Blackpool Teaching Hospitals NHS
NHS Foundation Trust

QUALITY ACCOUNT
2015 – 2016

Quality Account

Table of Contents

If you require any further information about the 2015/16 Quality Account please contact: The Corporate Assurance Team on 01253 655520 or email Judith Oates at judith.oates@fwhospitals.nhs.uk

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 throughout the year and we share our achievements and quality performance with you through our Quality Account.

Our staff have remained committed to providing safe, high quality care to all of our patients both within a hospital setting and a community setting. We truly believe that staff who enjoy their work and have pride in it, will provide patients with better care which is why part of our agreed organisational culture advocates that our staff are people centred, compassionate, positive and excellent.

These Quality Accounts are our seventh yearly published accounts as a Foundation Trust and I am delighted to highlight the excellent progress we have made over the past 12 months in ensuring our patients receive the highest quality care possible.

Ensuring patients receive high quality and safe care is our Trust's key priority and as our services are constantly changing and improving to meet the needs of the local health economy and community we have introduced new initiatives to improve the quality of care and patient experience. The Quality Account for the 2015/16 period highlights the work we have been doing over the past 12 months and it includes a detailed overview of the improvements we have made during 2015/16 whilst also setting out our key priorities for the next year 2016/17.

Ensuring our patients receive a positive experience of care is important to our staff and for us as an organisation and we are pleased with our results in our patient experience surveys and the positive feedback of the number of patients stating that they would recommend our services to a relative or friend.

Patient and relative positive feedback was also provided to the Care Quality Commission (CQC) who re inspected the Trust in September 2015. They reviewed our maternity services and our Accident and Emergency services. The overall rating for the Trust remained 'requires improvement' but I am pleased to report that the individual rating for maternity services improved to a rating of 'good'. Although our Accident and Emergency Services remained with a rating of 'requires improvement' there were many positive areas of good practice that were identified by the inspectors.

In its formal report on both of these services the CQC drew out a list of good practise, including:

- Improved leadership in the Accident and Emergency Department with a strong multi-disciplinary team.
- Staff were positive and proud of the work they did.
- Effective collaboration and communication among all of the multidisciplinary teams
- Trust investment in senior staff through leadership training and coaching.
- Staff observed treating patients with compassion, respect and dignity.
- A new midwifery staffing model was noted as having positive impacts.
- Patients were noted as having a high regard for staff and clinical teams.
- A good incident reporting culture was in place that promoted lessons learned culture.
- Midwifery 'star buddies' programme to support breast feeding was noted as outstanding practise.

The above gives real confidence to the people who access our services in the standard of care that is provided and of the dedication of our staff in all of their efforts to ensure we deliver best care to our patients. 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.

Looking forward to the year ahead, we intend to increase our efforts even further towards driving quality and safety improvements across the organisation. That is why we have spent the latter part of 2015 / 2016 reviewing our quality strategy in line with a Trust wide strategy review. We are pleased to be able to set out in the accounts the intention of the new Quality Strategy for the coming 3 years which is what we will be reporting against going forward into the coming year. The strategy focuses on three key principles that care will be

- Informed
- Timely
- Safe

Within these three domains are 2 primary metrics, each having a number of targets attributed to them in terms of measuring and monitoring the performance and progression of each of the domains.

We are pleased with our achievements as 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 and that going forward our Quality Strategy will continue to help us achieve this.

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 2015 – 31st March 2016 is a balanced and accurate account of the quality services we provide.

W. A. Swift

Wendy Swift
Interim Chief Executive

Date: 25th May 2016

2: Priorities for Improvements and Statements of Assurance from the Board

The Trust Board sees improving quality as a primary focus at Blackpool Teaching Hospitals NHS Foundation Trust and has endorsed the review and development of a new Quality Strategy (set out on page 24 of the Quality Accounts). The organisational Strategic Framework already in place underpins the current quality programme set out in this Quality Account for 2015/16 and will continue to be an enabler for the quality priorities set out in the new strategy. We believe the new Quality Strategy will enable us to maintain a focus on the quality and safety agenda, whilst the organisation completes and enacts its Trust-wide strategic review, which has taken place during 2015 /2016. Delivering the new Quality Strategy alongside the wider Trust Strategy will ensure improvements to the health and outcomes of our local population based on the values and principles set by the Board of Directors.

2.1 Rationale for the Selection of Priorities for 2016/ 2017

The Trusts priorities for 2016/17 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 2016/17 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 2016/17 and after consultation through the Quality Committee reporting into the Trust Board, the improvement priorities outlined in the metrics identified within the new Quality Strategy, 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 which set out the high-level national outcomes that the National Health Service (NHS) should be aiming to improve. The priorities focus on 3 key elements in the quality of care with the belief that care should always be;

- Informed
- Timely
- Safe

The quality improvement priorities selected by the Board of Directors for implementation in 2016/17 have been aligned to the new Trust Strategy and supports the implementation of the new Trust strategic progression forward.

The priorities will be measured through agreed targets for the metrics within the 3 key elements of quality and performance against these targets will be reported quarterly to the Quality Committee, which is a sub-committee of the Trust Board. The Non - Executive Director Chair for the committee will provide an assurance report to the Trust Board on progress against the agreed priority areas.

2.2 A Review of Quality Improvement Projects 2015/16

Below is a list of quality initiatives in progress and their current status. Each project is explained in the individual project pages

(= - Target achieved, < - behind plan, >> - close to target)

	Target Achieved / On Plan	Close to Target	Behind Plan
Harm Free Care		>>	
Sign up to Safety	= Stage 3&4		< Stage2
Reducing Patient Falls		>>	
Reduction in Pressure Ulcers	= Stage 3&4		< Stage2
Care of the Deteriorating Patient		>>	
Clinical Pathways			<
Patient Safety – Lessons Learned			
Duty of Candour			
Infection Prevention - MRSA			<
Infection Prevention – Cdiff			<
Patient Family and Carer Experience – FFT		>>	
Patient Family and Carer Experience – 'Tell Us' Campaign		>>	
Patient Family and Carer Experience – Always Events	=		
Patient Family and Carer Experience – PROM's		>>	
Dementia Care	=		
End of Life Care			
Spiritual Care			
Bereavement Care			

2.2.1 Harm Free Care

What:	Patients will be free from harm from falls, pressure ulcers, Catheter Associated Urinary Tract Infection (CA-UTI), Venous thromboembolism (VTE)
How much:	95%
Outcome:	93.5% all harms, 97.8% new harms.
Progress:	>> Close to target

To help us monitor the safety of our patients, each month we use a tool from the Department of Health called the Safety Thermometer to audit the care given to our patients. The safety thermometer measures harms that occur to patients whilst in our care and identifies how many of our patients experience one of the following four harms:

