoward incidents. In the year 2013/2014 there have been 14,527 untoward incidents reported and of these 11,016 were patient safety incidents and as such are reportable to the National Patient Safety Agency. Of these 11,016 patient safety incidents, 2,720 or 25% resulted in harm to the patient. In comparison to the number of attendances at the Trust (556,994) there is a patient safety incident reported for every 1 in 50 patients.

  However only one patient safety incident resulting in harm was reported for every 205 patients during 2013/14.

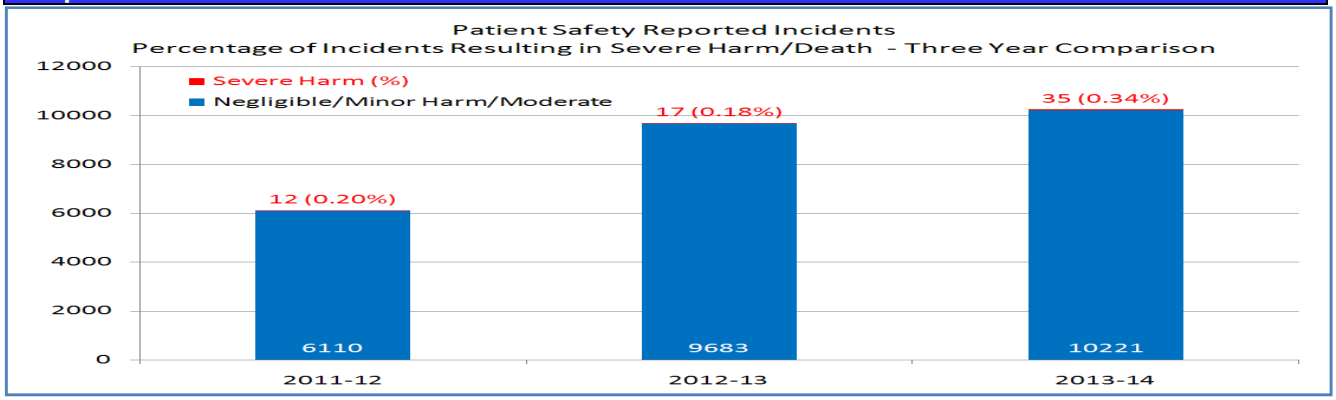
Graph 15



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

Since 2011/2012 there has been an increase in the number of patient safety incidents that have resulted in severe patient harm (Graph 16 and Table 29). This continues to be monitored through analysis of trends and themes, lessons being learned and actions being taken at lower level incidents. The Trust has a policy of reporting incidents within 24 hours of occurrence, 71% 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. The Trust is currently reviewing its policies and procedures in relation to holding staff accountable for actions or omissions in care which may impact on patient safety.

Graph 16



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

Table 29: Patient Safety Incidents That Resulted In Severe Patient Harm/Death

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
2013-14	27	8	35
Data source: Hospital Incident Reporting System (HIRS) provided by the Safeguard Information System. This data is not governed by standard national definitions			

In 2013/14 there have been 0 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 was one 'Never Event' incident reported at the end of the 2013/14 year which is being investigated under the Serious Untoward Incident investigation process.

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 fedback to staff within the Divisions through training, ward meetings and the Trust wide monthly "lessons learned" newsletter. Lessons learned are also discussed at the bi-monthly Learning from Incidents and Risks Committee. All completed SUI reports are published on the Trust's Risk Management site on the intranet so that any member of staff can access and use it as a learning tool. 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 was severely harmed or died.

- Engagement of the patient and their relatives/carers is very important to the Trust not only in developing an open and honest culture, but as a healing tool. Patients and relatives are informed when a serious incident has occurred and that an investigation is to be undertaken. In some cases they are asked for their version of events and this has been reflected within the report. Following completion of the investigation report they are given the opportunity to discuss the findings and any actions taken to prevent further occurrence. A section entitled Duty of Candour has been added to the SUI report template to ensure that communication with the patient/family/carer is captured and monitored.

Reduce the Incidence of Inpatient Falls by 30% at low, minor and Serious Impact levels – Resulting in Patient 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 2013/14 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 and introduced across the trust 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.

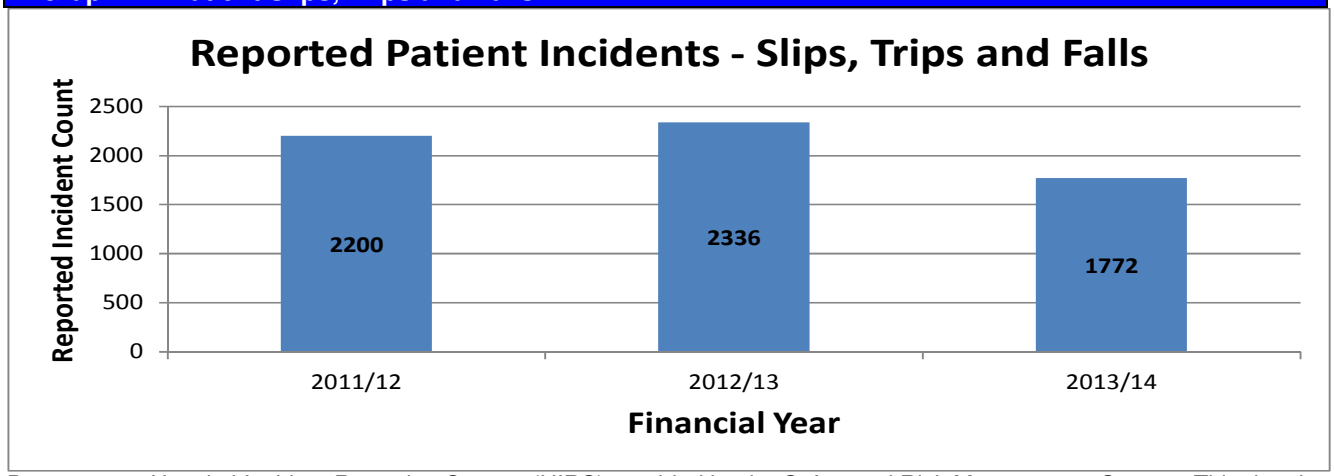
- The Trust Falls Steering Group has been re-invigorated and is now multi-disciplinary and includes voluntary agencies.
- A falls prevention workbook has been developed and rolled out across the organisation to improve education of staff this is currently being reviewed following feedback to simplify it for staff.
- Falls prevention leaflets have been developed to improve patient education.
- Ward level standards have been introduced in Scheduled Care.
- A trial of green wrist bands to identify patients at risk of fall is taking place in unscheduled care.
- Falls exercise programmes have been introduced within all localities of the community setting
- The current falls prevention policy is under review to incorporate community requirements and make it more robust
- A falls RCA template was being introduced in the New Year 2014, to support effective analysis of incidents and dissemination of lessons learned.
- Monthly falls data is now made available at trust, divisional and ward level, for interrogation and identification of trends/issues in order to implement quality improvements where required.

In 2012/13 there were 2336 falls with harm compared with 1772 in 2013/14 as demonstrated in Graph 17. This represents a reduction of 24%. However, the Trust recognises that there has been improved reporting of falls, which may account for the increase in number of incidents.

Please note that the data for the last two months of the year are unvalidated and all falls totals are liable to change.

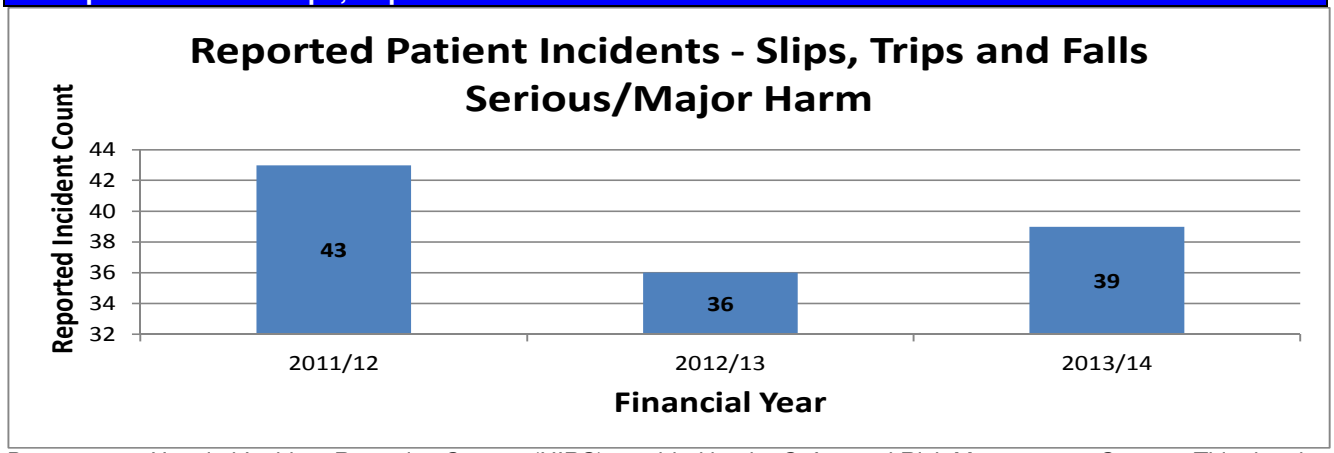
1733 falls resulted in low or minor harm being experienced by the patient and there were 39 patients who experienced a fall that resulted in a moderate/serious harm. This is an 8.3% increase on the number of patients who experienced serious harm or above in 2012/13 (36), but a 9.3% reduction on the 2011/12 figure of 43. Measures have been put into place as outlined above to ensure that the Trust will see a downward trend for patient falls in 2014/15. As seen in Graph 18.

Graph 17: Patient Slips, Trips and Falls



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

Graph 18: Patient Slips, Trips and Falls



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

Reduce the Incidence of Medication Errors by 30% 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 20. 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 19, 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.

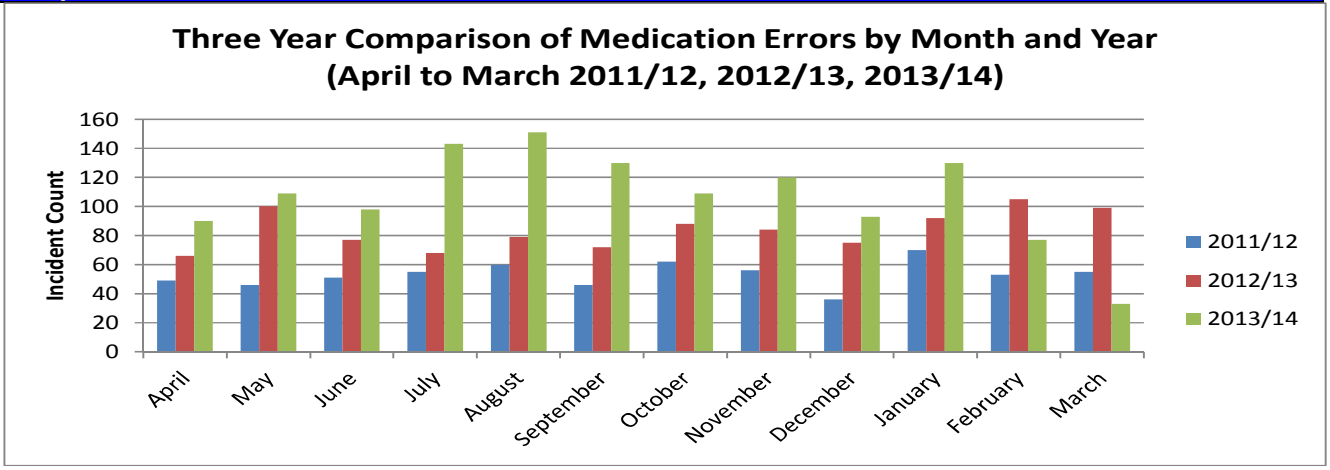
The September 2013 report published by the National Patient Safety (NPSA) is based on incidents which occurred between 1st October 2012 and 31st March 2013 and were reported to the National Reporting and Learning System (NRLS) by the 31st May 2013.

Medication incidents

A total number of 11461 incidents were reported by the Trust. 1283 were medication errors and this equates to 11.2% of all incidents. The total number of medication errors was 27.7% higher in 2013/14 than 2012/13. The number of drug administration errors with serious and above harms was 17 in 2012/13 and this fell to 7 in 2013/14, a reduction of 59%, though the number of drug administration errors with minor or less serious harms increased by 63.5% over the same period. (It should be noted that the data for February and March are yet to be validated at the time of writing and may change).

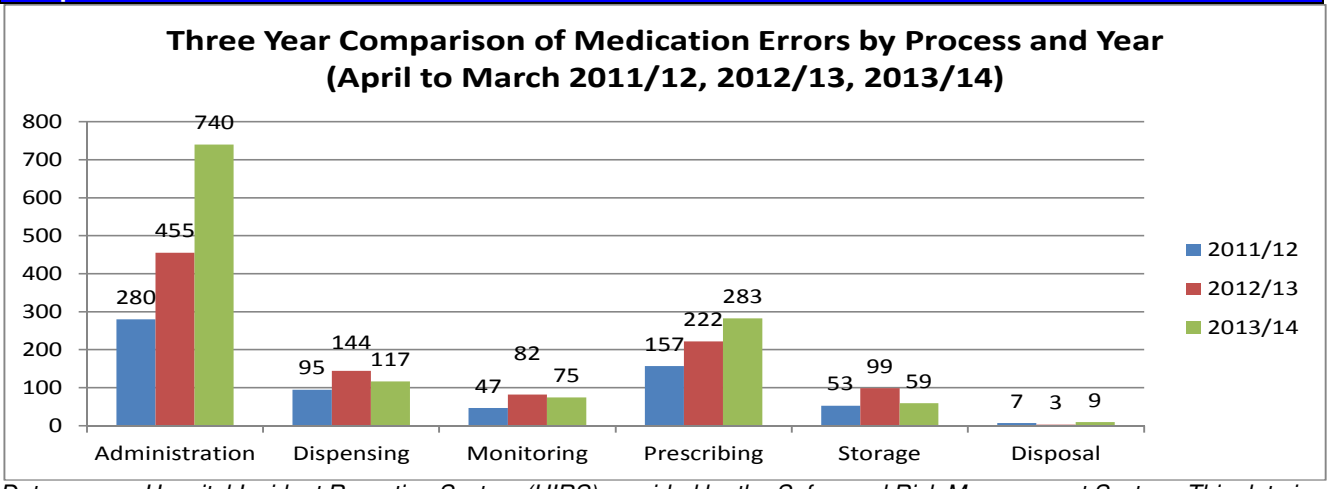
The Trust is able to report an improvement in the number of incidents reported by staff and a reduction in the level of serious patient harm. This emphasises the improvement in safety and medication awareness within clinical areas.

Graph 19 Medication Errors



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

Graph 20: Medication Errors



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

Reduce the Incidence of New Hospital Pressure Ulcers stage 2 by 30%, stage 3 by 40% and stage 4 by 100%.

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 2013/14. 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 21.

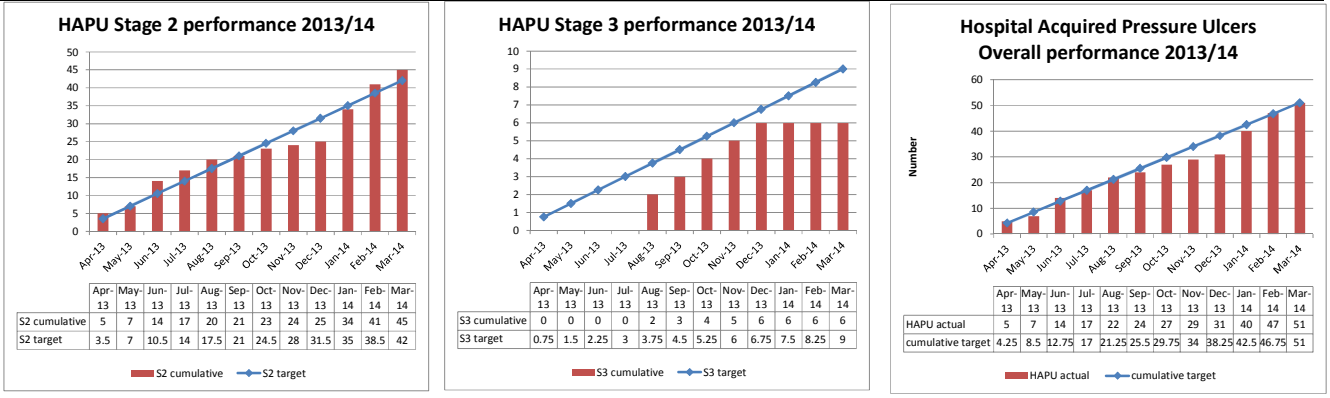
The above strand of work is being monitored to enable the Trust to measure progress in reducing avoidable patient harms and to improve patient outcomes and experiences.

Work will continue to ensure that changes are embedded into practice and the improvements in performance are sustained. During 2013, 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 84.34%. The last 12 months since April 2013 have seen a 32.89% reduction in the number of hospital acquired pressure ulcers.

Although the number of Stage 2 hospital acquired pressure ulcers slightly exceeded trajectory (45 reported against a trajectory of 42), the number of Stage 3 hospital acquired pressure ulcers was lower than trajectory (6 reported against a trajectory of 9) and there were zero Stage 4 hospital acquired pressure ulcers; hence overall the Trust met the overall target for its reduction in hospital acquired pressure ulcers.

Graph 21



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
S2 cumulative	5	7	14	17	20	21	23	24	25	34	41	45
S2 target	3.5	7	10.5	14	17.5	21	24.5	28	31.5	35	38.5	42

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
S3 cumulative	0	0	0	0	2	3	4	5	6	6	6	6
S3 target	0.75	1.5	2.25	3	3.75	4.5	5.25	6	6.75	7.5	8.25	9

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
HAPU actual	5	7	14	17	22	24	27	29	31	40	47	51
cumulative target	4.25	8.5	12.75	17	21.25	25.5	29.75	34	38.25	42.5	46.75	51

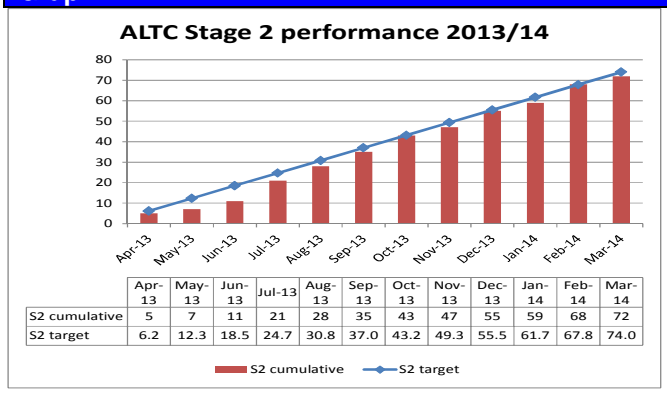
Data source: Ward-based prevalence audit. This data is governed by standard national definitions.

Reduce stage 2, 3 and 4 Community Pressure Ulcers by 10%

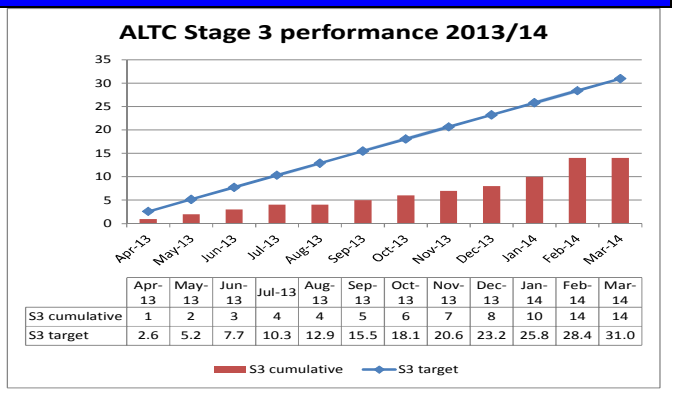
Target - Reduce stage 2, 3 and 4 pressure ulcers acquired whilst the patient is under the care of the community services Ulcers by 10%

In the Adult and Long Term (ALTC) community setting the aim was to reduce the number of new pressure ulcers by 10% across all Stages of pressure ulcers. Although the number of Stage 4 pressure ulcers slightly exceeded trajectory (10 reported against a trajectory of 9), the number of Stage 3 ulcers was much lower than trajectory (14 reported against a trajectory of 31) and the number of Stage 2 ulcers was below trajectory (72 reported against a trajectory of 74); This means that since April 2013, the trust has seen a reduction of 26.67% in pressure ulcers acquired whilst the patient was under the care of the community services, hence overall the Trust met the overall target for its reduction in new pressure ulcers in the community setting.
In addition, 93% of community based staff completed Pressure Ulcer Prevention training workbooks.

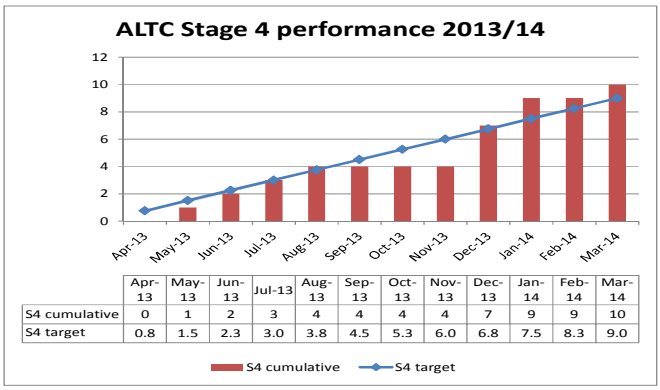
Graph 22



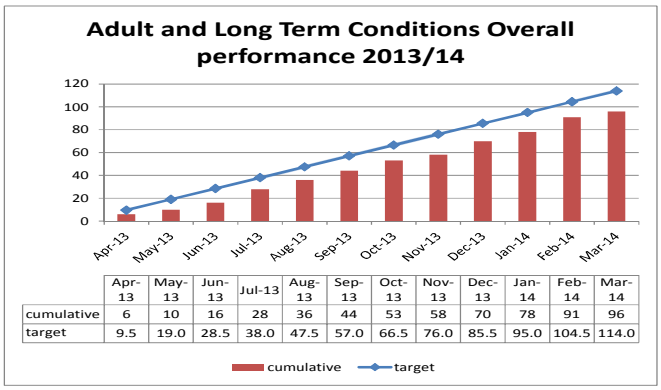
	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
S2 cumulative	5	7	11	21	28	35	43	47	55	59	68	72
S2 target	6.2	12.3	18.5	24.7	30.8	37.0	43.2	49.3	55.5	61.7	67.8	74.0



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
S3 cumulative	1	2	3	4	4	5	6	7	8	10	14	14
S3 target	2.6	5.2	7.7	10.3	12.9	15.5	18.1	20.6	23.2	25.8	28.4	31.0



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
S4 cumulative	0	1	2	3	4	4	4	4	7	9	9	10
S4 target	0.8	1.5	2.3	3.0	3.8	4.5	5.3	6.0	6.8	7.5	8.3	9.0



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
cumulative	6	10	16	28	36	44	53	58	70	78	91	96
target	9.5	19.0	28.5	38.0	47.5	57.0	66.5	76.0	85.5	95.0	104.5	114.0

To Introduce the Think Glucose Programme

Plans to take up the 'Think Glucose' campaign is underway. It is a new project that is soon to be launched, which will highlight the needs and care for patients with diabetes. The aim of the “Think Glucose” project is to improve patient care by promoting proactive care for patients who have diabetes as a secondary diagnosis. The project will also introduce a new referral system, as well as a rolling education programme and there will be a link nurse in place on each ward. This will improve staff knowledge on diabetes, reducing insulin errors and providing a better patient experience.