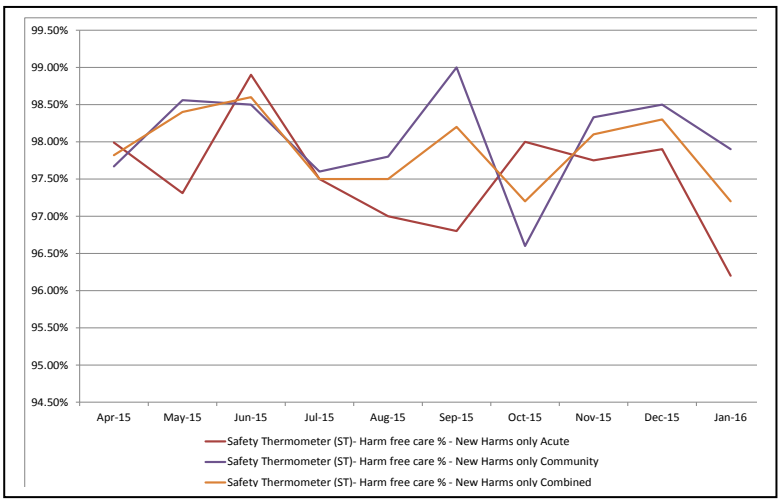
- pressure ulcers
- falls
- blood clots (VTE)
- urine infections for those patients who have a urinary catheter in place

This information helps us to understand where we need to make improvements in delivering harm free care. We pay particular attention to new harms as we are more able to prevent these happening.

In 2015/2016, based on Safety Thermometer data 45 out of 7931 hospital in-patients (0.57%) were reported as having a Catheter Associated Urinary Tract Infection (CAUTI). 47 out of 7931 hospital in-patients (0.59%) were reported as having a Venous thromboembolism (VTE). The Trust can report this demonstrates an improvement in year.

Each of the four harms are then looked at in more detail by individual project teams to learn how we can improve patient care and outcomes and implement improvements in the specific area. This year the infection prevention team have actively supported patient and staff education and training to promote the effective care of catheters to prevent infection. Focus in the year from a VTE perspective has been to ensure risk assessments are carried out and patients receive the correct treatment plan based on their risk.

Further details of successes with falls and pressure ulcers can be found on the individual topic area. The graph opposite shows percentage of patients who received harm free care as a result of new harms.



'Harmfree'care
A new mindset in patient safety improvement

This year we have also looked at the harm free care provided to our patients in their own homes as part of the community safety thermometer, and of patients receiving care from our maternity services as part of the maternity safety thermometer project.

2.2.2 Sign up to Safety

What:	Improve the safety of our patients and reduce avoidable harms
How much: By March 2017	Stage 2 pressure ulcers 30% reduction Stage 3 & 4 pressure ulcers 50% reduction Falls 20% reduction Failure to rescue deteriorating patients 50% Meet pathways compliance for sepsis & AKI
Outcome:	●Stage 2 pressure ulcers +13% *Stage 3 & 4 pressure ulcers 19.67% *Falls 6% *Failure to rescue deteriorating patients 17% ●Meet pathways compliance for sepsis & AKI - currently reviewing compliance measures
Progress:	= *On Target < ●Behind plan

Sign Up To Safety (SUTS) is a national campaign and unified programme for patient safety across the NHS in England. The aim of the programme is to reduce avoidable harm by half and save 6000 lives over the next 3 years, and to sustain the improvement over the following 3 years, whilst continuing the focus and drive on safety improvements.

The Trust has made 5 key safety pledges and is working with commissioners, Academic Health Science Network's, Health Foundation, NHS England and regulatory bodies to develop and embed safety initiatives to improve patient outcome and experience.
Our pledges were to:

- Put safety first and commit to reduce avoidable harm
- Continually learn and make our organisation more resilient to risks
- Be honest and transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
- Work collaboratively with local and regional services
- Support staff to understand why things go wrong and how to put them right

The Trust has identified that its key focus of safety will cover the following areas:

- Falls
- Pressure ulcers
- Clinical pathways
- Care of the deteriorating patient

These focus areas were identified as each has a risk that impacts on patient safety, supports the delivery of the Trust strategy and Quality Goals, supports the delivery of our Compassionate Care Strategy and supporting the delivery of standards for providing care that is safe, effective, caring, responsive to people's needs and well-led.

A multi-disciplinary project team which includes clinical and non-clinical staff, governor representation and patient experience representation, with Board level support oversees the work of the campaign.
Further detail of the successes can be found on the individual topic area.

2.2.3 Reducing Patient Falls

20%

What:	Reduce the number of patients experiencing a harm as a result of a fall
How much:	20% reduction by March 2017
Outcome:	On trajectory - reduction of 6% in year.
Progress:	>> Close to target

Sign up to SAFETY

NHS England

A fall is defined as "*inadvertently coming to rest on the ground, floor or other level, excluding intentional change in position to rest on furniture, wall or other objects*" (WHO 2007) As part of our patient safety programme we are focussing on falls prevention.

"Leaves are supposed to fall, people aren't." As a trust we have introduced the falling leaf symbol to identify patients at risk of falling. These symbols alert staff at safety briefings of the patient's risk of falling, so all staff are able to visually see and consider the patient's safety needs to prevent falls when planning and delivering their care.

As part of our Sign Up To Safety Campaign we have been lucky to employ two Falls Risk and Response Nurses this year who have provided intensive support to clinical staff in the hospital and community settings in promoting and ensuring patient safety in falls prevention and post fall care. In addition to the support, they have also introduced a variety of quality improvement initiatives, including educational tools, patient information, 'falls risk socks' and hosting a week long Falls awareness campaign that involved our Clinical Commissioning Group (CCG's), General Practitioner's (GP's) ambulance and voluntary services.

The team work closely with all disciplines across the health care environment to support the safe discharge of patients who have been hospitalised following a fall, to help prevent a re-occurrence.

2.2.4 Reduction in Pressure Ulcers – Acute/Community

30% Stage 2

50% Stage 3 & 4

What:	Reduce the number of patients experiencing a harm as a result of a pressure ulcer
How much: By March 2017	Stage 2 pressure ulcers 30% Stage 3 & 4 pressure ulcers 50%
Outcome:	●Stage 2 pressure ulcers +13% *Stage 3 & 4 pressure ulcers 19.67%
Progress:	= *On Target < ●Behind plan

A pressure ulcer is sometimes known as a pressure sore or bed sore. They can develop when a large amount of pressure is applied to an area of skin over a period of time. Patients in hospital are more at risk of developing pressure ulcers as they are ill and often immobile for a period.

By regular repositioning of patients and encouragement of mobility we assist in preventing pressure ulcer formation wherever possible. Within our Organisation we have a range of pressure redistribution mattresses available including cushions and offloading products.

As part of our Sign Up to Safety Campaign we have employed 2 additional Tissue Viability Nurses to implement quality improvement initiatives and support staff in the identification and correct grading of pressure ulcers which has resulted in the initial increase in reported stage 2 pressure ulcers. They are involved in a project to provide intensive wrap around support to wards and community localities to promote staff and patient education. Grade 3&4 pressure ulcers have reduced by 19.67% due to the early identification of patients' with existing tissue damage on admission. The project team have developed a new root cause analysis tool to help staff identify how we can make improvements through learning when a harm does occur.

The Tissue Viability Nurses also held a successful 'Stop the Pressure' day as part of a national campaign to raise awareness for the public and staff.

Improvements we have made this year

- Use of photography in the community so skin changes can be discussed with senior nurses who can advise on patient treatment and management.
- Development of a pressure ulcer pathway
- Dedicated Tissue Viability documentation
- Patient passport to support continuity of patient's skin care in different care settings

2.2.5 Care of the Deteriorating Patient

What:	Reduce avoidable harm caused by failure to rescue or failure to recognise the deteriorating patient
How much: By March 2017	50% reduction from our 2014 baseline of 'Failure to Rescue' 2222 calls
Outcome:	17% reduction
Progress:	>> Close to target

Patients who are admitted to hospital believe that they are entering a place of safety, where they and their families and carers have a right to believe that they will receive the best possible care (NICE CG50) (National Institute Health and Care Excellence). Should their condition deteriorate, we should be able to provide prompt and effective treatment provided by staff with the right competencies. Staff on the ward areas should be provided with education and training to recognise the deteriorating and /or acutely ill patients and also be able to identify the needs of and care for patients transferred from critical care.

Through the Critical Care Outreach service in collaboration with other key personnel, the Trust has developed a robust strategy for identifying the deteriorating patient

Each month we identify compliance failure and review all cardiac arrest calls. We also look at all reported incidents of patients deteriorating unexpectedly.
We use this information to look at where we can make improvements in our care to prevent where possible, patients deteriorating unexpectedly.

We have been able to demonstrate a reduction in emergency calls and failure to rescue events.

By preventing patients deteriorating, we aim to reduce avoidable admissions to critical care.

We are doing this through:

- Effectively managing the process of early identification of deterioration including:
- Accurate and reliable recording through adoption of National Early Warning Scoring system.
- Appropriate and early diagnosis of a patients deteriorating condition
- Implement a nurse led response to a deteriorating patient with appropriate medical support.
- Ensuring safety briefings on ward areas are implemented to aid the early identification of the deteriorating patient.
- Ensuring that appropriately documented 'ceilings of care' (patients previously expressed wishes, and/or limitations to their treatment) are identified for all patients.
- Ensuring appropriate Do Not Attempt Cardio-Pulmonary Resuscitation (DNA-CPR) decisions have been made and accurately recorded.
- Ensuring protocols and procedures support the early identification of a deteriorating patient and that hospital staff are appropriately trained in all aspects of timely recognition, escalation and care of these patients.

2.2.6 Clinical Pathways

What:	Improve the safety of our patients through delivery of care within defined evidence based pathways
How much:	Meet pathways compliance for priority pathways
Outcome:	Currently reviewing compliance measures
Progress:	< Behind plan

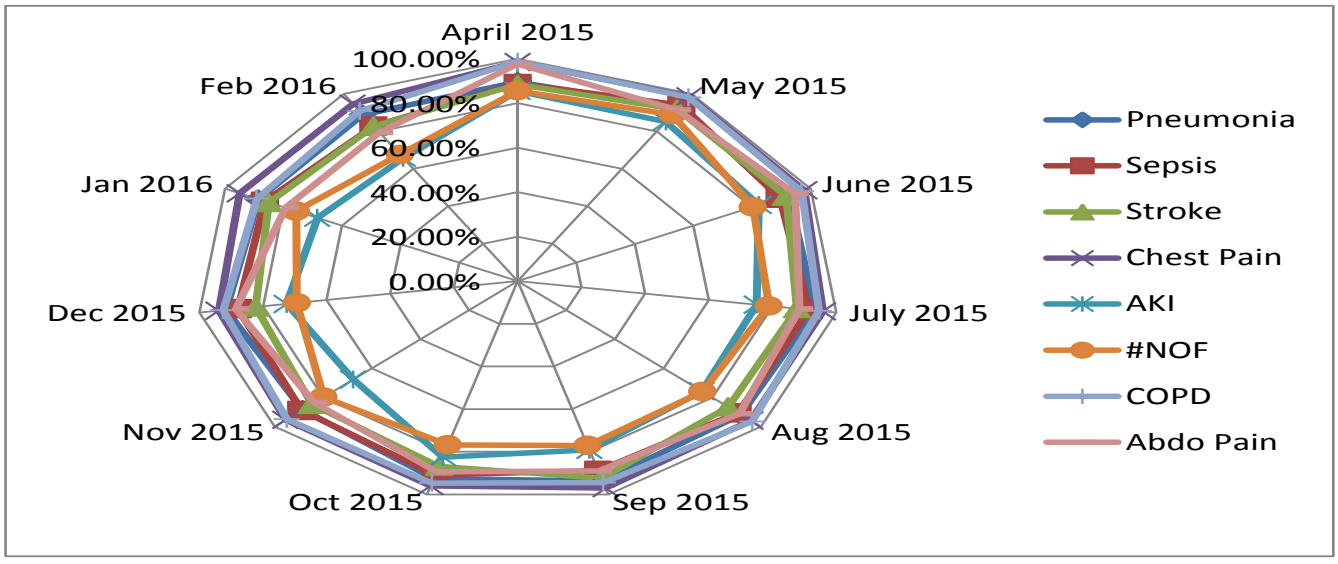
Our Better Care Now project - pathway stream, was launched in August 2013. This year the sepsis and Acute Kidney Injury (AKI) pathways in particular have been the focus of our Sign Up To Safety Campaign.
The delivery of clinical pathways in these areas is overseen by a Clinical Pathway work stream and aims to:

- Support a reduction in mortality
- Enhancing best practice standards

Throughout the year the team have worked hard to support the efficient management of the process of accurate and effective patient care through clinical pathways by:

- Introducing evidence-based medicine and nursing care through the pathways
- Standardised management of patient care within clinical guidelines
- Identification of key interventions
- Improved patient outcomes
- Reduced Length of Stay
- Providing real time audit feedback to Consultant and Nursing teams on performance.
- Improving the education of staff and patients

The team have worked closely with the clinical teams to make improvements in the pathway compliance throughout the year.



To be fully compliant with the pathway measurement you have to meet all criteria. Whilst this lets us identify where to focus on, it does not really reflect the standards of the care we deliver. To reflect this, this year we have also started to look at our opportunities to care and are now reviewing this information with the overall compliance information to help us identify areas to focus on – as shown in the spider diagram where those points closer to the centre of the web being identified as areas for focus.