The project is due to be piloted on Wards 11 and 18 over the next month, and further information will be available on the intranet in due course; details of which are still are still being finalised. Last week, the “Think Glucose” Clinical Nurse Specialist lead commenced the pre-audits on how diabetes is being managed on the wards and is ongoing with this. Both pre and post audits are undertaken to monitor the impact the project has. Staff will then be educated on diabetes management over a series of weeks and another audit will be performed post training to measure the level of improvement that has been made.

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 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

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.

Part 4:Appendices

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 must be included (Mandated) – 22.05.14

Re: Blackpool Teaching Hospitals NHS Foundation Trust Quality Account for 2013/14

Add statement verbatim

1.2 Fylde and Wyre Clinical Commissioning Group - must be included (Mandated)

Re: Blackpool Teaching Hospitals NHS Foundation Trust Quality Account for 2013/14

ADD TEXT

1.2 Statement from Governors – 12-05-2014

1.3 Statement from Local Healthwatch Blackpool - 12-05-2014

A comprehensive document detailing the many quality issues being addressed by the Trust both mandatory and in-house.

However, the sheer volume of the issues being addressed makes the Quality Account a not very user- friendly publication and in its present form it is not ideal for distribution to the general public as a whole. Its use of technical and medical terms would make it difficult to interpret by many. Couple this with the fact that the visually impaired would require the QA to be available in an alternative format as would certain ethnic minorities who do not have English as a first language. A separate publication, perhaps a 6 fold document, highlighting the salient points for public consumption could be produced and made available in patient/public areas, such as GP surgeries and libraries.

The Trust's comprehensive Clinical Audit and Research programmes ensure that BTHFT participates in identifying improvements in treatments and care in the National picture, and it is good to see that the Trust complies with the CQC and CQUIN standards.

However, it is concerning that the Trust has fallen behind plan (Red-lighted) in two important points in its Priority 1, namely medical and Nursing care indicators used to assess and measure standards of clinical care and patient experience, which should be at the fore-front of any Quality Account.

We would like to see more evidence of the use of the Family and Friends Test in future Quality Accounts.

1.4 Statement from Local Healthwatch Lancashire - 14-05-2014

1.5 Statement from Lancashire Health Overview and Scrutiny Committee - 14-05-2014

The Committee notes the progress that the Trust has made over the past 12 months and looks forward to effective engagement around their plans for 2014/15.

The Trust states that it *'will continue to listen to patients, staff, stakeholders, partners and Foundation Trust members'* and the Committee will maintain an oversight of how the Trust will evidence this and takes on board the views provided in the shaping of their priorities for the future.

1.6 Statement from Blackpool Health Overview and Scrutiny Committee - 13-05-2013

"The Health Scrutiny Committee would like to thank Blackpool Teaching Hospitals NHS Foundation Trust for the opportunity to view and comment on the Trust's 2013/14 Quality Account. The Committee is satisfied with the level of engagement and information it has received from the Trust throughout the year and is pleased with the way that the Trust has dealt with queries, requests for information and attendance at Committee meetings. In relation to the Account document, the Committee expressed the view that from the perspective of the general public, it was a lengthy document and could be difficult to interpret. It would therefore be in favour of the production of a document that summarised the main content and findings of the Account.
The Committee looks forward to working with the Trust during the coming year, particularly in the areas of scrutinising quality, safety and patient care".

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 incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support 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 the Quality Report is not inconsistent with internal and external sources of information including:

  - Board minutes and papers for the period April 2013 – April 2014 May and June 2014 are not yet available;
  - Papers relating to Quality reported to the Board over the period April 2013 to June 2014;
  - Feedback from the commissioners - Blackpool Clinical Commissioning Group and Fylde and Wyre Clinical Commissioning Group – dated xx/05/2014;
  - Feedback from Governors dated 12/05/2014, and xxxxxx;
  - Feedback from Local Healthwatch organisations - Local Healthwatch Lancashire dated xx/04/2014;
  - Feeback from Local Healthwatch organisations – Local Healthwatch Blackpool dated 12.05.2014
  - Feedback from the Blackpool Council's Health Scrutiny Committee dated 13.05.2014
  - The Trusts Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xx/04/2014;
  - The latest 2013 national patient survey published February 2013;
  - The latest 2013 national staff survey published February 2014;
  - The Head of Internal Audits annual opinion over the Trust's control environment approved 30/04/2014;
  - Care Quality Commission quality and risk profiles dated 31.05.2013, 30.06.2013 and 31.07.2013;
  - The CQC Intelligent Monitoring Report dated 21.10.2013, 13.03.2014.

- 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: 22nd May 2014

Chairman:
Ian Johnson

Date: 22nd May 2014

Chief Executive:
Gary Doherty

Annex C: Glossary of Abbreviations And Glossary Of Terms

Table 35 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)
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 36: 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

Table 36: Glossary of Terms	
Abbreviation	**Glossary of meaning**
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.
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.

Table 36 Glossary of Terms

Abbreviation	Glossary of meaning
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
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	Location of the latest published data can be accessed from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_131539

Thrombo-Embolism	
Clostridium. Difficile Target	Number of patients identified with positive culture for C. Difficile

Table 36: Glossary of Terms	
Abbreviation	**Glossary of meaning**
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
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 b y a consultation (see http://www.dh.gov.uk/prod-consum-dh/groups/dh-digitalassets/documents/digitalassset/dh-103431.pdf); • The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait); • The clock start date is defined as the date the referral is received by the Trust; and • The clock stop date is defined as the date of first definitive cancer treatment as defined in the NHS Dataset Change Notice (A copy of this can be accessed at: http://www.ish.nhs.u/documents/dscn/dscn2008/dataset/202008.pdf. In summary this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.
Rate of patient safety incidents and percentage resulting in severe harm or death	Location of the latest published data can be accessed from: http://www.nrls.npsa.nhs.uk/resources/?entryid45=132789

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Board of Directors Meeting

21st May 2014

Governance Review

Summary

1. This paper updates the Board on progress on the Governance Review taking place as a consequence of the recommendations of the KPMG internal audit report and the decision of the Board in 2013 to review the new Board and committee structure a year after commencing its implementation. It provides assurance that the KPMG recommendations have been adopted and proposes revised terms of reference for committees for Board approval, thereby completing this first phase of the review. The next phase will involve each committee ensuring that all its terms of reference are being met and that it has a sub-committee structure and scheme of delegation which will enable it to deliver its responsibilities. The paper recommends that the Board should agree a list of actions required during 2014/15 and a timetable for their completion in order to complete phase 2 of the review.

Background

2. At its meeting on 28 January 2014, the Audit Committee received the KPMG internal audit report on governance, which had welcomed the new structure but made some recommendations for minor changes. The Audit Committee forwarded comments to the Board meeting on 29 January in which it advised that the Board should incorporate the KPMG recommendations in its planned review of governance at the end of the first year of its new Board and Committee structure. The Board accepted this advice and resolved to ask Alan Roff to work with Wendy Swift and David Holden to make recommendations to a future Board meeting. A verbal update was given at the February Board which included an undertaking to provide a written update to the SAC meeting on 26 March. The update advised that each committee would be consulted on terms of reference before the first phase of the review could be completed. That consultation has now taken place and feedback has been obtained from SAC, Audit Committee, Finance Committee and Quality Committee. It is now therefore possible to make proposals to the Board to enable it to complete the first phase of the review.

Process

3. The following process has been followed:-

3.1 Wendy, David and Alan have met on two occasions to discuss the review. David and Alan met with the chairman. David has also met with Judith Oates and with the internal auditors. It was agreed to conduct the review in two phases. The first would involve taking account of the experience of operating the new committee structure and the KPMG report to determine and obtain Board approval for any changes to the terms of reference of the committees reporting directly to the Board. The second would involve each committee determining an appropriate sub-committee structure, establishing an appropriate scheme of delegation and taking whatever actions would be necessary to ensure that it complied with its terms of reference.

3.2 The terms of reference of the Board and its directly reporting committees were amended to take account of the KPMG recommendations and sent to the chairs of SAC, Audit Committee, Finance Committee and Quality Committee for consultation. Each chair decided to include the terms of reference on the agenda of the committee and accordingly discussion took place at meetings on 26 March, 29 April, 27 April and 24 April respectively.

3.3 As a result of the feedback from these discussions, the group met again to review the terms of reference and made further revisions. The resultant full set of proposed Terms of Reference is attached as Appendix 1 with any proposed amendments in red. Appendix 2 comprises the list of recommendations from KPMG with updated management statements as to how these recommendations will be/have been implemented.

3.4 Alan Roff addressed the Council of Governors on governance issues on 17 March and set out the changes which had been made to the procedures of the Board and its committees since the review in 2012/13. The Council welcomed the changes and formally endorsed the decision to have 8 public board meetings per year. It resolved to reschedule (some of) its meetings to take place on the afternoon of Board meeting so that it could challenge the Board Chairman and NEDs (representing Chairs of Quality and Finance Committees) on their actions/challenges to the CEO and EDs. This would also enable Governors to meet informally with Board members over lunch. We have included a statement in the terms of reference of the Board which states the responsibility of the Council of Governors to hold the Board to account and spells out the way in which this might be achieved. It would be good practice to ask the Council of Governors to endorse this statement.

3.5 The group has not addressed the terms of reference of the Council of Governors and its committee. Nor has it addressed the Corporate Trustee and its committees. The group was also aware that other pieces of Governance work that are already scheduled for the remainder of 2014/15 will be undertaken in the next 6 to 12 months, namely; reviewing the Trust Constitution and Standing Orders/SFIs. It has therefore not sought to make any recommendations on these documents.

Discussion of Proposed Amendments

4. Major changes to the structure and processes of the Board and its committees were made in 2013. Whilst this review proposes some amendments and clarifications in the light of experience in the first 12 months of operation and in order to improve consistency, it continues to support the 2013 structure and principles and does not propose any significant alteration to these. The report from KPMG likewise endorsed the 2013 changes and, whilst also recommending minor changes, made no recommendation for significant changes thereto. So, no changes to the basic structure agreed last year are proposed. The Board will meet 8 times a year and will continue to have a Quality Committee and a Finance Committee (to reflect its two primary responsibilities) reporting to it. It will retain a third non-statutory committee - the Strategy and Assurance Committee (meeting 4 times a year and with terms of reference clarifying its role). It will also retain the 2 directly reporting statutory committees – Audit and Remuneration – giving it a total of 5 directly reporting committees. All other committees (including the Risk Committee) will report to the Board through one of these 5 committees of the Board or through the Chief Executive.

5. The proposed changes to terms of reference can be seen in appendix 1 but are summarised in the sections 6 – 14 which summarise proposals for general changes, changes for the Board, changes introduced for all committees which report directly to the Board and for each directly reporting committee in turn.

6. The only general change proposed relates to the expected **attendance of members** of the Board and each of its subcommittees. This currently varies between committees and tends to be stated both in terms of a percentage and in terms of actual numbers of meetings. We are proposing that this should be changed to a general requirement for each member (of the Board or one of its directly reporting committees) to attend 75% of the meetings (of the Board or specific committee).

7. The Review group noted that the terms chair, chairman and chairperson are all used in the Trust and in the documents in the appendices to this paper. Many organisations have adopted a general practice of avoiding **gender specific terminology**. If the Trust Board wishes to follow that practice by removing gender specific terminology whenever a document is reviewed, it would be appropriate for this to be completed for this review.

8. With respect to the terms of reference of the **Board**, a number of minor changes have been proposed (and can be seen in red in appendix 1.1) including adding in statements concerning the role of NEDs, EDs and the SID (amended after discussion at SAC to include reference to appraisals and to make clear that this role will not normally be held by the Deputy Chairman). It is also proposed that, for ease of reference, we import from the Trust Constitution clauses describing quorum and voting. In the light of the decision to seek to appoint an additional NED, the group has produced an amended version of the terms of reference for the Board (the 7 NED version at Appendix 1.7), which removes the need for one of the EDs to be a non-voting member. (Similar 7 NED versions have been prepared for each of the committees requiring this as noted below).

9. There are two issues requiring Board decision with respect to committees as a whole. Both relate to the allocation of NEDs to committees reporting directly to the Board.

Firstly, the Board decided last year that no NED should be a member of both Finance Committee and Audit Committee. This is generally the practice in the corporate sector and has been adopted by most major companies. This does not appear to be replicated in the NHS. The argument for such separation is that it gives the Audit Committee independence when recommending the annual accounts to the Board and when carrying out its lead responsibility for safeguarding assets and ensuring value for money. This was the reason why the Board resolved to have this separation. The argument against is that this may unduly restrict our ability to allocate NEDs to committees. Finance Committee has proposed that the restriction be dropped. This however is a matter for Board decision and is not currently included in appendix 1. Whatever the Board decides, NEDs would be free to attend any committee meeting as an observer as at present.

Secondly, the Board needs to determine how a NED, who cannot attend a meeting of a committee of which s/he is a member, can select a NED to replace him/her. At present, this is left open to the individual NED but the group believes it would be more effective if, for each committee, we have a named NED alternate who is asked to act as substitute whichever NED is unavoidably absent. This would both give more continuity and would facilitate the smooth changeover when NEDs are rotated between committees. This change has not been included in appendix 1 but can be added if the Board requires this.

10. There are several minor modifications proposed to the terms of reference (Appendix 1.2) for the **Strategy and Assurance Committee** (SAC). These place more emphasis on the role of SAC in strategy development for the Trust (whilst retaining strategy approval at Board level) and less on assurance from the CEO, thereby providing more significant differences between Board and SAC meetings. The proposed changes are included in red in Appendix 1. It is envisaged that SAC will receive preliminary strategy papers from the CEO and EDs so that discussion can take place at an early stage prior to strategy proposals being submitted to the Board for approval. It might also receive and debate similar papers on the effectiveness of implementation of current strategy which could again feed into papers for Board approval. In line with the plan to reduce the emphasis on assurance, it is envisaged that the assurance report from the CEO to SAC would focus solely on any specific issue regarding urgent attention rather than looking more broadly across all issues in the way that the CEO presents his report to the Board. In this way, SAC will continue to be delegated to take action on behalf of the Board in between Board meetings but only on matters requiring urgent attention, thereby creating more space for discussion of strategy. A 7 NED version of the SAC terms of reference is included at Appendix 1.8

11. There are very few changes proposed to the terms of reference (Appendix 1.3) of the **Audit Committee**. In line with the recommendations of KPMG, it is proposed that the committee's lead responsibility for safeguarding the assets of the Trust and for value for money should be clearly stated. Likewise the responsibility for providing assurance to the Board will be more explicitly identified if the proposed changes are approved by the Board. See appendix 1 for fuller details in red.

12. There are more changes proposed for the terms of reference (Appendix 1.4) of the **Finance Committee**. Firstly, the committee has asked for delegated responsibility on some items on which its powers are currently limited to making recommendations to the Board. The review group supports this request for further delegated authority provided that actions taken under this new authority are reported to the Board in the committee's assurance report. Secondly, the review group supports the committee's request to revise the sections of its terms of reference with respect to attendance by Divisional teams and by the Director of Workforce & OD. It is also proposed that a representative of the Council of Governors should be invited to attend the Finance Committee. Thirdly, we have removed the stipulation that the Trust Chairman should be the NED who chairs the committee so that it will be possible for another NED to chair the committee without having to change the terms of reference. These and other minor changes are included in Appendix 1 in red.

13. There are some changes proposed for the terms of reference (Appendix 1.5) of the **Quality Committee**. Firstly, it is proposed that the Director of Workforce & OD should be a member of the committee and that a representative of the Council of Governors should be invited to attend. Secondly, there are also proposals for the committee to meet bi-monthly and for some clarification of the detailed list of reporting subcommittees and the duties of the committee, all of which are recommended for approval and are included in Appendix 1.5 in red. As with the Board, we have also produced a 7 NED version of the terms of reference (Appendix 1.9) so that we can expand the number of NEDs on the committee to 3, thereby matching the NED membership of Finance and Audit Committees.

14. Remuneration Committee endorsed a recommendation from the Director of Workforce and OD in January 2014 to change the terms of reference of the **Remuneration Committee** to comply with national guidelines concerning approval of settlement packages. This does not appear to have had formal approval by the Board and so has been included in Appendix 1.6 in red. We have also prepared a 7 NED version at Appendix 1.10.

RECOMMENDATIONS WITH RESPECT TO TERMS OF REFERENCE

15 It is recommended by the Review group that the Board should:-

15.1 DETERMINE its policy on:-

- **Gender specific terminology (para 7)**
- **NED membership of Finance and Audit Committees (para 9);and**
- **NED substitutes (para 9);**

15.2 APPROVE the changes to terms of reference of the Board and its directly reporting committees included in appendix 1.1 to 1.6 subject to any alterations which may be required as a result of its decisions on 15.1;

15.3 note the ASSURANCE given in appendix 2 with respect to compliance with the recommendations of KPMG;

15.4 APPROVE the changes to the terms of reference for the Board, SAC, Quality Committee and Remuneration Committee to be implemented if and when an additional NED joins the Board; AND

15.5 ask the Council of Governors to note the revised terms of reference for the Board and to endorse the statement therein concerning the Council of Governors.

FURTHER ACTIONS REQUIRED IN 2014/15 TO COMPLETE THE REVIEW

16. If the Board accepts the recommendations in 15 above, this will complete the 'end of year 1' review in a way that incorporates the KPMG recommendations. However, it should be recognised that the Board and its committees have **not** been operating in 2013/14 in full compliance with their terms of reference. In particular, not all committees are yet receiving the assurance reports they require from EDs and/or are providing the required assurance reports to the Board. In addition, there remains work to be done by each committee to consider how/if to revise the structure and terms of reference of subcommittees which report to it. Likewise, there are also outstanding items relating to schemes of delegation for each committee. Whilst it is understandable that, given the pressures on the Trust in 2013/14 and the necessity to acquire experience in operating the new structures, not all aspects of the new structures could be completed in 2013/14, it is imperative that this should be rectified in 2014/15 so that the Board and its committees are fully compliant with their own terms of reference and the Trust can therefore demonstrate the highest standards of Governance. If the Board is to demonstrate at the end of 2014/15 that committees are operating in compliance with terms of reference relating to assurance reports, subcommittees and schemes of delegation, it will be necessary for each directly reporting committee to complete their work on these matters by the end of 2014. It should be noted that the process of revising the committees reporting to Quality Committee (and associated schemes of delegation) is a substantial undertaking.

RECOMMENDATIONS for 2014/15

17 It is recommended that the Board should ask chairs of its directly reporting committees to provide written assurance reports to the Board with immediate effect.

18. It is recommended that the Board should require that, not later than 31 December 2014, each directly reporting committee should:-

18.1 make recommendations to the Board with respect to reporting subcommittees and schemes of delegation;

18.2 provide assurance that it has processes in place to receive appropriate assurance reports from EDs and these subcommittees.

Alan Roff
Wendy Swift

14 May 2014

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS
TERMS OF REFERENCE

TERMS OF REFERENCE

The terms of reference describe the role and working of the Board and are for the guidance of the Board, for the information of the Trust as a whole and serve as the basis of the terms of reference for the Board's own committees.

ROLE AND PURPOSE

The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.'

The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a committee of directors or to the Chief Executive. The Board consists of Executive Directors, one of whom is the Chief Executive, and Non-Executive Directors, one of whom is the Trust Chairman. The nominated deputy for the Chief Executive and Chairman, upon appointment to a substantive or acting up role, must be formally recorded in the minutes.

MEMBERSHIP

Trust Chairman (Chairperson)
6 Non-Executive Directors
Chief Executive
Director of Strategy/Deputy Chief Executive (non voting member)
Director of Finance
Medical Director
Director of Nursing and Quality
Director of Workforce & Organisational Development
Director of Operations
~~Director of Clinical Support and Facilities Management~~
~~Managing Director for Community Development and Transformation~~

Other members of the Trust may be invited to attend meetings (or for individual agenda items) as and when required. The meetings will be held in public subject to rules laid down by the Trust Board.

The Board leads the Trust by undertaking three key roles:-

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
- Shaping a positive culture for the Board and the organisation.

The general duty of the Board of Directors and of each director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

The Council of Governors is responsible for holding the Board to account, for example by attending and observing committees of the Board, attending Board meetings in public and meeting with the Chairman, Chief Executive and Committee Chairs on the day of Board meetings/Council of Governors' meetings.

The detailed practice and procedure of the meetings of the Board, and of its committees, are not set out here but are described in the Board's Standing Orders.

GENERAL RESPONSIBILITIES

The general responsibilities of the Board are:-

- To work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, accessible, effective and well governed services for patients and carers;
- To ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity; and
- To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

In fulfilling its duties, the Board will work in a way that makes the best use of the skills of Non-Executive and Executive Directors.

LEADERSHIP

The Board provides active leadership to the organisation by:-

- Ensuring there is a clear vision and strategy for patient care for the Trust that people know about and that this is being implemented within a framework of prudent and effective controls which enable risk to be assessed and managed.
- Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

STRATEGY

The Board:

- Sets and maintains the Trust's strategic vision, aims and objectives, ensuring the necessary financial, physical and human resources are in place for it to meet its objectives.
- Monitors and reviews management performance to ensure the Trust's objectives are met.
- Oversees both the delivery of services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required.
- Develops and maintains an annual business plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.
- Ensures that national policies and strategies are effectively addressed and implemented within the Trust.

CULTURE

The Board:

- Is r~~R~~esponsible for setting values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values.

GOVERNANCE

The Board:

- Ensures that the Trust has comprehensive governance arrangements in place that guarantee the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements.
- Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences.
- Ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to Foundation Trusts.
- Formulates, implements and reviews Standing Orders and Standing Financial Instructions as a means of regulating the conduct and transactions of Foundation Trust business.
- Ensures the proper management of, and compliance with, Monitor's Provider Licence, the Health & Social Care Act 2012 and other statutory and regulatory requirements of the Board.
- Ensures that the statutory duties of the Trust are effectively discharged.
- Acts as corporate trustee for the Trust's charitable funds.

- Establishes appeals panels as required by employment policies particularly to address appeals against dismissal and final stage grievance hearings.

RISK MANAGEMENT
The Board:
- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities.Ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services.
- Ensures there are appropriately constituted appointment arrangements for senior positions such as Consultant Medical Staff and Executive Directors.

ETHICS AND INTEGRITY
The Board:
- Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Foundation Trust business.
- Ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time.

COMMITTEES
The Board is responsible for maintaining committees of the Trust Board with delegated powers as prescribed by the Trust's Standing Orders and/or by the Board from time to time:

In general, the Board will delegate to committees the power to oversee the development (by the Chief Executive and Executive Directors) of strategy and policy; and the monitoring of the delivery of strategy and policy in the areas for which the committee is responsible. It will, however, require each committee to submit key strategies, policies and other specified items to the Board for approval and to provide assurance to the Board (through its Chairperson) that such strategies and policies are being successfully implemented, advising the Board of any areas where this is not occurring and drawing key issues to the Board's attention. More details of delegated powers and matters requiring Board approval are included in the sections which follow on each committee.

At the last meeting of each financial year, the Board will review the powers it has delegated to each committee and will make any changes it deems necessary to take effect in the next financial year. Every four years, it will set up a sub-group of the Board to draw evidence from Board members, committees and internal auditors so that it can thoroughly review the powers of delegation and make recommendations to the Board for any amendments deemed necessary.

Each committee will be responsible for developing clear powers of delegation to the Chief Executive and Executive Directors of matters which fall within the remit of the committee. These must be submitted to the Board for approval so that the Board is clearly apprised of matters which the committee has so delegated. The committee will be expected to review its powers of delegation at its last meeting of each financial year so that it can make recommendations to the Board concerning delegation for the following financial year. These powers will be thoroughly reviewed as part of the four yearly review set out in the previous paragraph.

COMMUNICATION
The Board:
- Ensures an effective communication channel exists between the Trust, its governors, members, staff and the local community.
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback.
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publically through Public Board meetings and also via the Trust's website.
- Publishes an Annual Report and Annual Accounts.

FINANCIAL AND QUALITY SUCCESS
The Board:

- Ensures that an effective system of finance and quality is embedded within the Trust.
- Ensures that the Trust operates effectively, efficiently and economically.
- Ensures the continuing financial viability of the organisation.
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved.
- Ensures that the Trust achieves the quality targets and requirements of stakeholders within the available resources.
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

ROLE OF THE TRUST CHAIRMAN

The Chairman is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.

The Trust Chairman reports to the Board of Directors and is responsible for the effective running of the Board and the Council of Governors.

The Trust Chairman is responsible for ensuring that the Board as a whole pays a full part in the development and determination of the Trust's strategy and overall objectives.

The Trust Chairman is the guardian of the Board's decision-making processes and provides general leadership of the Board and the Council of Governors.

RESPONSIBILITIES OF BOARD MEMBERS

All Members of the Board of Directors:

- have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the Chief Executive as the accounting officer.

- have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

The role of Executive Directors (EDs) is to:

- share collective responsibility with the Non-Executive Directors as part of a unified Board.
- shape and deliver the strategy and operational performance in line with the Trust's strategic aims.

The role of Non Executive Directors (NEDs) is to:

- bring a range of varied perspectives and experiences to strategy development and decision-making.
- ensure effective management arrangements and an effective management team are in place.
- hold the executive to account for performance of the operational responsibilities
- scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. NEDs should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.

ROLE OF THE SENIOR INDEPENDENT DIRECTOR (SID)

The Senior Independent Director (SID) is a Non-Executive Director appointed by the Board of Directors as a whole in consultation with the Council of Governors to undertake the role. Normally the SID will not be the Deputy Chair of the Board of Directors although this may be case if the Board deems it necessary.

The SID will be available to members of the Foundation Trust and to Governors if they have concerns which, contact through the usual channels of the Chairman, Chief Executive, Finance Director and ~~Company~~ Foundation Trust Secretary, has failed to resolve or where it would be inappropriate to use such channels.

The SID also has a key role in supporting the Chairman in leading the Board of Directors and acting as a sounding board and source of advice for the Chairman. The SID also has a role in supporting the Chairman as Chairperson of the Council of Governors. The SID will conduct the annual appraisal of the Chairman and will be appraised by the Deputy Chairman.

In addition to the duties described here, the SID has the same duties as the other Non-Executive Directors.

ROLE OF THE CHIEF EXECUTIVE

The Chief Executive (CEO) reports to the Trust Chairman and to the Board directly. All members of the management structure report either directly or indirectly to the CEO.

The CEO is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.

The CEO is responsible for implementing the decisions of the Board and its committees, providing information and support to the Board and Council of Governors.

FREQUENCY OF ATTENDANCE BY MEMBERS

The Board requires a minimum attendance of 75% of meetings per annum by the individual committee member unless he/she has been given specific leave of absence as agreed by the Board.

QUORUM AND VOTING

Four Directors including not less than two Executive Directors (one of whom must be the Chief Executive or the Deputy Chief Executive) and not less than two Non-Executive Directors (one of whom must be the Chairman or the Deputy Chairman of the Board of Directors) shall form a quorum.

The Board of Directors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

The Chairman of the Foundation Trust or, in his/her absence, the Deputy Chairman of the Board of Directors, is to chair meetings of the Board of Directors.

Subject to the following provisions of this paragraph, questions arising at a meeting of the Board of Directors shall be decided by a majority of votes.

- In case of an equality of votes the Chairman shall have a second and casting vote.

- No resolution of the Board of Directors shall be passed if it is opposed by all of the Non-Executive Directors present or by all of the Executive Directors present.

OTHER MATTERS

The Board shall be supported administratively by the Trust Secretary whose duties in this respect will include:

- Agreement of agenda for Board and Board Committee Meetings with the Trust Chairman and Chief Executive.
- Collation of reports and papers for Board Meetings.
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward.
- Advising the Board on governance matters.

A full set of papers comprising the agenda, minutes and associated reports will be sent within the timescale set out in Standing Orders to all directors and others as agreed with the Trust Chairman and Chief Executive from time to time.

The Board shall self assess its performance at least annually.

The terms of reference for the Board will be reviewed at least annually.

DETAILS OF NOMINATED NAMED DEPUTIES

Membership	Nominated Named Deputies
Trust Chairman (Chairperson)	Deputy Chairman (Chairperson)
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Chief Executive	Deputy Chief Executive
Director of Finance	Deputy Director of Finance
Medical Director	Deputy Medical Director
Director of Nursing and Quality	Deputy Director of Nursing ~~Corporate Affairs and Governance~~
Director of ~~HR~~ Workforce & OD	Deputy Director of Workforce & OD
Director of Operations	Deputy Director of Operations
~~Director of Clinical Support and Facilities Management (non-voting member)~~	~~Deputy Director of Clinical Support and Facilities Management~~
Director of Strategy/Deputy Chief Executive ~~Managing Director for Community Development and Transformation (non-voting member)~~	Deputy Director of Strategy ~~As designated by the Managing Director for Community Development and Transformation~~

Approved by the Board on: ~~31st July 2013~~ 21 May 2014

To be reviewed no later than: ~~30th July 2014~~ 31 May 2015

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

STRATEGY AND ASSURANCE COMMITTEE
TERMS OF REFERENCE

MAIN AUTHORITY / LIMITATIONS

The Board hereby resolves to establish a committee of the Trust to be known as the Strategy and Assurance Committee ('the Committee'). The Strategy and Assurance Committee is a committee of the Board of Directors and is authorised by the Board to investigate any activities within the scope of its Terms of Reference and obtain any information required from relevant parties to facilitate its understanding of the issues.

The Board has delegated to the Strategy and Assurance Committee the power to oversee the development and implementation of strategy and policies for the management of the Trust. The Committee will also consider compliance matters by exception and any urgent business in relation to assurance, ~~and for~~ taking urgent action on behalf of the Board in between Board meetings where it would not be in the interests of the Trust to delay decisions until the next Board meeting occurs. (Such requests to the Committee for immediate action may only come from the Chairman, Chief Executive or ~~from~~ other Committees of the Board). It will, however, require the ~~c~~Committee to provide a report to each Board meeting setting out ~~the~~ any urgent actions which the Committee has taken on its behalf. The Committee is not authorised to act on behalf of the Board with respect to approving the specified items listed below. These must instead be submitted to the Board for approval,

Specified Items for recommendation by the Strategy and Assurance Committee to the Board for approval:-

- Corporate Objectives
- Trust Constitution
- Review of Board Effectiveness
- Board Committee Structure Manual and Terms of Reference
- Confirmation of Chairman's Action
- Common Seal
- Significant Transactions – Merger/Acquisition/Separation/Dissolution

The structure of the Board and its committees and the Terms of Reference for each of those committees are set out in the Board Committee Structure Manual which may be amended from time to time.

Approved minutes of the committee are circulated to the Board for information. The Committee Chairperson provides the Board with an assurance report including a summary of the committee's work at the first available opportunity after each committee meeting. The Chairperson of the committee will escalate matters to the Board as deemed appropriate.

The Trust's Standing Orders and Standing Financial Instructions apply to the operation of this committee.

MAIN PRIORITY AND OBJECTIVES

~~The main priority for the Strategy and Assurance Committee is to be responsible for taking action to enable the Board to fulfil its responsibilities for the organisation's mission, vision and strategic direction. The Committee will ensure that an effective system of governance is embedded within the Trust and that it is under constant review and improvement. It will also keep the Board informed of all actions which it takes on behalf of the Board.~~

The main priority for the Strategy and Assurance Committee is to receive and discuss preliminary papers from the CEO on existing and proposed strategy and policy in order to promote the development of effective strategy and policy for the Trust, which can be considered and approved by the Board. The Committee will also consider compliance matters by exception and any urgent business in relation to assurance.

MEMBERSHIP

The Committee will comprise the Trust Chairman, all Non-Executive Directors and all Executive Directors (including non-voting Executive Directors). The Deputy Director of ~~Corporate Affairs and Governance~~ Strategy will be invited to attend the meetings..

Trust Chairman (Chairperson)
6 Non-Executive Directors
Chief Executive
Director of Finance
Medical Director
Director of Nursing and Quality
Director of ~~Human Resources~~Workforce and Organisational Development
Director of Operations
~~Director of Clinical Support and Facilities Management~~
~~Managing Director for Community Development and Transformation~~
Director of Strategy/Deputy Chief Executive
~~Deputy Director of Corporate Affairs and Governance~~
~~Deputy Director of Strategy~~

ATTENDANCE

Other members of the Trust may be invited to attend as and when required.

DEPUTY ATTENDANCE

It is the responsibility of each executive member of the committee to nominate a deputy. However, this will be the exception rather than the rule. In the event of a deputy attending the meeting, members must ensure they have been fully briefed and are able to inform decision making.

FREQUENCY OF ATTENDANCE BY MEMBERS

The Committee requires a minimum attendance of a minimum attendance of 75% of meetings per annum by the individual committee member unless he/she has been given specific leave of absence as agreed by the Board.

QUORUM

A quorum shall consist of 6 members. Where a quorum cannot be established the Committee will continue to meet but will be unable to approve any documentation (or confirm actions).

FREQUENCY OF MEETINGS

Meetings will be held ~~eight~~ four times a year. An annual timetable will be provided with dates for agenda items to be submitted.

DUTIES

The committee will assist the Board in the following areas:

- Formulating strategy.
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
- Contributing in shaping a positive culture for the Board and the organisation.
- Setting and maintaining the Trust's strategic vision, aims and objectives, ensuring the necessary financial, physical and human resources are in place for it to meet its objectives.
- Delivering planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required.

RESPONSIBILITIES OF MEMBERS OF THE COMMITTEE
As a member of the Committee, individuals represent clinical and corporate departments and are expected to:

- Actively participate in decisions pertaining to the Strategy and Assurance Committee ensuring that solutions and action plans have multidisciplinary perspectives and have considered the impact across all of the divisions/directorates and departments.

AGENDA ITEMS
Items for the agenda should be submitted to the Secretary of the Committee a minimum of two weeks prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting. ~~The main agenda items will be presented via a brief Chief Executive's Assurance Report.~~

Members will be expected to provide reports as required at dates agreed.

A list of minutes received will be noted on the agenda and each member will receive an e-mailed copy. The Secretary to the Committee will hold a master copy on file for reference.

A list of reports, circulars and documents received will be noted on the agenda and the Secretary of the Committee will hold master copies centrally.

An Annual Review of Effectiveness of the Committee must be undertaken.

MINUTES RECEIVED
The Committee will receive minutes and exception reports from each of the following reporting Committees:-

- None

DISTRIBUTION OF MINUTES
The minutes of the Strategy and Assurance Committee meetings will be formally recorded and forwarded to:

- All members of the committee; and
- Board of Directors.

REPORTING RESPONSIBILITIES
The Chairperson of the Committee will be responsible for focusing on strategy, for providing an assurance ~~and~~ report~~ing~~ to the Board and ~~shall~~ for draw~~ing~~ to the attention of the Board any issues that require disclosure or action.

REVIEW AND EVALUATION
The membership of the group and terms of reference will be reviewed every two years or as required.

DETAILS OF NOMINATED NAMED DEPUTIES

Membership	Nominated Named Deputies
Chairman (Chairperson)	Deputy Chairman (Chairperson)
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Chief Executive	Deputy Chief Executive
Director of Finance	Deputy Director of Finance
Medical Director	Deputy Medical Director
Director of Nursing and Quality	Deputy Director of Corporate Affairs and Governance
Director of ~~HR~~ Workforce & OD	Deputy Director of ~~HR~~Workforce & OD
Director of Operations	Deputy Director of Operations
~~Director of Clinical Support and Facilities Management~~	~~Deputy Director of Clinical Support and Facilities Management~~
Director of Strategy/Deputy Chief Executive	Deputy Director of Strategy

~~Managing Director for Community Development and Transformation~~	~~As designated by the Managing Director for Community Development and Transformation~~
~~Deputy Director of Corporate Affairs and Governance~~	~~As designated by the Deputy Director of Corporate Affairs and Governance~~

Revised ~~**Approved**~~ **by the Board on:** ~~31st July 2013~~ 21 May 2014

To be reviewed no later than: ~~30th July 2014~~ 31 May 2015

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

AUDIT COMMITTTEE
TERMS OF REFERENCE

MAIN AUTHORITY/LIMITATIONS

The Board hereby resolves to establish a committee of the Board to be known as the Audit Committee ('the Committee'). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

The committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee. The committee is authorised to obtain outside legal or other independent professional advice, which shall be shared with the Board, and to secure the attendance of outsiders with relevant experience if it considers it necessary.

The committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Risk Register and Assurance Framework in the management of the Trust's significant risks; the completeness and embeddedness of risk management within the Trust, the integration of governance arrangements and the appropriateness of any self assessment declarations of compliance made by the Board.

Approved minutes of the committee are circulated to the Board for information and to those regularly in attendance. The committee Chairperson provides the Board with an assurance report including a brief summary of the committee's work at the first available Board meeting opportunity after each committee meeting. The Chairperson of the committee will escalate matters to the Board as deemed appropriate.

The Board has delegated to the Audit Committee the power to oversee the development of audit strategy and policy; and the monitoring of the delivery of audit strategy and policy. It will, however, require the committee to submit key strategies, policies and the specified items listed below to the Board for approval and to provide assurance to the Board (through its Chairperson) that such strategies and policies are being successfully implemented, advising the Board of any areas where this is not occurring and drawing key issues to the Board's attention.

Specified Items for recommendation by the Audit Committee to the Board for approval:-

- Annual Report & Annual Accounts
- Quality Accounts
- Annual Governance Statement
- Representation Letter
- Standing Orders/Standing Financial Instructions
- Scheme of Delegation

The committee will be responsible for developing clear powers of delegation to the Chief Executive and Executive Directors of matters which fall within the remit of the committee. These must be submitted to the Board for approval so that the Board is clearly apprised of matters which the committee has so delegated. The committee will be expected to review its powers of delegation at its last meeting of each calendar year so that it can make recommendations to the Board concerning delegation for the following financial year. These powers will be thoroughly reviewed as part of the four yearly review of powers of delegation which the Board will conduct.

The structure of the Board and its committees and the Terms of Reference for each of those committees are set out in the Board Committee Structure Manual which may be amended from time to time

The Trust's Standing Orders and Standing Financial Instructions apply to the operation of this committee.

MAIN PRIORITY
The priority for the committee is to monitor the integrity of the Trust's financial statements and to review the Trust's financial and non-financial controls and management systems. The committee shall take a risk based approach to the overarching scrutiny of the Trust's assurance, risk and governance structures and processes so that the Board may be provided with assurance that the corporate objectives shall be met. In particular, the committee shall commission and scrutinise assurances that the Trust has operated, and shall continue to operate, in accordance with its Terms of Authorisation and that compliance requirements of Monitor and the Care Quality Commission shall be met, thereby ensuring that the Trust's licence to operate is maintained.

MEMBERSHIP
The Committee shall be appointed by the Board and shall comprise ~~of~~ three Non-Executive Directors of the Trust (who ~~do not attend~~ are not members of the Finance Committee) with the exception of the Trust Chairman who shall not be a member of the Committee. A Non-Executive Director with relevant financial experience will be appointed Chairperson of the Committee by the Board and, in his/her absence, one of the remaining Non-Executive Directors may deputise.

Non-Executive Director (Chairperson)
2 Non-Executive Directors

ATTENDANCE
The Director of Finance and appropriate Internal and External Audit representatives shall normally attend meetings. However, at least once a year the Committee should meet privately with the External Auditors and Internal Auditors.

The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement. He or she should also attend when the Committee considers the Draft Internal Audit Plan and the Annual Report and Accounts.

All other Executive Directors should be invited to attend, when the Committee is discussing areas of risk or operation that are the responsibility of that director.

DEPUTY ATTENDANCE
Any Non-Executive Director who is not a nominated member of the Audit Committee will be asked to attend the Audit Committee in place of any Non-Executive Director who cannot attend, in order to ensure that the meeting is quorate.

FREQUENCY OF ATTENDANCE BY MEMBERS

The Committee requires a minimum attendance of 75% of meetings per annum by the individual committee member unless he/she has been given specific leave of absence as agreed by the Board.

QUORUM
A quorum shall be two members, however, every effort will be made for three members to be present. Where a quorum cannot be established the Committee will continue to meet but will be unable to approve any documentation.

FREQUENCY OF MEETINGS

Meetings shall be held not less than six times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider it necessary.

AUTHORITY
The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

DUTIES
The duties of the Committee can be categorised as follows:-

Governance, Risk Management and Internal Control
The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:-

All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission Quality and Risk Standards), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these services. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

The Committee has lead responsibility for ensuring that the Trust safeguards its assets and delivers value for money. The Committee will take action to assure itself that governance processes are in place to achieve this.

Internal Audit
The Committee shall ensure that there is an effective internal audit function established by management that meets Government Internal Audit Standards in an FT and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:-

Consideration of the provision of the Internal Audit Service, the cost of the audit and any questions of resignation and dismissal;

Reviewing and approving the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.

Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal Auditors and External Auditors to optimise audit resources.

Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.

Annual review of the effectiveness of internal audit.

External Audit
The Committee shall review the work and findings of the External Auditors, appointed by the Council of Governors, and consider the implications and management's responses to their work. This will be achieved by:-

Consideration of the appointment and performance of the External Auditors, as far as the rules governing the appointment permit and recommendations to the Council of Governors.

Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy.

Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.

Reviewing all External Audit reports including the report to those charged with governance, including agreement of the annual audit letter before submission to the Board and the Council of Governors and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions
The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc) professional bodies with responsibility for the performance of staff or functions, e.g. Royal Colleges, accreditation bodies, etc).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this will include the Quality Committee and Risk Committee.

In reviewing the work of the Quality Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Counter Fraud
The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

Management
The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit), as they may be appropriate to the overall arrangements.

Financial Reporting
The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the system for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:-

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted miss-statements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letter of representation.
- Qualitative aspects of financial reporting.
- Major judgemental areas.

RESPONSIBILITES OF MEMBERS OF THE COMMITTEE
- Actively participate in discussions pertaining to committee business ensuring that solutions and action plans have multidisciplinary perspectives and have considered the impact Trust-wide;
- Disseminate the learning and actions from the meetings.

AGENDA ITEMS
An annual timetable will be provided with dates for agenda items to be submitted. Items for the agenda should be submitted to the Secretary to the Committee a minimum of two weeks prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting. Members will be expected to provide reports as required by the agreed dates.

MINUTES RECEIVED
- Quality Committee
- Risk Committee

The Chairperson of the Audit Committee can request minutes of any other Committee meetings. Alternatively, the Chief Executive can request the Audit Committee to review any items identified in committee minutes or assurance reports received by the Board.

DISTRIBUTION OF MINUTES
The minutes of the meeting shall be formally recorded and submitted to:
- All members of the Committee; and
- Board of Directors.

REPORTING RESPONSIBILITIES
The Chairperson of the Committee will be responsible for ensuring the Committee adheres to its Annual Work Plan and Annual Measurable Objectives.

The Chairperson of the Committee will be responsible for ~~reporting~~ making an assurance report to the Board of Directors and shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the Quality Accounts.

REVIEW AND EVALUATION
The membership of the group and terms of reference will be reviewed annually or as requested.

OTHER MATTERS
This will include enabling the development and training of Committee members.

The Committee shall be supported administratively by the PA to the Finance Director, whose duties in this respect will include:-

- Agreement of the agenda with Chairperson and attendees and collation of papers.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.
- Advising the Committee on pertinent areas.