2.2.7 Patient Safety

Lessons Learned

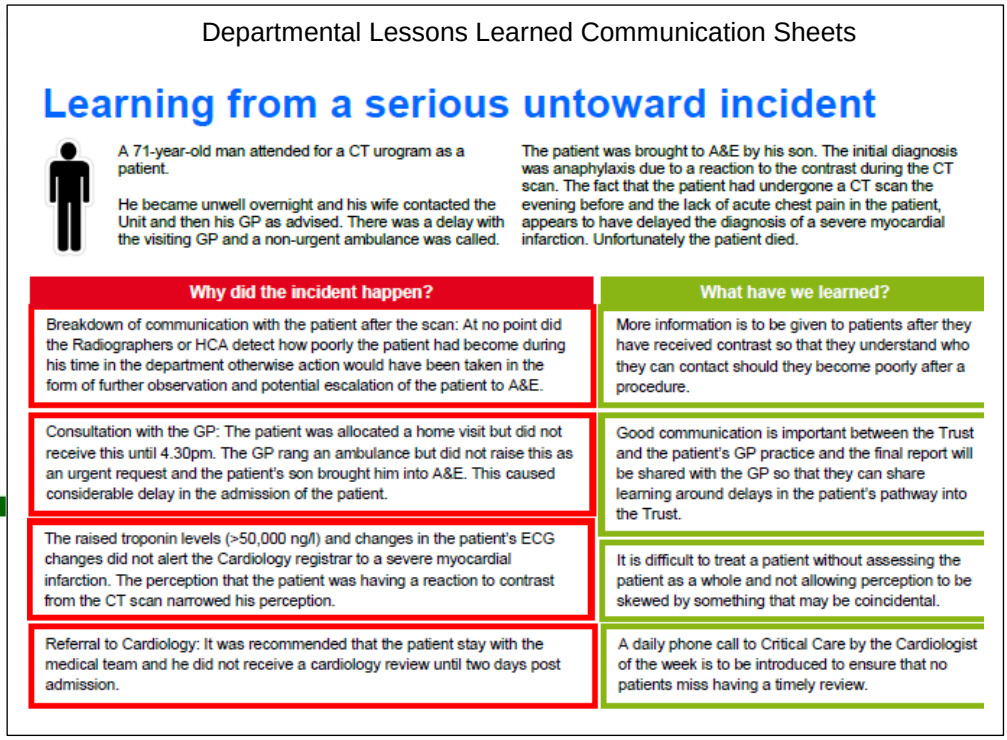
As a large healthcare organisation, which provides both acute and community care, Blackpool Teaching Hospitals NHS Foundation Trust has developed a very positive and proactive culture of patient safety incident reporting.

In the past year around 13,000 patient safety incidents were reported by staff ranging from near misses, low harm to moderate and severe harm incidents. Incidents are also reported which involve staff, visitors, contractors and other partnership organisations. Serious Incidents are investigated through the use of a Root Cause Analysis (RCA) which helps to establish if there have been gaps in care or treatment whilst also identifying best practice to be shared. Action plans, with timeframes and identified responsible leads, are compiled for each of these incidents. The Trust is very open in its investigation processes and RCA reports are made available to all staff to read and learn from through our Risk Management web site.

Some of the ways we currently share learning from patient safety incidents and trends and themes from incidents are through the use of:

- Discussing patient harm incidents, outcomes, trends and themes at high level organisational forums, governance and departmental meetings, ward level meetings, handovers and patient safety huddles.
- A bi-monthly dedicated forum (Learning from Incidents and Risk Committee) where Divisions report how they are managing patient safety and risk within their own areas.
- A quarterly Complaints, Litigation, Incidents and Patient Relations Service (PRS) (CLIP) Report developed to provide assurance that the Trust is learning from incidents, risks, claims and feedback from patients
- Posting Serious Incident RCA reports on the Risk Management intranet site for staff to review and utilise as a learning tool
- Sharing with Divisions monthly incident, complaints and litigation data, trends and themes and new initiatives established to improve patient safety
- External monitoring of our investigation processes and active learning from Serious Incidents by our local commissioners, the CQC, Monitor and NHS England.

Departmental Lessons Learned Communication Sheets



2.2.8 Patient Safety

Duty of Candour - Being Open - Saying Sorry

As a healthcare organisation, we are committed to patient safety and being open and honest following patient safety incidents, complaints and claims.

The Trust also has a duty to promote a culture of openness and truthfulness as a prerequisite to improving the safety of patients, staff and visitors as well ensuring the quality of healthcare systems. The culture of "Being open" is considered fundamental in relationships with and between our patients, the public, staff and other healthcare organisations.

The term 'Duty of Candour' (introduced from 1 April 2013) is the contractual requirement to ensure that the Being Open process is followed when a patient safety incident results in a patient suffering moderate harm, severe harm or death.

There is also a statutory Duty of Candour (Regulation 20), which applies to all healthcare providers registered with the Care Quality Commission (CQC), which came into force from 27 November 2014.

Being open and saying sorry is not a new concept or culture for most healthcare organisations and our staff have been communicating and being open with patients as part of their normal practice even when no harm has occurred. However, in line with the Duty of Candour Regulation 20, specific new steps have now been put in place for staff to follow, each time a patient is involved in a harm event where they have suffered moderate to severe harm, or death. These steps, along with helpful templates to use and guidance are contained in the Trust's 'Patient Safety Including Being Open and Duty of Candour' policy. Training presentations have also been rolled out for staff, to ensure they fully understand the policy and processes put in place.

Involving and communicating openly with patients, their relatives, or carers is essential in improving patient safety. Being open about what has happened and discussing the problem promptly, fully and compassionately can help patients cope better with the after effects when things have gone wrong. Through open communication in safety issues we aim to ensure that:

- Risks and patient safety problems will be proactively identified by patients.
- Concerns and ideas for improvement from patients and the public will be shared.
- Solutions generated in partnership with patients, all stakeholders and the public will be more realistic and achievable.

As a Trust, we promote an open and fair culture. This means that no disciplinary action will result from the reporting of adverse incidents, mistakes or near misses, except where there have been criminal or malicious activities, professional malpractice, acts of gross misconduct, repeated errors or violations have not been reported.

2.2.9 Infection Prevention

Reduce cases of Methicillin Resistant

Staphylococcus Aureus (MRSA) - Acute

What:	**Reduce cases of Methicillin Resistant Staphylococcus Aureus (MRSA) Blood Stream Infections within the Trust**
How much:	0 cases of MRSA Blood Stream Infections
Outcome:	6 cases of MRSA Blood Stream Infections 5 Avoidable MRSA Blood Stream Infections
Progress:	< Behind Plan

Methicillin Resistant Staphylococcus Aureus (MRSA) is a bacteria which can live on the skin and is perfectly harmless unless it gets into the blood stream where it can cause infection which is difficult to treat. Some patients will be screened on admission or in preparation for planned surgery to prevent them sustaining an infection in the blood stream.