DETAILS OF NOMINATED NAMED DEPUTIES

Membership	Nominated Named Deputies
Non-Executive Director (Chairperson)	Deputy Chairperson
Non-Executive Director (Deputy Chairperson)	As designated by the Non-Executive Director
Non-Executive Director	As designated by the Non-Executive Director

Approved by the Board on: ~~31st July 2013~~ 21 May 2014

To be reviewed no later than: ~~30th July 2014~~ 31 May 2015

FINANCE COMMITTEE
TERMS OF REFERENCE

MAIN AUTHORITY / LIMITATIONS

The Board hereby resolves to establish a committee of the Trust to be known as the Finance Committee ('the committee'). The Finance Committee is a committee of the Board of Directors and is authorised by the Board to investigate any activities within the scope of its Terms of Reference and obtain any information required from relevant parties to facilitate its understanding of the issues.

The Board has delegated to the Finance Committee the power to oversee the development and delivery of the Trust's Financial Strategy and associated policies. It will, however, require the committee to submit the Financial Strategy and the specified items listed below to the Board for approval and to provide assurance to the Board (through its Chairperson) that the Financial Strategy is being successfully implemented, advising the Board of any areas where this is not occurring and drawing key issues to the Board's attention. (Where the Committee develops other major strategies or policies in order to carry out its responsibilities, it should submit these to the Board for approval only if these may have a significant impact on other aspects of the Trust's work. If not, the Committee can use its delegated powers to approve such strategies and policies but should, through its Chairperson, notify the Board that it has done so in order that the Board can be fully apprised of strategy and policies developed on its behalf).

The committee will review and approve the following under delegated authority from the Board (subject to any actions made under this delegated authority being included in the assurance report to the Board):

- Quarterly Monitoring Return to Monitor (Finance)
- Financial Contracts
- Capital Plans
- Estates Strategy Funding
- Working Capital Facility
- FT Financing Facility Loan Agreement
- Directors and Officers Liability Insurance
- Information Governance Toolkit

The committee will review and make a recommendation to the Board on the following items:

- Operational Plan and Annual Budgets
- Standing Orders/Standing Financial Instructions
- Scheme of Delegation

The committee will be responsible for developing clear powers of delegation to the Chief Executive and Executive Directors of matters which fall within the remit of the committee. These must be submitted to the Board for approval so that the Board is clearly apprised of matters which the committee has so delegated. The committee will be expected to review its powers of delegation at its last meeting of each financial year so that it can make recommendations to the Board concerning delegation for the following financial year. These powers will be thoroughly reviewed as part of the four yearly review of powers of delegation which the Board will conduct.

The structure of the Board and its committees and the Terms of Reference for each of those committees are set out in the Board Committee Structure Manual which may be amended from time to time.

Approved minutes of the committee are circulated to the Board for information. The Committee Chairperson provides the Board with an assurance report including a brief summary of the committee's work at the first available opportunity after each committee meeting. The Chairperson of the committee will escalate matters to the Board as deemed appropriate.

The Trust's Standing Orders and Standing Financial Instructions apply to the operation of this committee.

MAIN PRIORITY AND OBJECTIVES

The main priority for the Finance Committee is to be responsible for ensuring that an effective system of financial governance is embedded within the Trust and that it is under constant review and improvement. It will make regular reports to the Board and to the Strategy and Assurance Committee setting out the level of assurance it can provide to the Board on financial issues. To this end the committee will require the Finance Director to provide a regular assurance report to the committee so that it can discuss this and determine the level of assurance it can provide through its Chairperson. The committee will act as the point of initial scrutiny of financial plans and its main objective is to review all significant financial risks as required and report to the Board accordingly.

MEMBERSHIP

The committee will include four Non-Executive Directors (including the Chairman but excluding members of the Audit Committee) and four Executive Directors. The Committee will be chaired by a Non-Executive Director. ~~Other members of the Trust may be invited to attend as and when required.~~

Trust Chairman ~~(Chairperson)~~
3 Non-Executive Directors
Chief Executive
Director of Finance
Director of Operations
Director of Strategy

ATTENDANCE

The Director of Workforce & OD and a Governor of the Trust (nominated by the Council of Governors) ~~may~~ will be invited to attend each meeting.
Other members of the Trust may be invited to attend meetings (or for individual agenda items) as and when required.

DEPUTY ATTENDANCE

It is the responsibility of each executive member of the Committee to nominate a deputy to ensure that the meeting is quorate. However, this will be the exception rather than the rule. In the event of a deputy attending the meeting, members must ensure they have been fully briefed.

FREQUENCY OF ATTENDANCE BY MEMBERS

The committee requires a minimum attendance of 75% of meetings per annum by the individual committee member unless he/she has been given specific leave of absence by the Board.

QUORUM

To be quorate a minimum of six members will be present, two of whom will be Non-Executive Directors. Where a quorum cannot be established the Committee will continue to meet but will be unable to approve any documentation.

FREQUENCY OF MEETINGS

The Committee shall meet at least eight times a year. The Chairperson may request that meetings are held more regularly if it is considered necessary.

DUTIES
The Committee will review the financial and operational performance of the Trust to ensure that it meets its obligations as a Foundation Trust.

The Finance Director will provide an assurance report to cover the following items discussed at each of its meetings:-

- The financial performance of the Trust, including the risks to non-delivery of target performance.
- The CIP report from the CIP Programme Director.
- A cash and liquidity report including a 12 month rolling forecast.

The Committee will review on a periodic basis:-

- The development of an Annual Plan. This will include a review and agreement of the annual budget before submission for approval to the Board of Directors.
- The proposed contracts with Commissioners.
- Progress on the Trust's Capital Programme including an assessment of funding and affordability of plans for future years.
- Proposed accounting treatments that have a material impact prior to submission to the Audit Committee.
- Any other matters that may be referred by the Board of Directors.

In addition Divisional teams may be invited to discuss their performance with the Committee as appropriate and following escalation through the Trust's performance review process.

RESPONSIBILITES OF MEMBERS OF THE COMMITTEE
- Actively participate in discussions pertaining to finance performance strategy ensuring that solutions and action plans have multidisciplinary perspectives and have considered the impact across relevant directorates and departments.
- Communicate the outcomes of discussions at the Committee to relevant colleagues, teams and involved parties.
- Ensure all issues discussed at the meeting which may suggest a risk score 12 or above (or deemed by the Committee to be of major significance) are appropriately escalated.
- Review and ratify all relevant quality strategies/policies and procedures.

AGENDA ITEMS
Items for the agenda should be submitted to the secretary of the committee a minimum of 2 weeks prior to the meeting. It is expected that the Finance Director will provide an assurance report to cover items discussed on the agenda.

Members wishing to discuss an item on the agenda must attend the meeting.

A list of reports, circulars and documents received will be noted on the agenda and copies held centrally by the secretary.

An Annual Review of Effectiveness of the committee must be undertaken.

STANDING AGENDA ITEMS
The following will be standing agenda items which will be included in the Finance Director's assurance report:

- Finance Report
- Contract Update
- Income and Expenditure Performance including EBITDA Performance
- Financial Risk Rating (FRR)/COS

REPORTING COMMITTEES
The Committee has the right to establish sub-committees to enable it to carry out its work but should report to the Board the establishment of any sub-committee and its terms of reference

so that the Board is fully apprised of subcommittee activity. The reporting committees are detailed below and any issues from these reporting committees will be included in the Finance Director's assurance report:

- Minutes of the Cash Committee
- Minutes of the Transformation and ~~QuIPP~~ CIP Programme Board
- Minutes of the Gateway Meeting

DISTRIBUTION OF MINUTES
The minutes of the meeting shall be formally recorded and submitted to:
- All members of the Committee; and
- Board of Directors.

REPORTING RESPONSIBILITIES
The Chairperson of the Committee will be responsible for making a report to the Board after each committee meeting, in order to provide assurance that the Finance Strategy is being successfully implemented, advising the Board of any areas where this is not occurring and drawing key issues to the Board's attention for disclosure or action. The report should also detail strategy, policy and other specific issues on which it is seeking Board approval (in line with the second paragraph of the section headed 'Main Authority/Limitations' above).

In addition, the Chairperson will submit an annual review to the Board of the work of the Finance Committee including recommendations on any changes to the Committee's terms of reference.

The Chairperson of the Committee will be responsible for ensuring the Committee adheres to its Terms of Reference and Annual Work Plan.

The Committee will oversee the work of the reporting committees.

REVIEW AND EVALUATION
The membership of the group and terms of reference will be reviewed annually or as required.

DETAILS OF NOMINATED NAMED DEPUTIES

Membership	Nominated Named Deputies
Chairman (Chairperson)	Deputy Chairman (Chairperson)
Non-Executive Director	As designated by the Non-Executive Director
Non-Executive Director	As designated by the Non-Executive Director
Non-Executive Director	As designated by the Non-Executive Director
Chief Executive	Deputy Chief Executive
Director of Finance	Deputy Director of Finance
Director of Operations	Deputy Director of Operations
Director of Strategy/Deputy Chief Executive	Deputy Director of Strategy

Approved by the Board: 21st May 2014

To be reviewed not later than 31 May 2015

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

QUALITY COMMITTEE

TERMS OF REFERENCE

MAIN AUTHORITY / LIMITATIONS

The Board hereby resolves to establish a committee of the Trust to be known as the Quality Committee ('the Committee'). The Quality Committee is a committee of the Board of Directors and is authorised by the Board to investigate any activities within the scope of its Terms of Reference and obtain any information required from relevant parties to facilitate its understanding of the issues.

The Board has delegated to the Quality Committee the power to oversee the development of a Quality Strategy and policies for assuring and delivering quality; and the monitoring of the delivery of the Quality Strategy and policy. It will, however, require the committee to submit the Quality Strategy and the specified items listed below to the Board for approval and to provide assurance to the Board (through its Chairperson) that the Quality Strategy is being successfully implemented, advising the Board of any areas where this is not occurring and drawing key issues to the Board's attention. (Where the Committee develops other major strategies or policies in order to carry out its responsibilities, it should submit these to the Board for approval only if these may have a significant impact on other aspects of the Trust's work. If not, the Committee can use its delegated powers to approve such strategies and policies but should, through its Chairperson, notify the Board that it has done so in order that the Board can be fully apprised of strategy and policies developed on its behalf).

Specified Items for recommendation by the Quality Committee to the Board for approval:-

- Quarterly Monitoring Return to Monitor (Quality and Governance)
- Compliance Monitoring Assurance Report
- Quality Schedule Contract
- Annual Reports

The committee will be responsible for developing clear powers of delegation to the Chief Executive and Executive Directors of matters which fall within the remit of the committee. These must be submitted to the Board for approval so that the Board is clearly apprised of matters which the committee has so delegated. The committee will be expected to review its powers of delegation at its last meeting of each calendar year so that it can make recommendations to the Board concerning delegation for the following financial year. These powers will be thoroughly reviewed as part of the four yearly review of powers of delegation which the Board will conduct.

The structure of the Board and its committees and the Terms of Reference for each of those committees are set out in the Board Committee Structure Manual which may be amended from time to time.

Approved minutes of the committee are circulated to the Board for information. The Committee Chairperson provides the Board with a brief summary of the committee's work at the first available opportunity after each committee meeting. The Chairperson of the Committee will escalate matters to the Board as deemed appropriate.

The Trust's Standing Orders and Standing Financial Instructions apply to the operation of this committee.

MAIN PRIORITY AND OBJECTIVES

The main priority for the Quality Committee is to provide assurance to the Board that the highest possible standards in quality of care and patient safety are set and achieved by the Trust. To this end it will require the Chief Executive to provide a quarterly assurance report on the quality of care and patient safety in the Trust for consideration by the Committee so that it can decide the level of assurance it can give to the Board. It will also ensure that effective systems of clinical governance and clinical audit are embedded within the Trust and that it is under constant review and improvement. A major objective is to review all significant quality risks as required to ensure that the Chief Executive is taking action to manage these risks and to report to the Board accordingly.

MEMBERSHIP

Non Executive Director (Chairperson)
Chief Executive (Deputy Chairperson)
Trust Chairman (Non Executive)
Non-Executive Director
Medical Director
Director of Nursing and Quality
Director of Workforce &OD
Deputy Director of Corporate Affairs and Governance
Divisional Representative from Unscheduled Care (DD, DDoP or ADoN)
Divisional Representative from Scheduled Care, (DD, DDoP or ADoN)
Divisional Representative from Families Division (HoD, HoM, ADoN or HoS)
Divisional Representative from Adult and Long Term Conditions, (DCD, DALTC or ADoN)
Divisional Representative from Clinical Support and Facilities Management
Head of Performance, Planning and Contracting

ATTENDANCE

A Governor of the Trust (nominated by the Council of Governors) ~~may~~ will be invited to attend each meeting. Other members of the Trust may be invited to attend meetings (or for individual agenda items) as and when required.

DEPUTY ATTENDANCE

It is the responsibility of each member of the committee to nominate a deputy (see attached list of nominated deputies). However, this will be the exception rather than the rule. In the event of a deputy attending the meeting, members must ensure they have been fully briefed and are able to inform decision making.

FREQUENCY OF ATTENDANCE BY MEMBERS

The Committee requires a minimum attendance of 75% of meetings per annum by the individual committee member unless he/she has been given specific leave of absence as agreed by the Board.

QUORUM

A quorum shall consist of 6 members. Where a quorum cannot be established the Committee will continue to meet but will be unable to approve any documentation (or confirm actions).

FREQUENCY OF MEETINGS

Meetings will be held bi-monthly. An annual timetable will be provided with dates for agenda items to be submitted.

DUTIES

Strategy:

- To provide assurance to the Board that the highest possible standards in quality of care and patient safety are set and achieved by the Trust.
- To provide a quarterly assurance report, from the Chief Executive, on the quality of care and patient safety in the Trust for consideration by the Committee so that it can decide the level of assurance it can give to the Board.
- To ensure that effective systems of clinical governance and clinical audit are embedded within the Trust and that it is under constant review and improvement.
- To review all significant quality risks as required to ensure that the Chief Executive is taking action to manage these risks and to report to the Board accordingly.
- To oversee the work of the relevant objectives within the Strategic Framework.
- To oversee the development of Quality Governance and Performance clinical indicators for all services.
- To oversee the development of a local Quality Governance Strategy and Annual Work Programme that reflects the NHS Outcomes Framework.
- To oversee the development of the Integrated Governance Dashboards; CQUIN Schemes; and Quality Accounts.
- To influence quality improvement programmes as part of the Strategic Plan priorities such as Advancing Quality Initiatives; AQUA; Privacy and Dignity Programme.
- To identify opportunities to address quality improvement across integrated services.
- To consider the implications of national, regional and local guidance and service reviews.
- To oversee the implementation of accreditation and revalidation arrangements for relevant professional groups e.g. JACIE Accreditation; JAG Review.
- To liaise with the Risk Committee and Executive Directors Committee to ensure effective delivery of responsibilities across the integrated Quality Governance agenda.

Quality Governance Monitoring

- To monitor the performance and compliance of CQUIN targets; PROMS; Advancing Quality initiatives and Quality Accounts.
- To monitor and review the CHKS Clinical Governance data on a quarterly basis and monitor Divisional actions taken to address areas identified for improvement.
- To monitor compliance with relevant national standards and statutory legislation requirements.
- To oversee the development of information analysis capacity and capability for measuring quality improvement.
- To review items of concern or exception which are being considered within the monthly Divisional Performance Review Meetings.
- To produce an Annual Quality Report for the public no later than June of each year to show progress on clinical quality improvements.
- To ensure the views and experiences of patients and carers have been built into the design and delivery of services.
- To review the findings of national and local surveys, complaints, PALS and other forms of feedback about the experience of patients of local health services.
- To ensure all issues discussed at the meeting which may suggest a risk score 12 or above (or deemed by the Committee to be of major significance) are appropriately escalated.
- To review and ratify all relevant quality strategies/policies and procedures.
- To verify and approve any relevant reports which have been developed.
- To keep the Risk Committee informed of any significant Quality Governance or patient safety concerns that may require remedial action.
- To review Trust clinical audits and ensure they are aligned and measured against national clinical audits and good practice. Approve the Trust's annual clinical audit plan.
- Ensure the implementation of NICE guidance in the Trust.

Reporting Committees

The Committee has the right to establish sub-committees to enable it to carry out its work but should report to the Board the establishment of any sub-committee and its terms of reference so that the Board is fully apprised of sub-committee activity. The Committee will scrutinise exception reports received from the reporting committees as detailed below and will challenge any areas of poor performance in order to provide a single assurance report to the Board in respect of quality in clinical care via the Chief Executive's Assurance Report:

Exception Report	Frequency
• To receive a quarterly Organisational and Divisional CHKS Clinical Governance Report to identify any areas of poor performance and identify any action to address these areas of concern	Quarterly
• To receive a quarterly hospital Mortality Assurance Report and actions taken to reduce Mortality rates including investigations as a result of Care Quality Commission mortality outlier alerts.	Quarterly
• To provide an overview on Infection Prevention activities at each of the meetings to ensure a sustained improvement and reduction in Healthcare Associated Infections.	Quarterly
• To receive and monitor the minutes of the Divisional Governance Meetings and ensure continued focus until any issues of concern are resolved.	Bi-monthly
• To receive a Divisional report on the assessment of compliance at least annually with national standards including the CQC essential standards.	Annually
• To receive a report on emerging risks on Complaints, Claims and Incidents and identify action to address these areas of concern.	Bi-monthly
• To receive a quarterly assurance report on Medicines Management activities including prescribing governance processes and reviewing compliance with the Controlled Drugs Policy.	Quarterly
• To receive an assurance report from the Clinical Improvement Committee on progress and action to address any potential lapses in implementation of NICE Guidance, Clinical Audit and Research Processes.	Quarterly
• To provide a quarterly report on pressure ulcers, falls, etc, and identify any action to address any areas of concern.	Bi-monthly
• To receive a report on emergent themes on Blood Transfusion Incidents and identify any action to address these areas of concern.	Quarterly
• To receive a quarterly report on the reduction of Resuscitation activities.	Quarterly
• To provide a quarterly Patient Experience Report and identify any action to address any areas of concern.	Bi-monthly
• To receive a quarterly CQUIN report.	Quarterly
• To receive a quarterly PROMS report.	Quarterly
• To receive a quarterly Advancing Quality Initiative report.	Quarterly
• To provide an assurance report on Safeguarding Children. Adults and Domestic Abuse activities and identify any action to address areas of concern.	Quarterly
• To receive a 6 monthly Organ Donation Report on areas of activity.	6 monthly
• To receive a quarterly Safeguarding Assurance Report.	Quarterly
• To receive a quarterly Infection Prevention Assurance Report – including Hygiene Code Compliance Report.	Quarterly
• To receive a quarterly Business Monitoring Report.	Quarterly

RESPONSIBILITES OF MEMBERS OF THE COMMITTEE

Members and attendees are expected to:

- Actively participate in discussions pertaining to the Quality Committee, ensuring that solutions and action plans have multidisciplinary perspectives and have considered the impact across all of the directorates and departments.
- Disseminate the learning and actions from the meetings within the divisions.
- Communicate to the Quality Committee the risks, issues and solutions discussed in Divisional meetings to support organisational learning.

AGENDA ITEMS

Items for the agenda should be submitted to the Secretary of the Committee a minimum of two weeks prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting.

Members will be expected to provide assurance reports to cover matters raised by members as required at dates agreed.

A list of minutes received will be noted on the agenda and each member will receive an e-mailed copy. The Secretary to the Committee will hold a master copy on file for reference.

A list of reports, circulars and documents received will be noted on the agenda and the Secretary of the Committee will hold master copies centrally.

An Annual Review of Effectiveness of the Committee must be undertaken.

MINUTES RECEIVED

The Committee will receive minutes and exception reports via the quality report from each of the following reporting Committees:

- Hospital Infection Prevention Committee
- Learning from Incidents and Risks Committee
- Medicines Management and Incident Review Committee
- Clinical Improvement Committee
- Hospital Transfusion Committee
- Patient and Carer Experience and Involvement Committee
- Organ Donation Committee
- NHS Litigation Authority Risk Management Standards Steering Group
- Mortality Board
- Trauma Steering Group
- Joint Commissioning Quality Review Group
- Safeguarding Children, Young People and Adults Committee.
- Workforce Committee

DISTRIBUTION OF MINUTES

The minutes of the meeting shall be formally recorded and submitted to:

- All members of the Quality Committee; and
- Board of Directors

REPORTING RESPONSIBILITIES

The Chairperson of the Committee will be responsible for making a report to the Board after each committee meeting, in order to provide assurance that the Quality Strategy is being successfully implemented, advising the Board of any areas where this is not occurring and drawing key issues to the Board's attention for disclosure or action. The report should also detail strategy, policy and other specific issues on which it is seeking Board approval (in line with the second paragraph of the section headed 'Main Authority/Limitations' above). The Chairperson of the Committee will be responsible for ensuring the Committee adheres to its Terms of Reference and Annual Work Plan.

The Committee will oversee the work of the reporting committees.

REVIEW AND EVALUATION

The membership of the group and terms of reference will be reviewed every two years or as required.

DETAILS OF NOMINATED NAMED DEPUTIES

Membership	Nominated Named Deputies
Non Executive (Chairperson)	As designated by the Non Executive
Chief Executive (Deputy Chairperson)	As designated by the Chief Executive
Trust Chairman (Non-Executive)	As designated by the Trust Chairman
Non-Executive Director	As designated by the Non-Executive
Medical Director	Deputy Medical Director
Director of Nursing and Quality	Deputy Director of Corporate Affairs and Governance
Deputy Director of Corporate Affairs and Governance	Governance, Patient Safety and Risk Manager
Divisional Representative from Unscheduled Care (DD, DDoP or ADoN)	Nominated Divisional Representative from Unscheduled Care
Divisional Representative from Scheduled Care, (DD, DDoP or ADoN)	Nominated Divisional Representative from Scheduled Care
Divisional Representative from Families Division, (HoD, HoM, ADoN or HoS	Nominated Divisional Representative from Families Division
Divisional Representative from Adults and Long-Term Conditions, (DCD, DALTC or ADoN)	Nominated Divisional Representative from Adults and Long-Term Conditions
Governor	Nominated Governor
Head of Performance, Planning and Contracting	Planning Officer

Approved by the Board on: 21 May 2014

To be reviewed no later than: 31 May 2015

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

REMUNERATION (OF EXECUTIVE DIRECTORS) COMMITTEE TERMS OF REFERENCE

CONSTITUTION
The Board hereby resolves to establish a Committee of the Board to be known as the Remuneration Committee (the Committee). The Committee is a non-executive Committee of the Board and will have the full-delegated authority to act on behalf of the Board in exercising the remit and functions described in the paragraphs below.

MEMBERSHIP
The Committee will comprise the Board Chairman and all Non-Executive Directors of the Trust. The Committee will appoint a Chairperson of the committee annually (but not the Trust Chairman).

Trust Chairman
6 Non-Executive Directors (one of whom will be the Chairperson).

ATTENDANCE
The Chief Executive and other Executive Directors (including non–voting Executive Directors) will not attend for discussions about their own remuneration and terms of service. The Director of ~~Human Resources~~ Workforce and Organisational Development shall attend meetings to act as Committee Secretary and to offer advice and guidance but he/she will withdraw from the meeting when discussions about his/her own recommendations and terms of service are held.

DEPUTY ATTENDANCE
All Non-Executive Directors are members of the Remuneration Committee therefore it is not appropriate for a deputy to be nominated.

FREQUENCY OF ATTENDANCE BY MEMBERS
The Committee requires attendance of ~~50%~~ 75% per annum by the individual committee member unless he/she has been given specific leave of absence as agreed by the Board.

QUORUM
At least four members (including the Trust Chairman) must be present for a meeting of the Committee to be quorate. Where a quorum cannot be established the Committee will continue to meet but will be unable to approve any documentation.

FREQUENCY OF MEETINGS
Meetings will be held at least annually, however, additional meetings will be held in the event of any changes in personnel amongst the Executive Directors (including non-voting Executive Directors). In the absence of the Chairperson of the Committee, one of the other Non-Executive Directors will take on the role of Chairperson for that meeting.

The Chairperson of the committee may at any time convene additional meetings of the Committee to consider business which may require urgent consideration.

CONDUCT
In fulfilling its Terms of Reference, the Committee shall have regard to the following: -

- Remuneration packages must be such as to enable people of appropriately high quality to be recruited, retained and motivated – within levels of affordability;
- All NHS Foundation Trust bodies are part of the public sector and what they do, including the pay of their employees, must be publicly defensible;
- A proper defensible remuneration package requires a clear statement of responsibilities with rewards linked to their measurable discharge;

- Wherever possible it is advisable to seek independent advice with regard to labour market rates of pay.

DUTIES

- To ensure that the Terms of Reference are adhered to.
- To determine, as delegated by the Board, appropriate remuneration and terms of service for the Chief Executive, other Executive Directors (including non-voting Executive Directors), and other senior managers who are on the senior management pay-scale including: -
  - All aspects of salary (including any performance related elements).
  - Provisions of other non-pay benefits including pensions.
  - Arrangements for termination of employment and other contractual terms.
- To determine, as delegated by the Board, the remuneration and terms of service of the Chief Executive, other Executive Directors (including non-voting Executive Directors), and other senior managers as determined by the Trust to ensure that they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate.
- To monitor and evaluate, through the Trust Chairman, the performance of the Chief Executive and monitor and evaluate, through the Chief Executive, the performance of other Executive Directors (including non-voting Executive Directors) and monitor and evaluate, through Executive Directors, the performance of other senior managers as determined by the Trust.
- To advise on, and oversee, appropriate contractual arrangements for the Chief Executive, other Executive Directors (including non-voting Executive Directors), and other senior managers as determined by the Trust including the proper calculation and scrutiny of termination payments, taking account of such national guidance as is appropriate.
- To take into consideration any relevant guidance or direction supplied by the Department of Health, or any other relevant body, in the review of any remuneration or terms and conditions of employment of senior staff.
- To consider the time commitments arising from any external interests of the Executive Directors and whether any payments made by other organisations for the exercise of such duties should be retained by the Executive Directors or paid to the Trust in recognition of the time away from Trust duties.
- To implement and manage the Trust framework for complying with national guidelines regarding approval of settlement packages following complex employment cases and Employment Tribunal claims.
- To disclose membership of the Committee in the Annual Report.
- To keep the Board and the Chief Executive informed (via the Chairperson) of any material matter which has come to the attention of the Committee.
- To be involved in the appointment of Interim Directors.

Note: The Trust will remunerate the Trust Chairman and Non-Executive Directors in accordance with the arrangements determined by the Council of Governors.

RESPONSIBILITIES OF THE CHAIRPERSON OF THE COMMITTEE

The duties of the Chairperson of the Remuneration Committee will be to:

- Keep the Board of Directors informed of any material matter which has come to the attention of the Committee;
- Ensure that the minutes of the meetings are an accurate reflection of discussion;
- Attend or designate another member of the Committee to attend public meetings of the Trust, as appropriate, to answer questions about the Committee's work.

AGENDA ITEMS

An annual timetable will be provided with dates for agenda items to be submitted. Items for the agenda should be submitted to the Secretary to the Committee a minimum of two weeks prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting. Members will be expected to provide reports as required at dates agreed.

MINUTES RECEIVED
The Committee will receive reports and minutes from the following reporting Committees: -

- None

DISTRIBUTION OF MINUTES
The minutes of the meeting shall be formally recorded and submitted to:

- All members of the Committee; and
- Retained on file by the Foundation Trust Secretary.

REPORTING RESPONSIBILITIES
The Chairperson of the Committee will be responsible for ensuring the Committee adheres to its Terms of Reference.

The Chairperson of the Committee will be responsible for reporting to the Board of Directors and shall draw to the attention of the Board of Directors any issues that require disclosure or require action.

The proceedings of the Committee may be reviewed by the External Auditor as part of the planned annual audit work.

REVIEW AND EVALUATION
The membership of the group and terms of reference will be reviewed every two years or as required.

DETAILS OF NOMINATED NAMED DEPUTIES

Membership	Nominated Named Deputies
Trust Chairman (Chairperson)	Deputy Chairman (Chairperson)
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A

Approved by the Board: 21st May 2014

To be reviewed no later than: 31st May 2015

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

BOARD OF DIRECTORS
TERMS OF REFERENCE

TERMS OF REFERENCE

The terms of reference describe the role and working of the Board and are for the guidance of the Board, for the information of the Trust as a whole and serve as the basis of the terms of reference for the Board's own committees.

ROLE AND PURPOSE

The Trust exists to 'provide goods and services for any purposes related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.'

The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a committee of directors or to the Chief Executive. The Board consists of Executive Directors, one of whom is the Chief Executive, and Non-Executive Directors, one of whom is the Trust Chairman. The nominated deputy for the Chief Executive and Chairman, upon appointment to a substantive or acting up role, must be formally recorded in the minutes.

MEMBERSHIP

Trust Chairman (Chairperson)
~~6~~7 Non-Executive Directors
Chief Executive
Director of Strategy/Deputy Chief Executive ~~(non voting member)~~
Director of Finance
Medical Director
Director of Nursing and Quality
Director of Workforce & Organisational Development
Director of Operations
~~Director of Clinical Support and Facilities Management~~
~~Managing Director for Community Development and Transformation~~

Other members of the Trust may be invited to attend meetings (or for individual agenda items) as and when required. The meetings will be held in public subject to rules laid down by the Trust Board.

The Board leads the Trust by undertaking three key roles:-

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
- Shaping a positive culture for the Board and the organisation.

The general duty of the Board of Directors and of each director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

The Council of Governors is responsible for holding the Board to account, for example by attending and observing committees of the Board, attending Board meetings in public and meeting with the Chairman, Chief Executive and Committee Chairs on the day of Board meetings/Council of Governors' meetings.

The detailed practice and procedure of the meetings of the Board, and of its committees, are not set out here but are described in the Board's Standing Orders.

GENERAL RESPONSIBILITIES

The general responsibilities of the Board are:-

- To work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, accessible, effective and well governed services for patients and carers;
- To ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity; and
- To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

In fulfilling its duties, the Board will work in a way that makes the best use of the skills of Non-Executive and Executive Directors.

LEADERSHIP

The Board provides active leadership to the organisation by:-

- Ensuring there is a clear vision and strategy for patient care for the Trust that people know about and that this is being implemented within a framework of prudent and effective controls which enable risk to be assessed and managed.
- Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

STRATEGY

The Board:

- Sets and maintains the Trust's strategic vision, aims and objectives, ensuring the necessary financial, physical and human resources are in place for it to meet its objectives.
- Monitors and reviews management performance to ensure the Trust's objectives are met.
- Oversees both the delivery of services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required.
- Develops and maintains an annual business plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.
- Ensures that national policies and strategies are effectively addressed and implemented within the Trust.

CULTURE

The Board:

- Is r~~R~~esponsible for setting values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values.

GOVERNANCE

The Board:

- Ensures that the Trust has comprehensive governance arrangements in place that guarantee the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements.
- Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences.
- Ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to Foundation Trusts.
- Formulates, implements and reviews Standing Orders and Standing Financial Instructions as a means of regulating the conduct and transactions of Foundation Trust business.
- Ensures the proper management of, and compliance with, Monitor's Provider Licence, the Health & Social Care Act 2012 and other statutory and regulatory requirements of the Board.
- Ensures that the statutory duties of the Trust are effectively discharged.
- Acts as corporate trustee for the Trust's charitable funds.

- Establishes appeals panels as required by employment policies particularly to address appeals against dismissal and final stage grievance hearings.

RISK MANAGEMENT
The Board:
- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities.Ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services.
- Ensures there are appropriately constituted appointment arrangements for senior positions such as Consultant Medical Staff and Executive Directors.

ETHICS AND INTEGRITY
The Board:
- Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of Foundation Trust business.
- Ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time.

COMMITTEES
The Board is responsible for maintaining committees of the Trust Board with delegated powers as prescribed by the Trust's Standing Orders and/or by the Board from time to time:

In general, the Board will delegate to committees the power to oversee the development (by the Chief Executive and Executive Directors) of strategy and policy; and the monitoring of the delivery of strategy and policy in the areas for which the committee is responsible. It will, however, require each committee to submit key strategies, policies and other specified items to the Board for approval and to provide assurance to the Board (through its Chairperson) that such strategies and policies are being successfully implemented, advising the Board of any areas where this is not occurring and drawing key issues to the Board's attention. More details of delegated powers and matters requiring Board approval are included in the sections which follow on each committee.

At the last meeting of each financial year, the Board will review the powers it has delegated to each committee and will make any changes it deems necessary to take effect in the next financial year. Every four years, it will set up a sub-group of the Board to draw evidence from Board members, committees and internal auditors so that it can thoroughly review the powers of delegation and make recommendations to the Board for any amendments deemed necessary.

Each committee will be responsible for developing clear powers of delegation to the Chief Executive and Executive Directors of matters which fall within the remit of the committee. These must be submitted to the Board for approval so that the Board is clearly apprised of matters which the committee has so delegated. The committee will be expected to review its powers of delegation at its last meeting of each financial year so that it can make recommendations to the Board concerning delegation for the following financial year. These powers will be thoroughly reviewed as part of the four yearly review set out in the previous paragraph.

COMMUNICATION
The Board:
- Ensures an effective communication channel exists between the Trust, its governors, members, staff and the local community.
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback.
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publically through Public Board meetings and also via the Trust's website.
- Publishes an Annual Report and Annual Accounts.

FINANCIAL AND QUALITY SUCCESS
The Board:

- Ensures that an effective system of finance and quality is embedded within the Trust.
- Ensures that the Trust operates effectively, efficiently and economically.
- Ensures the continuing financial viability of the organisation.
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved.
- Ensures that the Trust achieves the quality targets and requirements of stakeholders within the available resources.
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

ROLE OF THE TRUST CHAIRMAN

The Chairman is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.

The Trust Chairman reports to the Board of Directors and is responsible for the effective running of the Board and the Council of Governors.

The Trust Chairman is responsible for ensuring that the Board as a whole pays a full part in the development and determination of the Trust's strategy and overall objectives.

The Trust Chairman is the guardian of the Board's decision-making processes and provides general leadership of the Board and the Council of Governors.

RESPONSIBILITIES OF BOARD MEMBERS

All Members of the Board of Directors:

- have joint responsibility for every decision of the Board regardless of their individual skills or status. This does not impact upon the particular responsibilities of the Chief Executive as the accounting officer.

- have a responsibility to constructively challenge during Board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

The role of Executive Directors (EDs) is to:

- share collective responsibility with the non executive directors as part of a unified Board.
- shape and deliver the strategy and operational performance in line with the Trust's strategic aims.

The role of Non Executive Directors (NEDs) is to:

- bring a range of varied perspectives and experiences to strategy development and decision-making.
- ensure effective management arrangements and an effective management team are in place.
- hold the executive to account for performance of the operational responsibilities
- scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. NEDs should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.

ROLE OF THE SENIOR INDEPENDENT DIRECTOR (SID)

The Senior Independent Director (SID) is a Non-Executive Director appointed by the Board of Directors as a whole in consultation with the Council of Governors to undertake the role. Normally the SID will not be the Deputy Chair of the Board of Directors although this may be case if the Board deems it necessary.

The SID will be available to members of the Foundation Trust and to Governors if they have concerns which, contact through the usual channels of the Chairman, Chief Executive, Finance Director and ~~Company~~ Foundation Trust Secretary, has failed to resolve or where it would be inappropriate to use such channels.

The SID also has a key role in supporting the Chairman in leading the Board of Directors and acting as a sounding board and source of advice for the Chairman. The SID also has a role in supporting the Chairman as Chairperson of the Council of Governors. The SID will conduct the annual appraisal of the Chairman and will be appraised by the Deputy Chairman.

In addition to the duties described here, the SID has the same duties as the other Non-Executive Directors.

ROLE OF THE CHIEF EXECUTIVE

The Chief Executive (CEO) reports to the Trust Chairman and to the Board directly. All members of the management structure report either directly or indirectly to the CEO.

The CEO is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.

The CEO is responsible for implementing the decisions of the Board and its committees, providing information and support to the Board and Council of Governors.

FREQUENCY OF ATTENDANCE BY MEMBERS

The Board requires a minimum attendance of 75% of meetings per annum by the individual committee member unless he/she has been given specific leave of absence as agreed by the Board.

QUORUM AND VOTING

Four Directors including not less than two Executive Directors (one of whom must be the Chief Executive or the Deputy Chief Executive) and not less than two Non-Executive Directors (one of whom must be the Chairman or the Deputy Chairman of the Board of Directors) shall form a quorum.

The Board of Directors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

The Chairman of the Foundation Trust or, in his/her absence, the Deputy Chairman of the Board of Directors, is to chair meetings of the Board of Directors.

Subject to the following provisions of this paragraph, questions arising at a meeting of the Board of Directors shall be decided by a majority of votes.

- In case of an equality of votes the Chairman shall have a second and casting vote.

- No resolution of the Board of Directors shall be passed if it is opposed by all of the Non-Executive Directors present or by all of the Executive Directors present.

OTHER MATTERS
The Board shall be supported administratively by the Trust Secretary whose duties in this respect will include:

- Agreement of agenda for Board and Board Committee Meetings with the Trust Chairman and Chief Executive.
- Collation of reports and papers for Board Meetings.
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward.
- Advising the Board on governance matters.

A full set of papers comprising the agenda, minutes and associated reports will be sent within the timescale set out in Standing Orders to all directors and others as agreed with the Trust Chairman and Chief Executive from time to time.

The Board shall self assess its performance at least annually.

The terms of reference for the Board will be reviewed at least annually.

DETAILS OF NOMINATED NAMED DEPUTIES

Membership	Nominated Named Deputies
Trust Chairman (Chairperson)	Deputy Chairman (Chairperson)
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Chief Executive	Deputy Chief Executive
Director of Finance	Deputy Director of Finance
Medical Director	Deputy Medical Director
Director of Nursing and Quality	Deputy Director of Nursing ~~Corporate Affairs and Governance~~
Director of ~~HR~~ Workforce & OD	Deputy Director of Workforce & OD
Director of Operations	Deputy Director of Operations
~~Director of Clinical Support and Facilities Management (non-voting member)~~	~~Deputy Director of Clinical Support and Facilities Management~~
Director of Strategy/Deputy Chief Executive ~~Managing Director for Community Development and Transformation (non-voting member)~~	Deputy Director of Strategy ~~As designated by the Managing Director for Community Development and Transformation~~

Approved by the Board on: ~~31st July 2013~~ 21 May 2014

To be reviewed no later than: ~~30th July 2014~~ 31 May 2015

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

STRATEGY AND ASSURANCE COMMITTEE
TERMS OF REFERENCE

MAIN AUTHORITY / LIMITATIONS

The Board hereby resolves to establish a committee of the Trust to be known as the Strategy and Assurance Committee ('the Committee'). The Strategy and Assurance Committee is a committee of the Board of Directors and is authorised by the Board to investigate any activities within the scope of its Terms of Reference and obtain any information required from relevant parties to facilitate its understanding of the issues.

The Board has delegated to the Strategy and Assurance Committee the power to oversee the development and implementation of strategy and policies for the management of the Trust. The Committee will also consider compliance matters by exception and any urgent business in relation to assurance, ~~and for~~ taking urgent action on behalf of the Board in between Board meetings where it would not be in the interests of the Trust to delay decisions until the next Board meeting occurs. (Such requests to the Committee for immediate action may only come from the Chairman, Chief Executive or ~~from~~ other Committees of the Board). It will, however, require the ~~c~~Committee to provide a report to each Board meeting setting out ~~the~~ any urgent actions which the Committee has taken on its behalf. The Committee is not authorised to act on behalf of the Board with respect to approving the specified items listed below. These must instead be submitted to the Board for approval,

Specified Items for recommendation by the Strategy and Assurance Committee to the Board for approval:-

- Corporate Objectives
- Trust Constitution
- Review of Board Effectiveness
- Board Committee Structure Manual and Terms of Reference
- Confirmation of Chairman's Action
- Common Seal
- Significant Transactions – Merger/Acquisition/Separation/Dissolution

The structure of the Board and its committees and the Terms of Reference for each of those committees are set out in the Board Committee Structure Manual which may be amended from time to time.

Approved minutes of the committee are circulated to the Board for information. The Committee Chairperson provides the Board with an assurance report including a summary of the committee's work at the first available opportunity after each committee meeting. The Chairperson of the committee will escalate matters to the Board as deemed appropriate.

The Trust's Standing Orders and Standing Financial Instructions apply to the operation of this committee.

MAIN PRIORITY AND OBJECTIVES

~~The main priority for the Strategy and Assurance Committee is to be responsible for taking action to enable the Board to fulfil its responsibilities for the organisation's mission, vision and strategic direction. The Committee will ensure that an effective system of governance is embedded within the Trust and that it is under constant review and improvement. It will also keep the Board informed of all actions which it takes on behalf of the Board.~~

The main priority for the Strategy and Assurance Committee is to receive and discuss preliminary papers from the CEO on existing and proposed strategy and policy in order to promote the development of effective strategy and policy for the Trust, which can be considered and approved by the Board. The Committee will also consider compliance matters by exception and any urgent business in relation to assurance.

MEMBERSHIP
The Committee will comprise the Trust Chairman, all Non-Executive Directors and all Executive Directors (including non-voting Executive Directors). The Deputy Director of ~~Corporate Affairs and Governance~~ Strategy will be invited to attend the meetings..

Trust Chairman (Chairperson)
~~6~~7 Non-Executive Directors
Chief Executive
Director of Finance
Medical Director
Director of Nursing and Quality
Director of ~~Human Resources~~ Workforce and Organisational Development
Director of Operations
~~Director of Clinical Support and Facilities Management~~
~~Managing Director for Community Development and Transformation~~
Director of Strategy/Deputy Chief Executive
~~Deputy Director of Corporate Affairs and Governance~~
~~Deputy Director of Strategy~~

ATTENDANCE

Other members of the Trust may be invited to attend as and when required.

DEPUTY ATTENDANCE
It is the responsibility of each executive member of the committee to nominate a deputy. However, this will be the exception rather than the rule. In the event of a deputy attending the meeting, members must ensure they have been fully briefed and are able to inform decision making.

FREQUENCY OF ATTENDANCE BY MEMBERS
The Committee requires a minimum attendance of a minimum attendance of 75% of meetings per annum by the individual committee member unless he/she has been given specific leave of absence as agreed by the Board.

QUORUM
A quorum shall consist of 6 members. Where a quorum cannot be established the Committee will continue to meet but will be unable to approve any documentation (or confirm actions).

FREQUENCY OF MEETINGS
Meetings will be held ~~eight~~ four times a year. An annual timetable will be provided with dates for agenda items to be submitted.

DUTIES
The committee will assist the Board in the following areas:

- Formulating strategy.
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
- Contributing in shaping a positive culture for the Board and the organisation.
- Setting and maintaining the Trust's strategic vision, aims and objectives, ensuring the necessary financial, physical and human resources are in place for it to meet its objectives.
- Delivering planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required.

RESPONSIBILITIES OF MEMBERS OF THE COMMITTEE
As a member of the Committee, individuals represent clinical and corporate departments and are expected to:

- Actively participate in decisions pertaining to the Strategy and Assurance Committee ensuring that solutions and action plans have multidisciplinary perspectives and have considered the impact across all of the divisions/directorates and departments.

AGENDA ITEMS
Items for the agenda should be submitted to the Secretary of the Committee a minimum of two weeks prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting. ~~The main agenda items will be presented via a brief Chief Executive's Assurance Report.~~

Members will be expected to provide reports as required at dates agreed.

A list of minutes received will be noted on the agenda and each member will receive an e-mailed copy. The Secretary to the Committee will hold a master copy on file for reference.

A list of reports, circulars and documents received will be noted on the agenda and the Secretary of the Committee will hold master copies centrally.

An Annual Review of Effectiveness of the Committee must be undertaken.

MINUTES RECEIVED
The Committee will receive minutes and exception reports from each of the following reporting Committees:-

- None

DISTRIBUTION OF MINUTES
The minutes of the Strategy and Assurance Committee meetings will be formally recorded and forwarded to:

- All members of the committee; and
- Board of Directors.

REPORTING RESPONSIBILITIES
The Chairperson of the Committee will be responsible for focusing on strategy, for providing an assurance ~~and~~ report~~ing~~ to the Board and ~~shall~~ for draw~~ing~~ to the attention of the Board any issues that require disclosure or action.

REVIEW AND EVALUATION
The membership of the group and terms of reference will be reviewed every two years or as required.