Improvements achieved

- Compliance with hand hygiene practices to minimise infections
- Compliance with Aseptic Non Touch Technique to minimise infections
- Staphlyococcus Aureus policy developed to ensure compliance with screening as per patient group

Further Improvements identified

- To develop an Intravenous Therapy (IV) service to ensure best practice for placement and management of IV devices.
- Sustain a blood culture contamination rate
- Sustain compliance with hand hygiene practices
- Sustain compliance with Aseptic Non Touch Technique to minimise infections
- Review of Central lines to reduce entry points and potential introduction of infection
- A continued focus on the management of central lines and compliance with practice.

2.2.10 Reduce cases of Clostridium difficile (C-Diff) - Acute

40 cases

What:	**Reduce cases of Clostridium *Difficile* within the Trust**
How much:	40 avoidable cases of Clostridium *difficile*
Outcome:	66 cases of Clostridium *difficile* 43 avoidable cases of Clostridium *difficile*
Progress:	< Behind Plan

Clostridium Difficile is a common bacterium that lives harmlessly in the bowel of 3% of healthy adults and up to 30% of elderly patients. Antibiotics disturb the balance of bacteria in the bowel and Clostridium Difficile can then multiply rapidly and produce toxins which cause diarrhoea and illness

Improvements achieved

- Antibiotic Stewardship committee formed
- Overall 94% compliance with Antibiotic prescribing
- Enhanced cleaning processes incorporating deep clean programme as part of new contract for domestic services.
- 4th Consultant Microbiologist
- Sepsis Pathway provides guidance on best practice for prescribing antibiotics
- Pneumonia pathway provides guidance on best practice for prescribing antibiotics
- IV Commit service

Ongoing improvements identified

- Sustained compliance with antibiotic prescribing and review of audit tool
- A continued focus on reducing health care associated infections to minimise the use of antibiotics
- Sustain working with whole health economy to reduce incidences of Clostridium *difficile*
- Designated Infection Control Doctor
- Deep clean programme utilising Ultra Violet-C (UV-C)

2.2.11 Patient, Family and Carer Experience

i) NHS Friends and Family Test

96% of Blackpool Teaching Hospital patients would be likely to recommend the service to their friends or family if they needed similar care or treatment.

What:	Increase our Trust overall percentage of patients that are likely to recommend to 96% consistently based on a response rate that is indicative of each individual service.
How much:	96%
Outcome:	95%
Progress:	>> Close to target

In December 95% of Blackpool Teaching Hospitals patients were likely to recommend the service to their friends or family if they needed similar care or treatment. The Patient Experience Departments ambition is to consistently achieve 96% of our patients who would be likely to recommend the service to their friends or family if they needed similar care or treatment.

- The Friends and Family test was launched in 2013 following the Francis report.
- Blackpool Teaching Hospitals surveys all Inpatient, Outpatient, A&E, Maternity and community based services.
- In 2015 we surveyed 47,624 patients. With an average rating of likely to recommend

Building on the progress already made using predominantly paper based surveys the Patient Experience Department wish to develop use of tablet devices, kiosks and URL (Uniform Resource Locator – reference to a resource on the internet) messaging to improve our hard to reach service users as well giving more flexibility and opportunity to participate in the Friends and Family Test

2.2.11 Patient, Family and Carer Experience

ii) 'Tell Us' Campaign

"Patients and Carers to be 100% involved in decisions about their care"

What:	To be better than Trust average for Trusts in the National Inpatient Survey against Question: Patients wanted to be more involved in decisions about their care
How much:	41%
Outcome:	47% (2015)
Progress:	>> Close to target

We want all our patients to be involved in decisions about their care. This includes treatment plans, service designs and improvement schemes.

- The annual National Inpatient survey is undertaken by Picker Institute Europe.
- The 2015 survey gave us a score of 47% of patients who responded felt they wanted to be more involved in decisions around their care.
- This compares with a Picker Trust average of 41%

The Patient Experience Department continues to run the 'Tell Us' campaign as part of the 2015 - 2018 strategy. Running patient panels, awareness days and themed surveys alongside the information that our 'Listeners' collect information from both our national and local surveys the team use this information to influence and evolve services within the organisation.

2.2.11 Patient, Family and Carer Experience

iii) Always Event™

"I always know what to do when I get home or, if not, I know who to contact"

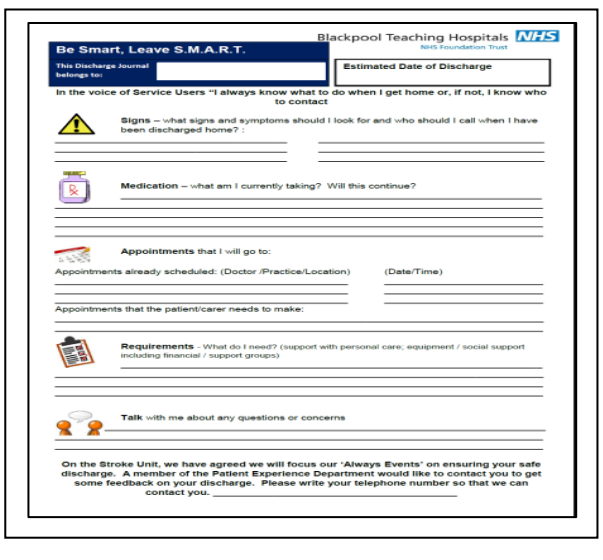
What:	Expand the number of pilot wards involved in the Always event programme. Embed further.
How much:	2 Participating areas at present across 2 divisions
Outcome:	2 participating areas in each division
Progress:	= Achieved

At the start of the financial year, representatives from the Patient Experience Department met with representatives from NHS England, the Institute for Health and Improvement in America, and members of our patient panel to discuss the roll out of the Always Event Programme. Always Events are "*aspects of the patient and family experience that should always occur when patients interact with health care professionals and the delivery system."*

Delays in discharge and information provided upon leaving our services are often flagged as a concern in our local patient feedback. Following consultation with patients, it was agreed to focus our Always Event on "*streamlining the discharge process to always ensure that patients receive a realistic date of discharge and know what to do once they have left our care should they have any worries or concerns".*

In the voice of service users, *"I always know what to do when I get home or, if not, I know who to contact".*
The Always Event pilot commenced on Ward 39 in June 2015; and then on the Stroke Unit in September 2015. Following the SMART form (Signs, Medication, Appointments, Requirements, Time) being co-designed and co-produced by patients and carers', a copy is now given to every patient for them to write down any questions or concerns that they may have prior to discharge.
The aim is to roll out this process wider across the organisation over the coming year.