DETAILS OF NOMINATED NAMED DEPUTIES

Membership	Nominated Named Deputies
Chairman (Chairperson)	Deputy Chairman (Chairperson)
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Chief Executive	Deputy Chief Executive
Director of Finance	Deputy Director of Finance
Medical Director	Deputy Medical Director
Director of Nursing and Quality	Deputy Director of Corporate Affairs and Governance
Director of ~~HR~~ Workforce & OD	Deputy Director of ~~HR~~Workforce & OD
Director of Operations	Deputy Director of Operations
~~Director of Clinical Support and Facilities Management~~	~~Deputy Director of Clinical Support and Facilities Management~~
Director of Strategy/Deputy Chief Executive	Deputy Director of Strategy

~~Managing Director for Community Development and Transformation~~	~~As designated by the Managing Director for Community Development and Transformation~~
~~Deputy Director of Corporate Affairs and Governance~~	~~As designated by the Deputy Director of Corporate Affairs and Governance~~

Revised ~~**Approved**~~ **by the Board on:** ~~31st July 2013~~ 21 May 2014

To be reviewed no later than: ~~30th July 2014~~ 31 May 2015

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

QUALITY COMMITTEE

TERMS OF REFERENCE

MAIN AUTHORITY / LIMITATIONS

The Board hereby resolves to establish a committee of the Trust to be known as the Quality Committee ('the Committee'). The Quality Committee is a committee of the Board of Directors and is authorised by the Board to investigate any activities within the scope of its Terms of Reference and obtain any information required from relevant parties to facilitate its understanding of the issues.

The Board has delegated to the Quality Committee the power to oversee the development of a Quality Strategy and policies for assuring and delivering quality; and the monitoring of the delivery of the Quality Strategy and policy. It will, however, require the committee to submit the Quality Strategy and the specified items listed below to the Board for approval and to provide assurance to the Board (through its Chairperson) that the Quality Strategy is being successfully implemented, advising the Board of any areas where this is not occurring and drawing key issues to the Board's attention. (Where the Committee develops other major strategies or policies in order to carry out its responsibilities, it should submit these to the Board for approval only if these may have a significant impact on other aspects of the Trust's work. If not, the Committee can use its delegated powers to approve such strategies and policies but should, through its Chairperson, notify the Board that it has done so in order that the Board can be fully apprised of strategy and policies developed on its behalf).

Specified Items for recommendation by the Quality Committee to the Board for approval:-

- Quarterly Monitoring Return to Monitor (Quality and Governance)
- Compliance Monitoring Assurance Report
- Quality Schedule Contract
- Annual Reports

The committee will be responsible for developing clear powers of delegation to the Chief Executive and Executive Directors of matters which fall within the remit of the committee. These must be submitted to the Board for approval so that the Board is clearly apprised of matters which the committee has so delegated. The committee will be expected to review its powers of delegation at its last meeting of each calendar year so that it can make recommendations to the Board concerning delegation for the following financial year. These powers will be thoroughly reviewed as part of the four yearly review of powers of delegation which the Board will conduct.

The structure of the Board and its committees and the Terms of Reference for each of those committees are set out in the Board Committee Structure Manual which may be amended from time to time.

Approved minutes of the committee are circulated to the Board for information. The Committee Chairperson provides the Board with a brief summary of the committee's work at the first available opportunity after each committee meeting. The Chairperson of the Committee will escalate matters to the Board as deemed appropriate.

The Trust's Standing Orders and Standing Financial Instructions apply to the operation of this committee.

MAIN PRIORITY AND OBJECTIVES

The main priority for the Quality Committee is to provide assurance to the Board that the highest possible standards in quality of care and patient safety are set and achieved by the Trust. To this end it will require the Chief Executive to provide a quarterly assurance report on the quality of care and patient safety in the Trust for consideration by the Committee so that it can decide the level of assurance it can give to the Board. It will also ensure that effective systems of clinical governance and clinical audit are embedded within the Trust and that it is under constant review and improvement. A major objective is to review all significant quality risks as required to ensure that the Chief Executive is taking action to manage these risks and to report to the Board accordingly.

MEMBERSHIP

Non Executive Director (Chairperson)
Chief Executive (Deputy Chairperson)
Trust Chairman (Non Executive)
2 Non-Executive Directors
Medical Director
Director of Nursing and Quality
Director of Workforce &OD
Deputy Director of Corporate Affairs and Governance
Divisional Representative from Unscheduled Care (DD, DDoP or ADoN)
Divisional Representative from Scheduled Care, (DD, DDoP or ADoN)
Divisional Representative from Families Division (HoD, HoM, ADoN or HoS)
Divisional Representative from Adult and Long Term Conditions, (DCD, DALTC or ADoN)
Divisional Representative from Clinical Support and Facilities Management
Head of Performance, Planning and Contracting

ATTENDANCE

A Governor of the Trust (nominated by the Council of Governors) ~~may~~ will be invited to attend each meeting. Other members of the Trust may be invited to attend meetings (or for individual agenda items) as and when required.

DEPUTY ATTENDANCE

It is the responsibility of each member of the committee to nominate a deputy (see attached list of nominated deputies). However, this will be the exception rather than the rule. In the event of a deputy attending the meeting, members must ensure they have been fully briefed and are able to inform decision making.

FREQUENCY OF ATTENDANCE BY MEMBERS

The Committee requires a minimum attendance of 75% of meetings per annum by the individual committee member unless he/she has been given specific leave of absence as agreed by the Board.

QUORUM

A quorum shall consist of 6 members. Where a quorum cannot be established the Committee will continue to meet but will be unable to approve any documentation (or confirm actions).

FREQUENCY OF MEETINGS

Meetings will be held bi-monthly. An annual timetable will be provided with dates for agenda items to be submitted.

DUTIES

Strategy:

- To provide assurance to the Board that the highest possible standards in quality of care and patient safety are set and achieved by the Trust.
- To provide a quarterly assurance report, from the Chief Executive, on the quality of care and patient safety in the Trust for consideration by the Committee so that it can decide the level of assurance it can give to the Board.
- To ensure that effective systems of clinical governance and clinical audit are embedded within the Trust and that it is under constant review and improvement.
- To review all significant quality risks as required to ensure that the Chief Executive is taking action to manage these risks and to report to the Board accordingly.
- To oversee the work of the relevant objectives within the Strategic Framework.
- To oversee the development of Quality Governance and Performance clinical indicators for all services.
- To oversee the development of a local Quality Governance Strategy and Annual Work Programme that reflects the NHS Outcomes Framework.
- To oversee the development of the Integrated Governance Dashboards; CQUIN Schemes; and Quality Accounts.
- To influence quality improvement programmes as part of the Strategic Plan priorities such as Advancing Quality Initiatives; AQUA; Privacy and Dignity Programme.
- To identify opportunities to address quality improvement across integrated services.
- To consider the implications of national, regional and local guidance and service reviews.
- To oversee the implementation of accreditation and revalidation arrangements for relevant professional groups e.g. JACIE Accreditation; JAG Review.
- To liaise with the Risk Committee and Executive Directors Committee to ensure effective delivery of responsibilities across the integrated Quality Governance agenda.

Quality Governance Monitoring

- To monitor the performance and compliance of CQUIN targets; PROMS; Advancing Quality initiatives and Quality Accounts.
- To monitor and review the CHKS Clinical Governance data on a quarterly basis and monitor Divisional actions taken to address areas identified for improvement.
- To monitor compliance with relevant national standards and statutory legislation requirements.
- To oversee the development of information analysis capacity and capability for measuring quality improvement.
- To review items of concern or exception which are being considered within the monthly Divisional Performance Review Meetings.
- To produce an Annual Quality Report for the public no later than June of each year to show progress on clinical quality improvements.
- To ensure the views and experiences of patients and carers have been built into the design and delivery of services.
- To review the findings of national and local surveys, complaints, PALS and other forms of feedback about the experience of patients of local health services.
- To ensure all issues discussed at the meeting which may suggest a risk score 12 or above (or deemed by the Committee to be of major significance) are appropriately escalated.
- To review and ratify all relevant quality strategies/policies and procedures.
- To verify and approve any relevant reports which have been developed.
- To keep the Risk Committee informed of any significant Quality Governance or patient safety concerns that may require remedial action.
- To review Trust clinical audits and ensure they are aligned and measured against national clinical audits and good practice. Approve the Trust's annual clinical audit plan.
- Ensure the implementation of NICE guidance in the Trust.

Reporting Committees

The Committee has the right to establish sub-committees to enable it to carry out its work but should report to the Board the establishment of any sub-committee and its terms of reference so that the Board is fully apprised of sub-committee activity. The Committee will scrutinise exception reports received from the reporting committees as detailed below and will challenge any areas of poor performance in order to provide a single assurance report to the Board in respect of quality in clinical care via the Chief Executive's Assurance Report:

Exception Report	Frequency
• To receive a quarterly Organisational and Divisional CHKS Clinical Governance Report to identify any areas of poor performance and identify any action to address these areas of concern	Quarterly
• To receive a quarterly hospital Mortality Assurance Report and actions taken to reduce Mortality rates including investigations as a result of Care Quality Commission mortality outlier alerts.	Quarterly
• To provide an overview on Infection Prevention activities at each of the meetings to ensure a sustained improvement and reduction in Healthcare Associated Infections.	Quarterly
• To receive and monitor the minutes of the Divisional Governance Meetings and ensure continued focus until any issues of concern are resolved.	Bi-monthly
• To receive a Divisional report on the assessment of compliance at least annually with national standards including the CQC essential standards.	Annually
• To receive a report on emerging risks on Complaints, Claims and Incidents and identify action to address these areas of concern.	Bi-monthly
• To receive a quarterly assurance report on Medicines Management activities including prescribing governance processes and reviewing compliance with the Controlled Drugs Policy.	Quarterly
• To receive an assurance report from the Clinical Improvement Committee on progress and action to address any potential lapses in implementation of NICE Guidance, Clinical Audit and Research Processes.	Quarterly
• To provide a quarterly report on pressure ulcers, falls, etc, and identify any action to address any areas of concern.	Bi-monthly
• To receive a report on emergent themes on Blood Transfusion Incidents and identify any action to address these areas of concern.	Quarterly
• To receive a quarterly report on the reduction of Resuscitation activities.	Quarterly
• To provide a quarterly Patient Experience Report and identify any action to address any areas of concern.	Bi-monthly
• To receive a quarterly CQUIN report.	Quarterly
• To receive a quarterly PROMS report.	Quarterly
• To receive a quarterly Advancing Quality Initiative report.	Quarterly
• To provide an assurance report on Safeguarding Children. Adults and Domestic Abuse activities and identify any action to address areas of concern.	Quarterly
• To receive a 6 monthly Organ Donation Report on areas of activity.	6 monthly
• To receive a quarterly Safeguarding Assurance Report.	Quarterly
• To receive a quarterly Infection Prevention Assurance Report – including Hygiene Code Compliance Report.	Quarterly
• To receive a quarterly Business Monitoring Report.	Quarterly

RESPONSIBILITES OF MEMBERS OF THE COMMITTEE

Members and attendees are expected to:

- Actively participate in discussions pertaining to the Quality Committee, ensuring that solutions and action plans have multidisciplinary perspectives and have considered the impact across all of the directorates and departments.
- Disseminate the learning and actions from the meetings within the divisions.
- Communicate to the Quality Committee the risks, issues and solutions discussed in Divisional meetings to support organisational learning.

AGENDA ITEMS

Items for the agenda should be submitted to the Secretary of the Committee a minimum of two weeks prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting.

Members will be expected to provide assurance reports to cover matters raised by members as required at dates agreed.

A list of minutes received will be noted on the agenda and each member will receive an e-mailed copy. The Secretary to the Committee will hold a master copy on file for reference.

A list of reports, circulars and documents received will be noted on the agenda and the Secretary of the Committee will hold master copies centrally.

An Annual Review of Effectiveness of the Committee must be undertaken.

MINUTES RECEIVED

The Committee will receive minutes and exception reports via the quality report from each of the following reporting Committees:

- Hospital Infection Prevention Committee
- Learning from Incidents and Risks Committee
- Medicines Management and Incident Review Committee
- Clinical Improvement Committee
- Hospital Transfusion Committee
- Patient and Carer Experience and Involvement Committee
- Organ Donation Committee
- NHS Litigation Authority Risk Management Standards Steering Group
- Mortality Board
- Trauma Steering Group
- Joint Commissioning Quality Review Group
- Safeguarding Children, Young People and Adults Committee.
- Workforce Committee

DISTRIBUTION OF MINUTES

The minutes of the meeting shall be formally recorded and submitted to:

- All members of the Quality Committee; and
- Board of Directors

REPORTING RESPONSIBILITIES

The Chairperson of the Committee will be responsible for making a report to the Board after each committee meeting, in order to provide assurance that the Quality Strategy is being successfully implemented, advising the Board of any areas where this is not occurring and drawing key issues to the Board's attention for disclosure or action. The report should also detail strategy, policy and other specific issues on which it is seeking Board approval (in line with the second paragraph of the section headed 'Main Authority/Limitations' above). The Chairperson of the Committee will be responsible for ensuring the Committee adheres to its Terms of Reference and Annual Work Plan.

The Committee will oversee the work of the reporting committees.

REVIEW AND EVALUATION

The membership of the group and terms of reference will be reviewed every two years or as required.

DETAILS OF NOMINATED NAMED DEPUTIES

Membership	Nominated Named Deputies
Non Executive (Chairperson)	As designated by the Non Executive
Chief Executive (Deputy Chairperson)	As designated by the Chief Executive
Trust Chairman (Non-Executive)	As designated by the Trust Chairman
Non-Executive Director	As designated by the Non-Executive
Medical Director	Deputy Medical Director
Director of Nursing and Quality	Deputy Director of Corporate Affairs and Governance
Deputy Director of Corporate Affairs and Governance	Governance, Patient Safety and Risk Manager
Divisional Representative from Unscheduled Care (DD, DDoP or ADoN)	Nominated Divisional Representative from Unscheduled Care
Divisional Representative from Scheduled Care, (DD, DDoP or ADoN)	Nominated Divisional Representative from Scheduled Care
Divisional Representative from Families Division, (HoD, HoM, ADoN or HoS	Nominated Divisional Representative from Families Division
Divisional Representative from Adults and Long-Term Conditions, (DCD, DALTC or ADoN)	Nominated Divisional Representative from Adults and Long-Term Conditions
Governor	Nominated Governor
Head of Performance, Planning and Contracting	Planning Officer

Approved by the Board on: 21 May 2014

To be reviewed no later than: 31 May 2015

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

REMUNERATION (OF EXECUTIVE DIRECTORS) COMMITTEE TERMS OF REFERENCE

CONSTITUTION
The Board hereby resolves to establish a Committee of the Board to be known as the Remuneration Committee (the Committee). The Committee is a non-executive Committee of the Board and will have the full-delegated authority to act on behalf of the Board in exercising the remit and functions described in the paragraphs below.

MEMBERSHIP
The Committee will comprise the Board Chairman and all Non-Executive Directors of the Trust. The Committee will appoint a Chairperson of the committee annually (but not the Trust Chairman).

Trust Chairman
~~6~~7 Non-Executive Directors (one of whom will be the Chairperson).

ATTENDANCE
The Chief Executive and other Executive Directors (including non–voting Executive Directors) will not attend for discussions about their own remuneration and terms of service. The Director of ~~Human Resources~~ Workforce and Organisational Development shall attend meetings to act as Committee Secretary and to offer advice and guidance but he/she will withdraw from the meeting when discussions about his/her own recommendations and terms of service are held.

DEPUTY ATTENDANCE
All Non-Executive Directors are members of the Remuneration Committee therefore it is not appropriate for a deputy to be nominated.

FREQUENCY OF ATTENDANCE BY MEMBERS
The Committee requires attendance of ~~50%~~ 75% per annum by the individual committee member unless he/she has been given specific leave of absence as agreed by the Board.

QUORUM
At least four members (including the Trust Chairman) must be present for a meeting of the Committee to be quorate. Where a quorum cannot be established the Committee will continue to meet but will be unable to approve any documentation.

FREQUENCY OF MEETINGS
Meetings will be held at least annually, however, additional meetings will be held in the event of any changes in personnel amongst the Executive Directors (including non-voting Executive Directors). In the absence of the Chairperson of the Committee, one of the other Non-Executive Directors will take on the role of Chairperson for that meeting.

The Chairperson of the committee may at any time convene additional meetings of the Committee to consider business which may require urgent consideration.

CONDUCT
In fulfilling its Terms of Reference, the Committee shall have regard to the following: -

- Remuneration packages must be such as to enable people of appropriately high quality to be recruited, retained and motivated – within levels of affordability;
- All NHS Foundation Trust bodies are part of the public sector and what they do, including the pay of their employees, must be publicly defensible;
- A proper defensible remuneration package requires a clear statement of responsibilities with rewards linked to their measurable discharge;

- Wherever possible it is advisable to seek independent advice with regard to labour market rates of pay.

DUTIES

- To ensure that the Terms of Reference are adhered to.
- To determine, as delegated by the Board, appropriate remuneration and terms of service for the Chief Executive, other Executive Directors (including non-voting Executive Directors), and other senior managers who are on the senior management pay-scale including: -
  - All aspects of salary (including any performance related elements).
  - Provisions of other non-pay benefits including pensions.
  - Arrangements for termination of employment and other contractual terms.
- To determine, as delegated by the Board, the remuneration and terms of service of the Chief Executive, other Executive Directors (including non-voting Executive Directors), and other senior managers as determined by the Trust to ensure that they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate.
- To monitor and evaluate, through the Trust Chairman, the performance of the Chief Executive and monitor and evaluate, through the Chief Executive, the performance of other Executive Directors (including non-voting Executive Directors) and monitor and evaluate, through Executive Directors, the performance of other senior managers as determined by the Trust.
- To advise on, and oversee, appropriate contractual arrangements for the Chief Executive, other Executive Directors (including non-voting Executive Directors), and other senior managers as determined by the Trust including the proper calculation and scrutiny of termination payments, taking account of such national guidance as is appropriate.
- To take into consideration any relevant guidance or direction supplied by the Department of Health, or any other relevant body, in the review of any remuneration or terms and conditions of employment of senior staff.
- To consider the time commitments arising from any external interests of the Executive Directors and whether any payments made by other organisations for the exercise of such duties should be retained by the Executive Directors or paid to the Trust in recognition of the time away from Trust duties.
- To implement and manage the Trust framework for complying with national guidelines regarding approval of settlement packages following complex employment cases and Employment Tribunal claims.
- To disclose membership of the Committee in the Annual Report.
- To keep the Board and the Chief Executive informed (via the Chairperson) of any material matter which has come to the attention of the Committee.
- To be involved in the appointment of Interim Directors.

Note: The Trust will remunerate the Trust Chairman and Non-Executive Directors in accordance with the arrangements determined by the Council of Governors.

RESPONSIBILITIES OF THE CHAIRPERSON OF THE COMMITTEE

The duties of the Chairperson of the Remuneration Committee will be to:

- Keep the Board of Directors informed of any material matter which has come to the attention of the Committee;
- Ensure that the minutes of the meetings are an accurate reflection of discussion;
- Attend or designate another member of the Committee to attend public meetings of the Trust, as appropriate, to answer questions about the Committee's work.

AGENDA ITEMS

An annual timetable will be provided with dates for agenda items to be submitted. Items for the agenda should be submitted to the Secretary to the Committee a minimum of two weeks prior to the meeting. Members wishing to discuss an item on the agenda must attend the meeting. Members will be expected to provide reports as required at dates agreed.

MINUTES RECEIVED
The Committee will receive reports and minutes from the following reporting Committees: -

- None

DISTRIBUTION OF MINUTES
The minutes of the meeting shall be formally recorded and submitted to:

- All members of the Committee; and
- Retained on file by the Foundation Trust Secretary.

REPORTING RESPONSIBILITIES
The Chairperson of the Committee will be responsible for ensuring the Committee adheres to its Terms of Reference.

The Chairperson of the Committee will be responsible for reporting to the Board of Directors and shall draw to the attention of the Board of Directors any issues that require disclosure or require action.

The proceedings of the Committee may be reviewed by the External Auditor as part of the planned annual audit work.

REVIEW AND EVALUATION
The membership of the group and terms of reference will be reviewed every two years or as required.