- Since April 2015 to date (Feb 2016), the Stroke Unit has received one formal complaint about communication around discharge and no informal complaints have been received.
- Ward 39 has not received any formal or informal complaints about discharge or medication


Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Be Smart, Leave S.M.A.R.T.

This Discharge Journal belongs to:

Estimated Date of Discharge

In the voice of Service Users "I always know what to do when I get home or, if not, I know who to contact

Signs – what signs and symptoms should I look for and who should I call when I have been discharged home? :

Medication – what am I currently taking? Will this continue?

Appointments that I will go to:

Appointments already scheduled: (Doctor /Practice/Location) (Date/Time)

Appointments that the patient/carer needs to make:

Requirements - What do I need? (support with personal care; equipment / social support including financial / support groups)

Talk with me about any questions or concerns

On the Stroke Unit, we have agreed we will focus our 'Always Events' on ensuring your safe discharge. A member of the Patient Experience Department would like to contact you to get some feedback on your discharge. Please write your telephone number so that we can contact you.

2.2.11 Patient, Family and Carer Experience

iv) Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) take into account patients views of quality, and assist us in improving the quality of these services for all of our

What:	PROMS data to be consistently collected, reported on and fully utilised. Achieve the national average health gain for each individual measure.
How much:	Differs for each of the 4 measures.
Outcome:	Presently above average for Knee and Varicose Vein below for Hip and Hernia
Progress:	>> Inconsistent return of whole sets of data with return rate to be enhanced

Patient reported outcome measures (PROMs) measure quality from the patient perspective, and seek to calculate the health gain experienced by patients following one of the following four clinical procedures:

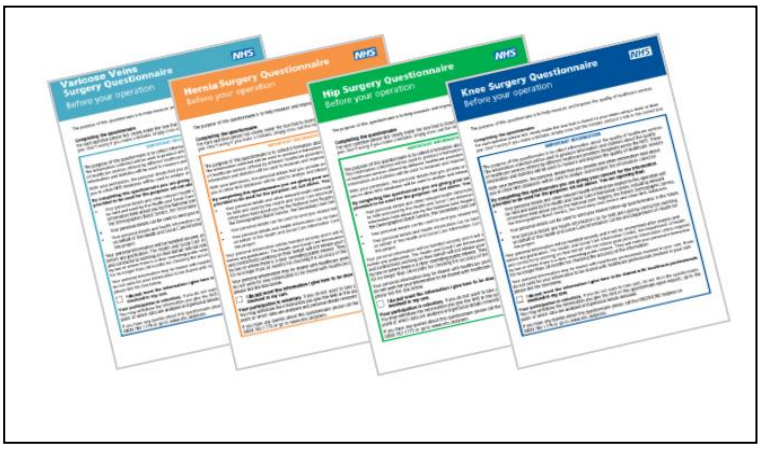
- Hip replacement
- Knee replacement
- Hernia repair
- Varicose vein treatment

Patients who have these procedures are asked to complete a short questionnaire which measures a patient's health status or health related quality of life at a single point in time. The same questionnaire is given both before and after their surgery or treatment. The difference between the two sets of responses is used to determine the outcome of the procedure as perceived by the patient.

The information captured from patients in this way provides an indication of the quality of care delivered.

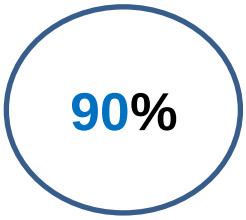
We continue to participate in the National PROMs programme, the Patient Experience Department acknowledge that the response rate requires improvement. We aim to increase the promotion of PROMs with patients at the time of pre op and improve the involvement and engagement of staff to promote and support the process to gain an increase in PROMs patient feedback data.

- PROMs have been collected by all providers of NHS-funded care since April 2009
- The second PROMs questionnaire is sent to our patients homes 6 months post-surgery, so that a reasonable time is allowed for the patient to feel the effects of the procedure



2.2.12 Improving care for patients living with dementia

What:	90 % patients age of 75 years or over are assessed on admission
How much:	90%
Outcome:	94 %
Progress:	= Target Achieved



Dementia is a progressive condition which may include memory loss, confusion, difficulties with thinking, problem solving or language abilities. As a consequence people suffering from dementia are less able to care for themselves. Dementia can also be a lonely and frightening condition, often devastating for the patient and their loved ones.

The National Dementia Strategy highlights the need to improve care for people with dementia in hospital. At the Trust, we take the care needs of people with dementia and their carers' seriously. We want to do our best to ensure that patients and their carers' are given the understanding and support they need by everyone they come into contact with, whether that be in a hospital environment or in their own homes. This is reflected in the work we have taken, and continue to take, to improve the care experience for our patients.

Delivery of care within our Compassionate Care Strategy has supported the Trust to drive forward and improve the care of people with dementia and their carers under the 'Remember the 'Me in Dementia' campaign. This has seen the Trust realise the following progress in relation to dementia care over 2015 / 2016;

Identification of a lead clinician for Dementia Care
Development of our Dementia friends campaign
Production of awareness videos
Development of our Dementia Champions Role
Implementation of the Butterfly Scheme
Comfort boxes on each ward to support cognition
Paint me a picture initiative implemented
The Dementia Corridor provision
Collaborative working with the Blackpool Carers' Centre
Use of 'Pictures to Share'
National Dementia Screening Tool use
Registration in the RCP National Audit of Dementia Care
Utilisation of rem pods and reminiscence resources
Facilitation of dementia awareness sessions
Signing up to support the National Johns Campaign
Participation in National Dementia Awareness Campaigns

Engagement events have been held with staff, carers, patients, local health economy partner organisations, and voluntary services throughout 2015/2016 which are informing agreed priority action areas within the development of a Trust-wide Dementia Strategy for the next 3 years.

2.2.13 End of Life Care

Transforming End of Life Care

There have been some exciting developments within End of Life and Specialist Palliative Care at Blackpool Teaching Hospitals over the past year. The 'Transforming End of life care in Acute Hospitals' project has demonstrated significant improvements in the delivery of End of Life Care on the wards where it has been implemented. As well as training large numbers of staff (over 7000 throughout the projects duration), we have achieved a reduction in emergency readmission rates for people in the last days of their life, with a greater number of patients being cared for in their preferred place of care. In addition, surveys have shown improved knowledge and confidence amongst staff when looking after patients at the end of their life. This has been reflected in positive experiences reported by patients and relatives. Indeed, we continue to work closely with our colleagues in the Patient Experience Team to ensure that the care we provide to our patients and their families remains of the highest possible standard.