DETAILS OF NOMINATED NAMED DEPUTIES

Membership	Nominated Named Deputies
Trust Chairman (Chairperson)	Deputy Chairman (Chairperson)
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A
Non-Executive Director	N/A

Approved by the Board: 21st May 2014

To be reviewed no later than: 31st May 2015

Ref	Priority	Issue and Recommendation	Management response
1314-GA-R01	Low	**Terms of Reference** The Trust has revised terms of reference for the Board and its sub-committees, following the recent review of the governance structure. These are largely consistent with guidance and good practice. There is a commitment by the Trust to review them annually. However: ■ The accountability of the Board to the Council of Governors is not clear. ■ The role and responsibilities of the Senior Independent Director are not included. ■ The responsibilities of the Audit Committee in relation to safeguarding assets and delivering value for money are not clear. There is therefore a risk that the Trust will be unable to demonstrate clearly: ■ its accountability to the Trust membership and the wider community; or ■ its role in ensuring the Trust's resources are protected and being used efficiently and effectively. The Trust should update its terms of reference for the points mentioned above to ensure there is a robust framework to support good governance throughout the organisation.	**Management Response** The Board of Directors' Terms of Reference will be amended to reflect that the Council of Governors holds the Board to account. The role and responsibilities of the SID will be included in the Board of Directors' Terms of Reference. The responsibilities of the Audit Committee in relation to safeguarding assets and delivering value for money will be included in the Audit Committee Terms of Reference. **Responsible Officer** Judith Oates **Due Date** 31.3.14 **Complete**
1314-GA-R02	Low	**Strategy and Assurance Committee** Membership of the Strategy and Assurance Committee is virtually the same as the Board, and its role according to its Terms of Reference is to: ■ oversee the development and implementation of strategy and policies for the management of the Trust; and ■ for taking action on behalf of the Board in between Board meetings where is would not be in the interests of the Trust to delay decisions until the next Board meeting occurs. The Committee's responsibilities and duties are less detailed and defined than other committees. There are no reporting committees and no mention in the Terms of Reference as to which reports will be considered during the meetings. There is a risk that meetings of this Committee could be perceived as being used to come to decisions without the public scrutiny that would be provided in a Board meeting. There is also a risk	**Management Response** Consideration will be given to the role of the SAC, particularly in view of the increase in the number of Board Meetings held in public. It has been agreed that the SAC meetings will focus primarily on strategic issues and the Terms of Reference have been amended to reflect this agreement. **Responsible Officer** Chairman/Director of Strategy **Due Date** 31.3.14 **Complete**

		of confusion between the business of the Board and the Committee. We recommend that the Trust reviews the role of this Committee and revises the Terms of Reference accordingly.	
1314-GA-R03	● Low	**Legal Briefing** It is not clear from the terms of reference and the work plans of the Board and its sub-committees or from the assurance map where the legal briefing should be presented. Documentation suggests that the briefing should be received by the Board and the Risk Committee, however there is no evidence that this has happened in year. The Audit Committee get a Legal Update but it is not required by its Terms of Reference or Annual Work Plan. There is a risk that legal issues are not considered appropriately by the Trust. The Trust should ensure that there is clear governance process in place for the legal briefing.	**Management Response** The Legal Briefing has previously been included within the Chairman's section of the Board agenda and, more recently, within the Reference Folder. Arrangements will be made for the Legal Briefing to be included within the ~~"Chairman's Update"~~ Chief Executive's Assurance Report to the Board, giving assurance that the Trust is taking account of legal advice and highlighting any areas of interest for Board members and referring to the full document in the Reference Folder. Any specific issues will be directed to the relevant ED or sub-committee, i.e. Risk Committee, Quality Committee, Audit Committee. The Deputy Director of Corporate Governance and Communications will be responsible for ensuring that there are satisfactory governance processes in place in respect of the Legal Briefing. **Responsible Officer** David Holden/Judith Oates **Due Date** 31.3.14 **Complete**

1314-GA-R04	● Low	**Agenda timings** Agendas for the Board and Audit Committee now include timings to improve the focus and efficiency of meetings and to ensure all items have sufficient time allocated. However timings are not included on the agendas of the Risk Committee, the Quality Committee or the Finance Committee. There is a risk that too much time is spent on early agenda items and, due to time pressure, insufficient consideration is given to later agenda items. The Trust should implement timed agendas for all committees.	**Management Response** Agendas for all Board sub-committees will include timings. The default timing for each Board report will be 10 minutes unless otherwise notified to the FT Secretary. **Responsible Officer** Judith Oates **Due Date** 31.3.14 **Complete**
1314-GA-R05	● Low	**Attendance** Attendance at Board and sub-committee meetings is good and in line with the terms of reference. Attendance monitoring is also a standing item on agendas. However, there were a number of occasions when a member did not attend and did not nominate a deputy as required. There is a risk that key information from the non-attendee is not considered by the remaining members which could lead to gaps in assurance and exposure to increased risk. Further important information arising at meetings may not be communicated to the rest of the team. The Trust should ensure that where an Executive Board member or committee member cannot attend a meeting, their nominated deputy attends. The deputy should be appropriately briefed and made responsible for the dissemination of information to the wider team.	**Management Response** Executive Directors will be reminded about ensuring that a nominated deputy attends Board/sub-committee meetings in their absence and that he/she is appropriately briefed. ~~This requirement is not relevant to NEDs.~~ A formal substitution policy for NEDs has been adopted. **Responsible Officer** David Holden **Due Date** 31.3.14 **Complete**
1314-GA-R06	● Low	**Reporting to Committees** We found some instances where an item on a Committee Annual Cycle of Business was not presented for discussion or approval at the appropriate meeting. Further, there was no indication in the minutes as to why this had happened or what action would be taken as a result. There is a risk that the information and assurance that should have been contained in such reports goes unreported. This could lead to a gap in assurance or a delay in key decision making. The Trust should ensure that where an item is not presented, according to the Annual Cycle of	**Management Response** Reports will be included on agendas in accordance with the Annual Cycle of Business/Work Plans, however, where this is not achievable the reason for non-submission and any subsequent action will be minuted. **Responsible Officer** David Holden **Due Date** 31.3.14 **Complete**

		Business, that this is minuted with appropriate actions identified to resolve any issues that arise as a result.	
1314-GA-R07	Medium	**Attendance at the Quality Committee** Our review of the minutes of the Quality Committee found that attendance was in excess of that stated in the Terms of Reference. We also noted that there was no governor representation in the meetings despite governor membership being set out on the Terms of Reference. We also found that there was an inconsistency between the reports specified to be received in the Terms of Reference and those which were actually received by the Committee. Specifically, we noted that the Workforce Assurance Report was presented to the October meeting. There is no representative from Human Resources and Organisational Development on the Committee. There is a risk that: ■ Inappropriate attendance could lead to inefficient meetings unless very tightly controlled; ■ The Trust cannot demonstrate appropriate accountability without a governor in attendance; and ■ Workforce issues are discussed without an appropriate representative in attendance leading to in accurate conclusions and decisions being made. The Trust should revisit the membership of the Quality Committee. There has been a change to the format of the committee structure, including the Quality Committee, hence a transition period and a period of 6 months to review the changes.	**Management Response** The membership of the Quality Committee has recently been reviewed but will be further reviewed to ensure appropriate attendance. Two immediate actions from the review have been to increase the number of meetings from quarterly to bi-monthly (for both the Quality Committee and the Risk Committee) and to include one Public Governor (Fylde Constituency) within ~~the membership.~~those invited to attend The Terms of Reference were reviewed at the Quality Committee meeting on 24.2.14 and again on 24.4.14 and recommended changes were agreed by the Board in May. **Responsible Officer** David Holden **Due Date** 31.3.14 **Complete**

1314-GA-R08	● Low	**Volume of information** Our review of agendas, minutes and work plans found that whilst good progress has been made in streamlining the papers presented to the Board, there are still a significant number of reports and minutes received by the Audit Committee and the Quality Committee. Some improvements have been made regarding the effectiveness of the Quality Committee, for example, Divisions now report on an exception basis. However, there is a concern that the volume and complexity of information presented could be overwhelming. There is a risk that key messages may be lost as the Committees focus on getting through all the information presented rather than on the content. The Trust should review the Terms of Reference of the Quality Committee and the Audit Committee and streamline the papers presented to ensure that the committees can function effectively. This should be considered as part of the annual evaluation of each committee. This would ensure a focus on the priority areas.	**Management Response** The Terms of Reference of ~~the Quality Committee and the Audit~~ the Board and all its directly reporting Committees have recently been reviewed ~~but will be further reviewed~~ to ensure appropriate submission of reports. One immediate action from the review has been to increase the number of meetings from quarterly to bi-monthly for both the Quality Committee and the Risk Committee. **Responsible Officer** David Holden **Due Date** 31.3.14 **Complete**
1314-GA-R09	● Low	**Appropriate Challenge** It was not evident from minutes whether action plans presented to the Board or the Strategy and Assurance Committee, had been appropriately challenged by members. This could indicate either a lack of challenge or a weakness in minute taking. There is a risk that management assurances over actions taken are not subject to sufficient scrutiny and may lack robustness and a sufficient audit trail. The Trust should ensure that there is an appropriate level of challenge regarding the management responses included in action plans and that this challenge is documented. Chairs should assess the extent to which their minutes reflect the actual level of challenge.	**Management Response** The Trust Chairman and Committee Chairs will be reminded about ensuring that there is an appropriate level of challenge regarding the management responses included in action plans and that the challenge is appropriately documented in the minutes. **Responsible Officer** David Holden **Due Date** 31.3.14 **Complete**

1314-GA-R10	Low	**Integrated Action Plan** Numerous different action plans are presented to the Board and the Strategy and Assurance Committee for consideration, approval and follow up. It is potentially confusing for Board and Committee members to be clear about the progress made on individual action plans. There is also a risk of duplication. The Trust should produce a single action plan showing the progress on all key recommendations arising from internal and external reviews. This should be presented to the Board or Strategy and Assurance Committee on a monthly basis.	**Management Response** An integrated action plan will be produced outlining the progress on all key recommendations arising from internal and external reviews and presented to the Board/SAC on a monthly basis. This has been progressed and will be submitted to the Board from April 2014. **Responsible Officer** David Holden **Due Date** 31.3.14 **Complete**

Response to the internal audit (KPMG) review of Governance Arrangements –

Board Reporting – Management Response

Introduction: Key Points to note:

1. This paper was to be presented to the April, 2014 meeting of the Board but in the event was deferred until the May 2014 meeting to allow Committees more time to assess their terms of Reference.

2. All ten items have had a management response and were signed off by the Chairman and Chief Executive before being returned to internal audit (KPMG) before the 31 March, 2014 deadline.

3. The Board should expect significant assurance on all matters listed. However 2 matters require specific mention:

4. A. Item RO7 – Attendance at the Quality Committee – At the time of writing, the Chair of the Committee with Committee members and officers of the Trust is reviewing the workings of the Committee and advised in February, 2014 that this working review would be completed in June, 2014.

5. B. Item RO9 – Appropriate Challenge – Board and Committee members have been reminded about ensuring appropriate challenge and that challenge is appropriately documented in minutes of the Board and its Committees. Discussions have taken place in terms of how robust challenge can be when meetings are held in public. This matter will require ongoing review.

David Holden
May 2014

Board of Directors Meeting

21st May 2014

Chief Executive's Assurance Report

1. Introduction

The Chief Executive's Assurance Report aims to highlight key issues for Board attention/discussion. The aim of the report is to inform the Board of the issues that are progressing well, the issues which are not progressing as planned, and therefore the level of assurance that can be provided to the Board in terms of achieving a range of targets/objectives. Where Board members would like further assurance, detailed reports can be accessed from the Reference Folder. Wherever I am in a position to do so I will either give a rating of:

- No assurance - little or no prospect of recovering the position/delivering going forward.
- Limited assurance - improvements are expected but full delivery is considered high risk.
- High assurance - significant improvements are expected and full delivery is considered likely.
- Full assurance - full delivery is expected.

The report is divided into key sections as shown below, although each area is interlinked to each other/the whole:

- Quality
- Risk
- Workforce
- Audit
- Finance
- Strategy

2. Quality

Overall we are making good progress in improving the quality of our services and overall I would give high assurance in this area. The following items are raised as areas where the Board can take positive assurance:

External Assurance

PLACE Assessment (for approval)

Annual PLACE Assessments have been undertaken during March/April at Blackpool Victoria Hospital and Clifton Hospital. Patient assessors make up 50% of the audit team. Environment assessments were carried out at ward and departmental level, from a patient perspective, each PLACE visit will generate a score in the four separate domains of:

- Cleanliness
- Food and Hydration
- Privacy, Dignity and Confidentiality
- Buildings & Grounds

Both assessments went extremely well with a number of positive comments being received from the patient assessors. It was extremely encouraging across all sites to receive excellent feedback from patients with regard to cleanliness of their room, food and food service, privacy and dignity and the nursing care they received. The HSCIC aim to notify Trusts of their preliminary results in July 2014, with final publication scheduled for September 2014.

National Care of the Dying Audit for Hospitals

This national report was published on 15th May 2014. 131 Trusts participated in this important audit of patient in care in June 2013. The audit focussed on the goals of care within the Liverpool Care Pathway and also involved case note review of a sample of all patients dying in hospital in their last days and hours of life. The report contains 18 clinical/organisational KPIs. Overall we have done very as summarised below:

Score	Number of KPIs
Highest score possible	3
High Score	5
Above Average	3
Achieved	2
Not achieved/below average	5

The results showed that we have shown good improvements in a number of areas including:

- MDT recognition that the patient is dying
- Review of patient's nutritional and hydration requirements
- Assessing spiritual needs for patients and relatives
- Anticipatory prescribing for the five symptoms at the end of life
- Review of the care after death

The audit results have identified that there are still improvements we can make with regards to open and sensitive communication with patients about their wishes and preferences for preferred place of death. This was an area we had recognised and we were successful in being supported with funding for 2 years to support a training programme delivered by a team of dedicated nurses to improve staff knowledge and skills around the provision of best care at end of life for patients and their families.

It should also be noted that the CQC Hospital Inspection highlighted the excellent work undertaken in End of Life Care and rated the Trust as outstanding in the domains of caring and responsive care at End of Life.

CHKS 40 Top Hospitals 2014

CHKS is a leading provider of healthcare benchmarking data and healthcare improvement services. Each year they rate all NHS Trusts and identify the top 40 performers. Blackpool Teaching Hospitals NHS Foundation Trust has been named as one of the CHKS 40 Top Hospitals for 2014. The rankings are based on 22 key measures of quality; including clinical effectiveness; patient experience and quality of care.

Care Quality Commission Hospital Inspection

The detailed action plan in response to the CQC Hospital Inspection findings and compliance actions was submitted to the CQC on 2nd May 2014. As yet there has been no further feedback from the CQC following receipt of the action plan although the CQC has been going through some organisational changes including the appointment of a new Inspection Manager for Lancashire. The action plan will be submitted by the 20th of each month and as well as our internal monitoring progress on implementation will be shared monthly with the Fylde Coast Commissioning Advisory Board.

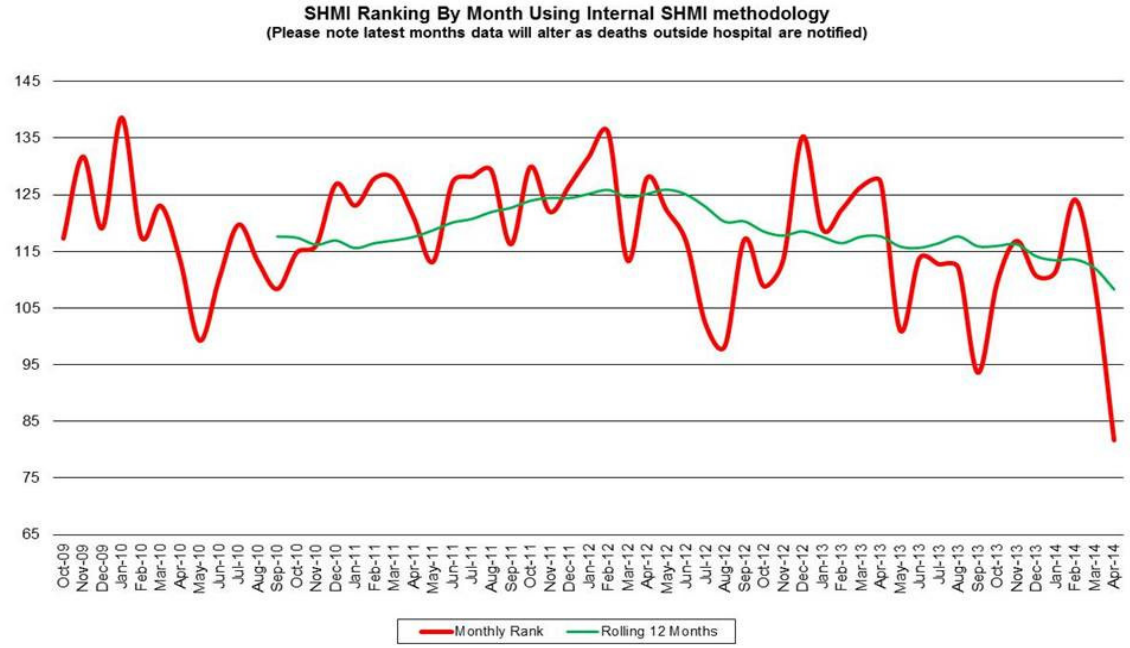
On the 30th April 2014 the Royal College of Obstetricians visited the Trust to undertake the invited review of Post Partum Haemorrhage, Maternity Services. 31 sets of notes were reviewed and overall there were no major clinical effectiveness / patient safety issues raised at the time of the visit. We await the final written report and as agreed at the Quality Summit this report will be shared with the CQC to inform a date for a re-inspection of Maternity Services.

Friends and Family Test

The Friends and Family Test score for April is 72 (same as March 2014) based on 2563 responses, which is our highest response rate to date. A & E achieved a 22% response rate, Inpatient 43% and Maternity 22%. 2353 patients recorded that they would be extremely likely or likely to recommend our services. The March 2014 combined national FFT net promoter score was 63.

Internal Assurance

Mortality Rates



Infection Control

C Diff performance is in line with trajectory (assuming no further cases in May). Zero cases of MRSA Bacteraemia.

Nursing Care Indicators

For the month of April the overall position is green for the hospital areas. Adult and Long Term Conditions showed a slight deterioration in April moving from 77% to 74%. Falls Assessment needs to improve.

Cancer Waiting times

All quarterly cancer performance standards were met for Quarter 4. There are a number of internal validation peer reviews scheduled over the coming months which the teams are preparing for in order to ensure compliance.

18 Week Waiting times

All 3 access standards were achieved for April. Capacity challenges remain in Cardiology and Cardiac which are being discussed with the Specialist Commissioners in order to come to an agreed resolution.

The following are raised as areas where either current performance or potential/perceived performance issues are such that I cannot give complete assurance to the Board.

Waiting Times in the Emergency Department (A&E)

Further to the details provided to Board members on a weekly basis with regards to A & E performance there are a number of management arrangements that have been put in place to strengthen the out of hours period and a refresh of policies associated with the management of emergency care. These include:

- Director of Operations/Deputy Director of Operations presence on site until 20;00 hours Monday to Friday
- Director of Operations/Deputy Director of Operations rota at the weekend to support the on call Executive Director
- Duty Manager on site from 20;00 hours until 22;00 hours to support the transition from the late to the night shift
- Review of medical staff payments to reduce the use of agency staff for key shifts in A & E and AMU
- A Locum A&E consultant has been headhunted
- Review of the current agency provision against the contract standards
- Launch of the internal professional standards across the Trust which supports the flow of patients from A & E into specialty wards
- Review of the Observation Ward Access Policy
- Review of the Escalation Policy and the associated action cards, this will be consulted on week commencing 19th May 2014

The ECIST review will commence on 30th May 2014. This review will encompass the emergency provision at the Victoria Hospital site, i.e. UCC, PCAU, A & E, Observation ward, AMU and SAU.

Dementia Screening

Performance in April for the 'find' and 'assess' elements of the Dementia CQUIN has deteriorated to 58.9% and 65.9% respectively. The data is now available on the number of patients referred for further diagnostic advice/ follow up and for the month of April performance was 53.8%. The actions reported to the April board meeting are being implemented and I have asked the Director of Nursing & Quality to lead the required performance improvement.

3. Risk

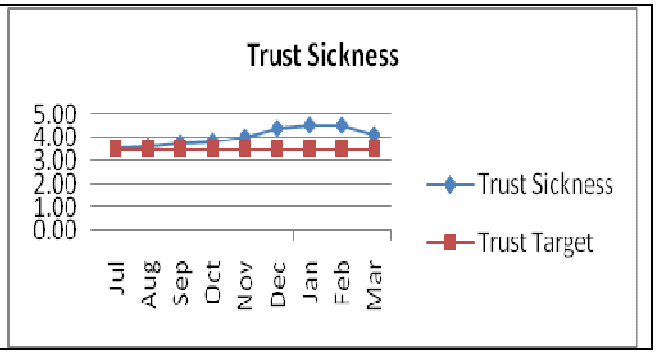
There is nothing to formally report as the Board meeting has been brought forward ahead of the Risk Committee meeting.

4. Workforce

Overall we are making progress and overall I would give high assurance in this area, although there are areas where improvement is needed.

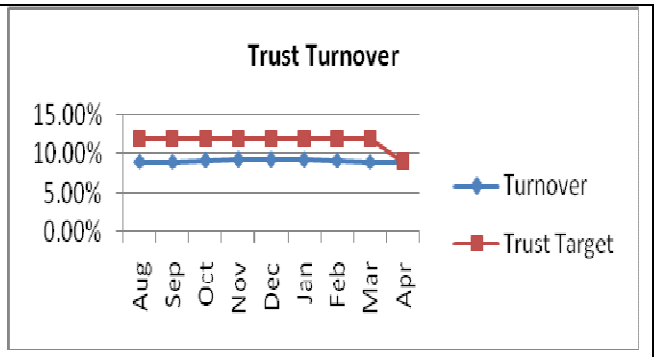
Sickness Absence

Trust Target	February	March
3.5%	4.52%	4.12%



Turnover

Trust Target	February	March	April
<9%	9.13%	8.92%	8.94%



Workforce Strategy

The workforce strategy was submitted to the Workforce Committee for consideration by members and a positive discussion took place with changes required to the current version prior to submitting to the Strategy and Assurance Committee in June. A summary on a page will be developed for staff to support the communication of the new strategy.

Consultant Recruitment Update

As at 12th May 2014, there are currently 60 vacancies recorded within the Medical Workforce department compared to 57 in March 2014. The current total is made up of 34 consultant and 26 non consultant vacancies. 60% of vacancies are either currently being advertised, within the selection process or under offer. Clearly the vacancy levels for the medical workforce are high and this incorporates a mixture of grades, additional new posts and leavers. The projected vacancies trajectory based on the time to hire for these posts or start dates where already known, as well as known vacancies in the pipeline, indicates there will be a firm handle on current vacancies between August – October 2014 in the majority of divisions. However, based on current time to hire and performance to date, the control on vacancies in Unscheduled Care is likely to be more protracted and could even be extended further if current interventions prove ineffective. Recognising this, a series of alternative resourcing approaches are either being developed or are well underway to increase the chances of meeting the projected targets for Unscheduled Care.

Job Planning

The position has changed little since last month; with 95% of job plans now inputted on to the system and for 80% of those inputted, consultants are now reviewing their job plans and engaging in discussion meetings with their line managers. Communication was circulated by the Medical Director informing individuals that job plans must be fully signed off by 31st May 2014 and the Medical Workforce team are reporting an increase in activity on the system by individuals to achieve sign off by this date.

Mandatory Training

Trust Target	February	March	April
90%	80%	79%	82%

Mandatory Training compliance is at the highest it has ever been since records began. E-learning is fast becoming the completion method of choice.

Corporate

Corporate Induction is at 85% compliance against a target of 90%. This has been facilitated by tighter controls around new starter reports and the booking of the new staff onto the programmes. Also, there is dedicated administrative support for this in the L&D department.

Non-Medical Appraisal

At the close of the Appraisal Window in 2013 the compliance rate for non-medical appraisal reached 73% against a target of 90%. Many improvements to the e-system, the training, access, the publicity and the marketing lead to an offering of high assurance for non-medical appraisal for August 2014.

Medical Appraisals

The overall completion rate is 84%, which has increased from 82% in March 2014. This includes an increase for consultants to 88% from 86% in March 2014.

For SAS doctors (Specialty Doctors and Associate Specialists) the appraisal rate has decreased slightly to 74% from 75% in March 2014.

5. Audit

Following the Audit Committee meeting on 29th April 2014, the Chairman of the Audit Committee has produced an Assurance Report for the Board (accessible from the Reference Folder). The Audit Committee is able to give the Board strong assurance on three areas reviewed at its meeting and limited assurance on two areas.

There is one recommendation from the Audit Committee to the Board for approval as follows:-

- The internal audit programme includes part of a day to support a discussion session with the Board to enable it to review and update its risk appetite. This is proposed in order to support the current strategic thinking of the Board and to allow the updated risk framework to reflect the risk appetite accurately in the content of the Board Assurance Framework.

6. Finance

Income and Expenditure

The 2014-15 Operational Plan was submitted to Monitor on the 4th April 2014.

The Trust reported a deficit of £1.1m for April, which is £0.1m worse than the plan for the period. The main variances to the plan are as follows: -

- Income £0.5m worse than plan predominantly as a result of lower than planned clinical activity / income and lower than planned NWLA income where income and expenditure are matched;
- Operating expenditure £0.3m better than plan due to unfilled vacancies and lower than planned NWLA expenditure.
- CIP performance is in line with plan, with non-recurrent fortuitous savings currently supporting the delivery;
- Non-operating expenditure £0.1m better than plan linked to a reduction in both depreciation and the PDC dividend.

As a result the Trust has delivered a better than planned Continuity of Services Risk Rating (CoSR) of 3.

The main highlights of the year to date performance are: -

- **Income** – Income is £0.5m worse than the plan, with clinical income, including the impact of the assured contract, currently £0.3m worse than the plan. Non-clinical income is £0.2m worse than the plan predominantly relating to the NWLA where income and expenditure are matched (see below).

- **Pay Expenditure** – Pay expenditure is £0.3m better than the plan with lower than planned expenditure across all substantive staff groups other than consultants. Gross agency expenditure is £0.6m worse than the plan.

- **Non-Pay Expenditure** – Non-pay expenditure is marginally better than the plan. Drug expenditure is £0.1m worse than the plan. Other non-pay expenditure is £0.2m better than the plan with £0.1m predominantly due to lower than planned NWLA expenditure which is matched by income (see above).

Contractual Performance

The Trust has agreed hybrid contracts with both Blackpool CCG and Fylde and Wyre CCG. These contracts incorporate national Payment by Results rules in respect of planned work (elective inpatients, daycases and outpatients etc.) and an assured contract in respect of unplanned work (A&E, non-elective inpatients etc.). In addition, a number of elements of these contracts are also block funded.

The Trust is £0.1m ahead of plan against the Blackpool CCG assured element of the contract and £0.2m ahead of plan against the PbR element of the contract. The net performance for Blackpool CCG is £0.2m ahead of plan. The Trust is £0.1m behind plan against the Fylde and Wyre CCG assured element of the contract and £0.1m ahead of plan against the PbR element of the contract. The net performance for Fylde and Wyre CCG is £0.1m ahead of plan. The Trust is still in negotiation with the Specialist Commissioners to agree a contract. The Specialist Commissioners currently have an affordability gap and are looking at options to close this gap. The Trust is currently £0.4m behind plan based on reimbursement at full Payment by Results rules / tariffs.

Total clinical income is currently £0.3m worse than plan.

Cost Improvement Programme (CIP) Performance

The April CIP performance is in line with plan with non-recurrent fortuitous savings currently supporting the delivery. Lower than planned delivery by the Procurement, Medicines Management, Divisional and Theatre Productivity themes are being offset by higher than planned delivery by the Workforce theme.

Cash Performance

The end of April cash balance is £7.7m better than plan. The main components of the higher than forecast cash balance are as follows: -

- Capital cash undershoot £0.2m
- Active management of trade creditors £1.1m
- Underlying cash improvement in March £2.3m
- Improvement in debtors / accrued income £1.0m
- Contract under performance £3.1m

Overall Financial Plan

The 2014-15 Financial Plan forecasts a deficit of £1.3m with a CoSR of 2 throughout the period.

The cash balance is forecast to reach a minimum of £13.0m in March 2015.

Based upon the size/risk of the CIP challenge, much of which is scheduled to be delivered in the second half of the year and the cash balance there is limited assurance that a CoSR of 2 will be achieved at the end of the financial year. Given the level of challenger Monitor requires the Trust to return monthly financial monitoring templates from Month 2 onwards.

7. Strategy

7.1 Strategic Planning Update

The Trust must submit its 5-year strategic plan to Monitor on 30th June 2014. Several actions have been completed or are underway to support this:

- Launch of the vision, values and strategic objectives through ten events (with invites to 50 members of staff to each session) that will be facilitated by the Organisational Development team using an appreciative inquiry approach.

- Ongoing meetings of the three strategic working groups (Community-Centred Care, In-Hospital Care and Lancashire Partnerships) to further develop the detail around the Trust's high level strategic intent in each of these key areas. Each group has Executive Director, Non-Executive Director and Divisional Director membership, and has been asked to identify initiatives and desired outcomes associated with their theme.

- Discussions with Specialised Commissioners regarding the 5-year strategic plan for specialised services, which will be subject to consultation from July 2014.

- Participation in pan-Lancashire strategy setting including the Lancashire Transformation Executive Group (led by the Lancashire Area Team), the Morecambe Bay Strategic Board and "Stakes in the Ground" sessions (led by University Hospitals of Morecambe Bay NHS Foundation Trust), and a Directors of Strategy / Business Development working group.

- Development of plans in partnership with the Clinical Commissioning Groups to ensure that there is a shared vision for the future of healthcare services across the health economy. A Strategic Planning Assurance session was held by the Lancashire Area Team on 13th May 2014, at which the Trust and the two CCGs discussed their joint vision and initiatives to support delivery.

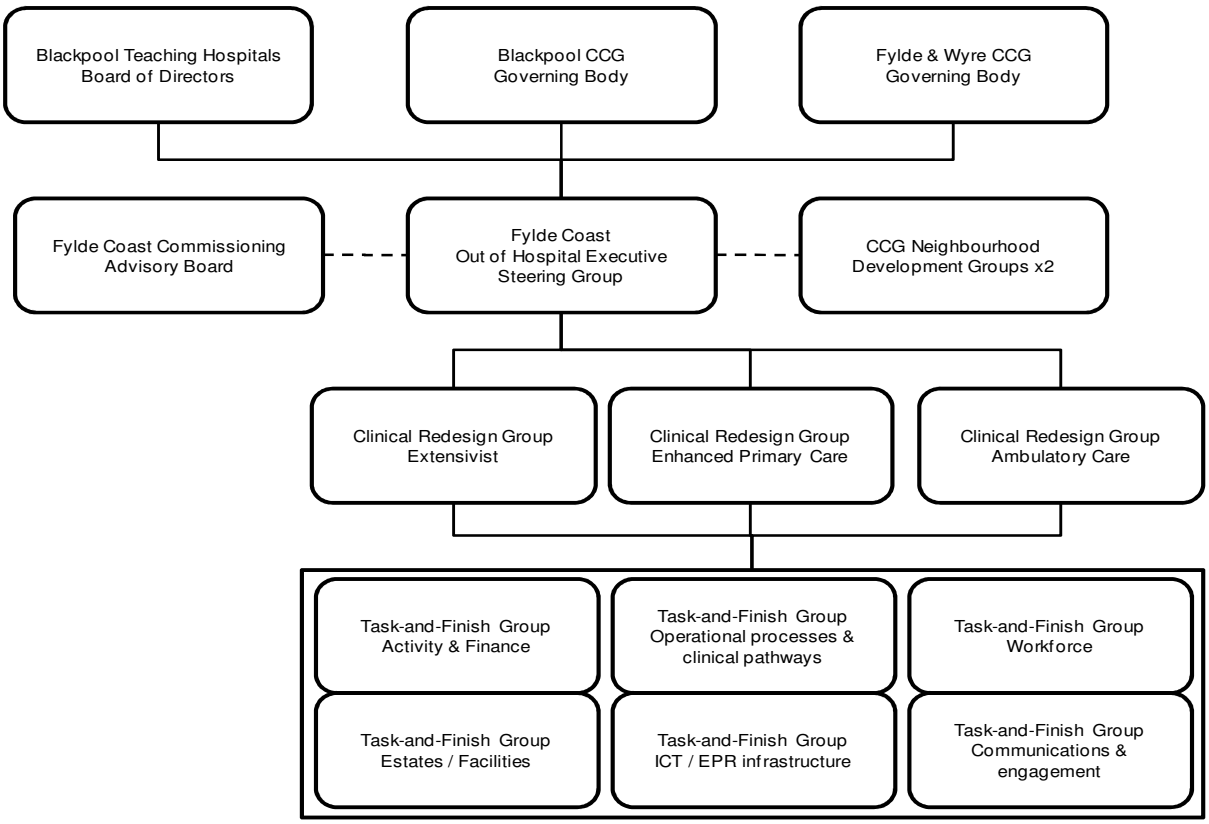
- Further joint planning work with the CCGs and the Local Authorities (Blackpool / Lancashire) is underway through various workstreams and regular meetings of the Fylde Coast Commissioning Advisory Board and the Better Care Fund Programme Board.

- Establishment of a Fylde Coast Out of Hospital Executive Steering Group, with representation from the Trust, two CCGs, local authorities, mental health services and the Lancashire Area Team. The group is leading on the redesign of three key clinical models of care: (i) extensivist services which will support the frail elderly and patients with multiple long term conditions to receive care and support closer to home wherever possible; (ii) enhanced primary care services which will support patients with one or two long term conditions in effectively managing their care within primary care wherever possible; and (iii) ambulatory care services which will see a transfer of non-acute services into community-based settings. The initial focus is on the extensivist clinical model, and a redesign team with representation from consultants, GPs, nurses and AHPs has been established to identify the most effective way of providing care.

An overview of the Trust's 5-year strategic plan will be presented to the Board of Directors in July 2014.

7.2 Governance Framework (for approval)

There are various working groups and committees across the local health economy that are tasked with creating and reviewing strategic plans, as well as shaping the initiatives that will deliver the required changes to clinical services. The governance structure that supports this is shown below:



All groups have clinical representation from the Trust and CCGs.

Within the Trust, the three strategic working groups (Community-Centred Care, In-Hospital Care and Lancashire Partnerships) will feed into this governance framework where appropriate.

The Board of Directors is asked to note and approve these governance arrangements.

7.3 Fleetwood Twenty-bed Nurse-led Rehabilitation Facility (for approval)

NHS Fylde and Wyre Clinical Commissioning Group (CCG), NHS Blackpool CCG and Blackpool Teaching Hospitals NHS Foundation Trust undertook a review of elderly care rehabilitation services across the Fylde Coast in 2012. This included community hospital inpatient and community rehabilitation services. The aim was to put in place a new service model more focused on rehabilitation, on improving the services supporting people in the community, and on discharging people from hospital sooner. The proposals, which went out to formal consultation in November 2012, included a new 20 bed rehabilitation service at Fleetwood Hospital.

After considering the outcome of the consultation, NHS Fylde and Wyre CCG confirmed that Fleetwood would be the future location of the 20 nurse-led rehabilitation beds at its governing Body meeting in September 2013. At this meeting, the CCG Governing Body announced an appraisal of available sites in Fleetwood. This was because circumstances had changed since the time of the original review which had identified Fleetwood Hospital as the proposed site. Fleetwood Health and Wellbeing Centre in Dock Street was not part of the original review as it was not open at the time. As the centre's potential as a future site was unclear, the Governing Body agreed that it was important to consider all current options.

The CCG Governing Body asked Blackpool Teaching Hospitals NHS Foundation Trust to conduct an appraisal of the two sites to determine where the beds would be located. This has included a detailed financial and clinical evaluation, the latter of which involved doctors and nurses from the hospital and primary care assessing the suitability of both sites to deliver the new service.

The clinical and financial appraisals have now been completed. A stakeholder event is scheduled for early June 2014 to consider the preferred location. Ultimately it will be a CCG decision whether to accept or amend the recommendation of the option appraisal.

The Board of Directors is asked to give delegated authority to the Chairman and Chief Executive to work with the CCG regarding the final decision of the preferred location after the stakeholder event.

8. Annual Reports 2013/14 (for approval)

- Patient Relations Annual Report

The Annual Report provides information regarding informal concerns and formal complaints received in the Trust between 1st April 2013 to 31st March 2014.

The Board of Directors is asked to approve the content of the report.

9. Policies/Procedures/Plans/Guidelines (for approval)

- Registration Authority Policy and Procedure

The purpose of the document is to provide information and guidance of the national obligations, roles and responsibilities of the Registration Authority (RA) and the registration process to issue and update NHS Smartcards to Users.

The RA, within the local governance structure, will ensure that all aspects of Registration Authority services and operations are performed in accordance with the Policy/Procedure.

The document provides an overview of registration and the assignment of access to NHS Smartcard applicants by the local Registration Authority and Sponsors using current available processing systems.

The Board of Directors is asked to ratify the recommendation of the Health Informatics Committee and the Trust Management Team.

Gary Doherty
Chief Executive

Board of Directors Meeting

Wednesday 21st May 2014

Subject:	Chief Executive's Update
Report Prepared By:	Gary Doherty
Date of Report:	14th May 2014
Service Implications:	For the Board to be updated on matters the Chief Executive has been involved in.
Data Quality Implications:	None.
Financial Implications:	QuIPP essential to sustainability.
Legal Implications:	None.
Links to the Principles of The NHS Constitution:	Links to the Principles of the NHS Constitution throughout.
Links to the Blackpool Way:	The Blackpool Way is in place to promote employee engagement as a means of transforming the culture and performance of the enlarged organisation. The report covers a number of items pertinent to the Blackpool Way.
Links to Key Organisational Objectives:	Providing 'Best in NHS" Care for our patients.
Links to Care Quality Commission Quality and Safety Standards	Links to all CQC outcomes
In case of query, please contact:	Gary Doherty, Chief Executive (ext 6853)

Purpose of Report/Summary: - To provide the Board of Directors with an overview of activities during the past two months.

Key Issues: None to highlight specifically.

The Board is asked to: Review and note the contents of the report.

Risk Rating (Low/Medium/High): Low **BAF/CRR Number: N/A**	**Board Review Date:** March 2013

Report Status: the Author must indicate whether the document is "for information", "for discussion" or "for approval" (please indicate).

1 **For Information** ☐	**2** **For Discussion** X	**3** **For Approval** ☐

Document Status: the Author must indicate the level of sensitivity of the document (please indicate).This relates to the general release of information into the public arena.

1 **Not sensitive:** X **For immediate publication**	**2** **Sensitive in part:** ☐ **Consider redaction prior to release.**	**3** **Wholly sensitive:** ☐ **Consider applicable exemption**
Reason for level of sensitivity selected		

Board of Directors

21st May 2014

CHIEF EXECUTIVE UPDATE

There are a number of external/internal CEO activities since the last meeting that I would draw to the Board's attention in addition to those mentioned in the April CEO activity report or the May CEO assurance report:

On the 25th April the Chairman and I met with Ben Wallace MP for Wyre and Preston North/ later that day we met with Blackpool Healthwatch where we covered a range of key issues including our CQC report.

On the 1st of May I spent some time in our Coding Department. Clinical coders are vital. They use our written and electronic records to classify our admissions and operations into standard, NHS-wide codes which is the basis for our funding as well as being able to have any meaningful analysis of issues such as mortality rates, lengths of stay, day case rates etc.

On the 7th May the Chairman and I sat on a consultant appointment panel for diabetes/endocrinology. I'm delighted to say that we made two excellent appointments. We had a local GP on the appointment panel, which strengthened the process and is an idea I would like to see spread to other panels where appropriate.

On the 8th May I met with pupils and staff from Highfurlong Special School who had taken part in a special project aimed to help us improve the quality of service we deliver to young adults. The pupils visited a number of local health care premises in the area and reported back to staff from the hospital and a number of our partners on their findings. The group brought up important topics such as accessibility and other areas such as the language we used which can be quite confusing at times. There were some ideas including pictures of consultants in treatment areas and including more details of the facilities we offer on our website that we can work on quickly. We will put together an action plan and let the pupils know how we have put their ideas into practice.

On the 9th May I gave an opening address at our Safe and Compassionate Practice event, which was part of International Nurses Day. There were speakers from teams working in the community and acute settings with many of the talks based on the Six Cs of care, courage, commitment, compassion, competence and communication. On the 9th May I also accompanied the Chairman on a visit to Blackpool Sixth College. We met with Felicity Greeves (Principal) and John Boyle (Chair) to discuss how we might better work together on a range of areas, but particularly how we could get across the very wide range of career opportunities that exist within the local heath service.

On the 6th and 9thMay the Chairman and I met with each of our key governor groups - Blackpool, Fylde, Wyre and staff governors.

On the 12th May I represented the Trust at the "Mayor making" ceremony at Blackpool Town Hall. The new Mayor is Councillor Val Haynes who represents the Hawes Side Ward. The Deputy Mayor is Councillor Chris Ryan, who works in the Trust Transport Department.

Gary Doherty
Chief Executive

Board of Directors Meeting

21st May 2014

Chairman's Update

Trust Activities

- I have now completed the annual appraisal process for the Non-Executive Directors. Feedback was provided to the Nominations Committee on the 6th May and will be provided to the Council of Governors on the 16th May.

- As part of my request to Heads of Departments to attend one of their consultant departmental meetings, I have attended two further specialty meetings, namely, Radiology and Accident & Emergency.

- I chaired an Advisory Appointments Committee for the post of Consultant in Endocrinology/Diabetes. Dr Qazi and Dr Aye have been appointed and their official start date has yet to be confirmed.

- Board members will recall previous reference to a potential NED candidate with a clinical background, whom Dr O'Donnell and I have previously met. Following discussion at the Nominations Committee meeting on the 6th May, arrangements were made for Board members to meet with the candidate on the 9th May which included myself, Gary Doherty, Wendy Swift and Tony Shaw. Arrangements are now being made for a formal interview to take place in June.

- I attended the Nurses-Midwives-Therapies Day on the 9th May to give the closing remarks. The event, which celebrated safe and compassionate practice, was extremely successful and attracted more than 100 healthcare professionals.

- The Chief Executive, Director of Strategy and I met with representatives from Fylde & Wyre CCG on the 13th May, namely Mary Dowling, Tony Naughton, Peter Tinson and Kate Hurry, to discuss the future arrangements for Fleetwood Hospital.

- Following the recent opening of the new Multi-Storey Car Park and Main Entrance, I would like to express thanks, on behalf of the Board, to Robert Bell and his team for ensuring that the scheme was completed on time and within budget. It is an excellent facility which has been very well received by patients, relatives and staff.

Governors and Membership

- The Chief Executive and I met with individual Governor Constituencies on the 6th May and 9th May when a number of issues/concerns were discussed, one of which was in relation to tackling our recruitment problems by working with local schools and colleges to encourage students to take up health care careers in the local area.

- I met with Mr Zacharias on the 28th April to discuss proposals around increasing Governor interest in the northern part of the community and the possibility of arranging seminars and inviting previous and existing patients of the Lancashire Cardiac Centre.

- I had my quarterly update meeting with the Lead Governor (Peter Askew) on the 2nd May and Chris Smith (Deputy Lead Governor) joined us for part of the meeting.

- I chaired the Governors' Nominations Committee meeting on the 6th May which included discussion about my appraisal/objectives (reported by Tony Shaw in his capacity as Senior Independent Director), the NEDs' appraisals/objectives, the re-appointment of two of the NEDs and proposals regarding NEDs' annual remuneration.

- I met with Amanda Eagle, Learning & Organisational Development Facilitator, on the 7th May to discuss proposals for a Governors Development Programme, which it is intended will commence after the 2014 Governor elections in September for three months, i.e. October/November /December.

- Following the proposal and approval in principle for the Institute of Directors and the Citizen Advice Bureau to be stakeholder organisations on the Council of Governors, I have now received formal notification of the name of their nominee which is Philip Hargreaves and Tony Winter respectively.

- This year's Annual Members' and Public Meeting will take place on Monday 22nd September 2014 at 6.00 pm

External Relations

- The Chief Executive and I met with Ben Wallace (MP) on the 25th April, following which I attended a meeting with the Consultant Cardiologists which Mr Wallace had been invited to attend.

- The Chief Executive and I met with representatives from Blackpool Healthwatch on the 25th April.

- I attended a King's Fund Event on the 1st May entitled "Developing Models of Integrated Care for Chronic Conditions" which explored different models of integrated care and identified ways in which teams and individuals can help to make real improvements to local services

- I met with Maggie Cornall, Director of Housing at Blackpool Council, on the 2nd May.

- On the 9th May, the Chief Executive and I met with the Principal and Chairman of Blackpool Sixth Form College (Felicity Greeves and John Boyle) to discuss possible joint working on a range of areas, in particular how to promote the very wide range of career opportunities that exist within the local heath service.

- Following my involvement on the interview panel for the appointment of a Chairman at Wrightington, Wigan & Leigh NHS FT, I met with the successful candidate (Robert Armstrong) on the 13th May.

Future Meetings

Looking forward, I am attending the following events/meetings:

- Council of Governors Meeting – 16th May.

- Monitor Conference Call – 19th May.

- AQuA Masterclass: Leading Deep Cultural Change – 20th May.

- Chairs Forum for NHS North West Leadership Academy Members – 22nd May.

- AAC for Trauma/Orthopaedics – 23rd May.

- Interview Panel for Non-Executive Director Recruitment at North West Ambulance Service – 11th June.

Ian Johnson
Chairman

BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST

REGISTER OF INTERESTS

1ST APRIL 2014 – 31ST MARCH 2015

INTEREST	SIGNATURE	DATE

Board of Directors Meetings – Attendance Monitoring
1st April 2014 to 31st March 2015

Key: **G- Attended** **Y- Apologies** **R-No Apologies** **Blue- N/A**

* Extraordinary Board Meetings

Attendees	30.4.14	21.5.14	30.7.14	24.9.14	29.10.14	17.12.14
Ian Johnson (Chairman)	G					
Tony Shaw	G					
Karen Crowshaw	Y					
Doug Garrett	G					
Alan Roff	G					
Jim Edney	G					
Michele Ibbs	Y					
Gary Doherty	G					
Marie Thompson	G					
Dr Mark O'Donnell	G					
Pat Oliver	G					
Wendy Swift	G					
Nicky Ingham	G					
Tim Bennett	G					