Throughout the year there has been a multitude of training covering all aspects of a patient's journey when approaching the end of life: including advance care planning, rapid discharge, care for the dying person, the Amber Care Bundle (recognition of patients with an uncertain recovery), communication skills training and bereavement care. In addition to running Sage and Thyme communication sessions for all staff, we have recently developed a training programme for senior doctors looking at communication skills in relation to cardiopulmonary resuscitation decisions and discussions which have been extremely well evaluated by all attendees.

We are delighted to have appointed 3 associate nurse specialists to the Hospital Palliative Care Team, to enable us to provide more specialist palliative care to a larger number of people and to continue the education legacy that the 'Transforming End of Life Care' project has begun.

There has been a lot of hard work in improving how we deliver End of Life Care in the Trust over the past year from all staff and the team were delighted to have this recognised when we were chosen as the 'End of Life Care' Team of the Year at the 2015 Patient Safety Awards, where judges described having been 'blown away' by our entry.

2.2.14 Spiritual Care

The Chaplaincy service at Blackpool Teaching Hospitals continues to provide spiritual care for patients, visitors and staff. As a small team of chaplains time is strategically used to deliver direct care within the following settings responding to patients with end of life needs:

- Blackpool Victoria Hospital
- Clifton Hospital
- Trinity Hospice, Brian House and associated Palliative Care Services
- Care into community settings such as patients own home / care home (responding to specific criteria / referral or continuity of care from hospital to post-discharge). Chaplains are only able to offer limited community support due to inpatient needs.

The provision of a 24hr service ensures that spiritual care remains a high priority when patients are in the dying phase. A new Chaplaincy Support Sheet filed with the nursing notes ensures increased communications with staff concerning the care chaplains provide.

Spiritual Care training continues to be delivered and available to all staff in the local healthcare economy. This training helps staff to identify spiritual needs towards the end of life and when to appropriately involve chaplaincy services. New Spiritual Care Pocket Guides assist staffs to recognise spiritual needs at end of life and they are available for all staff via our team of chaplains. These guides support the Chaplaincy and Spiritual Care Procedure which in the last year has been revised to enhance spiritual care for all. Referrals for support from the chaplaincy team have remained positive throughout the year and it has been noted that the removal of the Liverpool Care Pathway in July 2014 did not result in decrease referral rate for patients who were expected to die and in need of chaplaincy support.

The recent completion of a refurbishment of the chapel has resulted in an enhanced space for supporting relatives of those patients who are very poorly. Chaplains will often support relatives in this space regardless of the person's belief or declared religion. Many relatives find it helpful to light a candle at the invitation and supervision of a chaplain.

2.2.15 Bereavement Care

As part of the chaplaincy team leader's role there has been the development and delivery of an annual bereavement care action plan. Chaplaincy in collaboration with the Patient Relations Team has monitored and administrated the Bereavement Care Survey offered to relatives following the death of their loved one. Quarterly reports continue to be sent to divisions and ward areas. Returns of the survey have significantly increased over the year and actions taken to address the feedback themes within the survey results.

One such action has included the development of the Visitor Support Packs which are offered to relatives who are sitting at the bedside of patients who are at the end of their life. Positive feedback has been received through a small survey which is included in the packs. This project will continue to be sustained and developed over the coming year using funds raised each year at the Tree of Lights evening.

'… so very grateful, we used the lovely blanket to keep mum warm in her final days and we are keeping it'

'It is an excellent touch to help families at a very difficult time'

2.3 Our Plans for the Future

2.3.1 The Quality Improvement Strategy 2015 – 2018

We have achieved significant improvements in Quality over the last few years, infection control, clinical care pathway developments, harm free care reduction and improved patient experience and the Trust acknowledges and recognise our achievements against quality of care. It is recognised however, that we cannot stand still and must continue to improve quality and safety.

Our new quality strategy sets out our ambition to provide the best patient care that is informed, timely and safe. To achieve this it relies on everyone committing to continuous improvement and placing quality and safety at the heart of everything we do for our patients and their families whilst signing up to the principle that care must be 'Informed, Timely and Safe - ITS how we care'.

IT'S how we care

2.3.2 Quality

Quality centres around the implementation of effective interventions to ensure care is safe and that care provides as positive an experience for our patients as possible. The Strategy recognises that care for our patients should be evidence based and delivered in a way and in an environment that keeps our patients involved and informed about their plan of care.

We are committed to ensuring that:
Care is informed
Care will be informed by evidence base and delivered in a way that ensures patients are informed and involved in the planning of their care
Care is timely
Care will be delivered in appropriate timescales according to clinical need and appropriate pathways of care
Care is safe
Care will be provided in a way that protects patients from harm and in an environment that promotes a safety culture

Quality Governance is how structures and processes supports the implementation of our quality domains at all levels of the organisation and the Trust Board, Quality Committee, Divisional Boards and Local Improvement Teams are the structures that will all support the governance around the delivery of the Strategy. The processes pivotal in implementing the quality domains include;

Sign Up to Safety
Patient Experience and Patient Relations
Clinical Audit
Serious Untoward Incident Reporting
Lessons Learned and Feedback
Identification and Management of Quality Risks
Peer Reviews
Standards of Quality Investigations and Action Planning
Implementing Openness and Honesty
'Tell Us' Systems
Better Care Now
Clinical Pathways
Best Practice Guidance

The purpose of the Quality Strategy is to support the delivery of the organisation's vision, values, quality goals and strategic objectives. Our vision is to create a culture of continuous improvement where;

'Our care will be safe, high quality and managed within available resources, provided in the most appropriate environment and to agreed pathways of care' and

'Our highly skilled and motivated workforces will be patient centred, caring and compassionate, living our values every day.'

The strategy closely supports the Trust's overall strategy by identifying and prioritising delivery of specified key improvements in the three quality and safety domains set out below, thereby enabling the delivery of the 2 key quality related measures (lowering the mortality rate and securing improved patient experience and involvement). We have set two goals for each domain to provide staff , patients and the public with a clear view of what our quality and safety priorities are and how these will be measured going forward. Achieving these goals will require us to have excellent staff, excellent record keeping and to excel at working in partnership . We call these our 3 'strategic enablers'. Progress towards achieving the goals and strategic enablers will be monitored by the Trust's Quality Committee and will be formally described in the Trust's Yearly Quality Accounts.

CARE IS INFORMED

1. Enhancing the Patient Experience & Promoting Patient Involvement

2. Providing Evidence Based Care

CARE IS TIMELY

3. Care at the right time

4. Care in the right place

CARE IS SAFE

5. Harm Free Care

6. Open and Honest Culture

STRATEGIC ENABLERS

Qualified, Motivated and Safe Staff

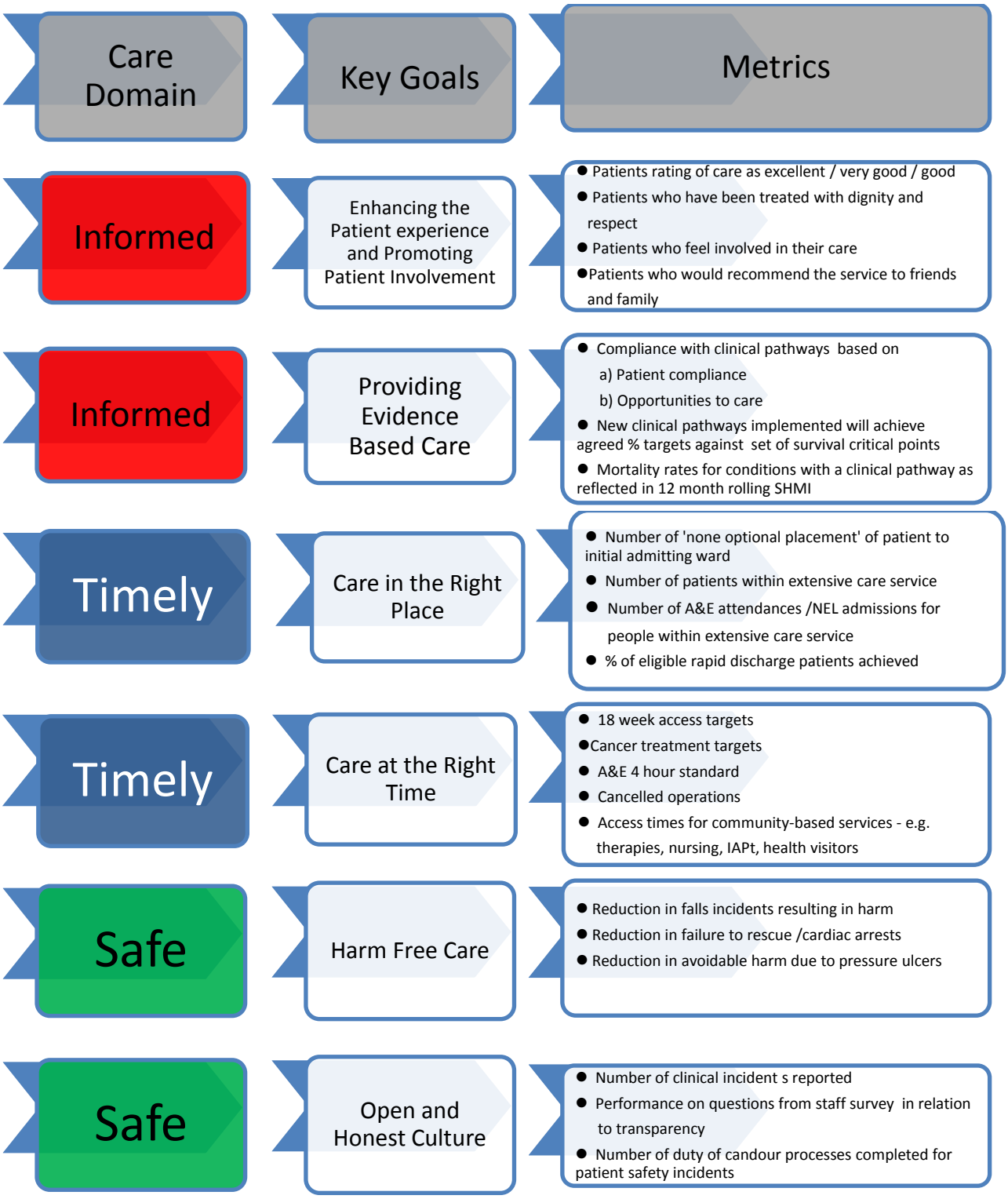
Excellent, Accessible Clinical Documentation

Partnership Working

Prior to the commencement of each of the Planning Years, the Quality Committee will approve an annual Quality Plan with detailed targets to be achieved at the end of the Planning Year as a staging point for delivering the 3 year Strategy. Each of these targets will have quarterly milestones which will be monitored at the end of each quarter by the Quality Committee so that assurance can be given to the Board with respect to progress made in implementing the Quality Strategy. Each of these will support the achievement of the small set of strategic measures by which the Board will assess overall strategic progress of the Trust. The Annual Plan will also clearly set out the Committee's expectations for the Executive for the year. The Annual Plan will be recommended by the Committee to the Board for approval prior to the commencement of the Planning Year.

The metrics for each quality and safety domain are set out below, each of which will have yearly targets set against them the achievement of which will be reported in the Trusts annual accounts.

2.3.3 Quality Improvement Metrics



IT'S how we care

2.4 Our Quality Priorities 2016 / 2017

Our Quality Strategy 2016/2019 outlines a number of projects which we will be focusing on in the coming year. This however is closely aligned to our new strategic vision developed throughout 2015/2016 by a clinically led process. This is a five year strategy to help us achieve our vision for 2020:

As a high performing Trust operating as part of an integrated care system, we will provide high quality, safe and effective care. This will be achieved in a financially sustainable way, through our skilled and motivated workforce.

This will be delivered through seven work-streams with aspirations to reach the highest level of clinical quality, patient experience, operational performance and staff satisfaction. Through this ambitious transformation programme quality remains a priority within all of the seven strategic work-streams.

We would like to highlight within the quality accounts the following projects of key priorities under the quality domain:

Reducing Mortality (SHMI)
Reducing Infections
Reducing Re-Admissions within 30 days
Increase the positive outcomes reported for PROMS
Reducing Serious Incident Reports
Reducing Never Events
Enhancing Patient Experience
Reducing the Attendance to A&E within 30 days
Improving CQC A&E Rating
Reducing Mortality from Chronic Diseases

2.4.1 Statements of Assurance from the Board of Directors

Review of Services

During 2015/16 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 2015/16 represents 90 per cent of the total income generated from the provision of relevant health services by the Blackpool Teaching Hospitals NHS Foundation Trust for 2015/16.

2.4.2 Participation in Clinical Audits and National Confidential Enquiries

During 2015/16, 51 national clinical audits and 4 national confidential enquiries covered relevant Health services that Blackpool Teaching Hospitals NHS Foundation Trust provides.

During that period Blackpool Teaching Hospitals NHS Foundation Trust participated in 91% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Blackpool Teaching Hospitals NHS Foundation Trust was eligible to participate in during 2015/16 are as follows;

2.4.3 Table 1 National Clinical Audits

Title
Acute coronary syndrome or Acute myocardial ischaemia (MINAP)
NBOCAP: bowel cancer
Cardiac Rhythm Management (CRM)
CMP: adult critical care units ICNARC
Child health clinical outcome review programme (CHR/UK) NCEPOD

Title
Congenital Heart Disease Paediatrics
Coronary angioplasty
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)
Diabetes (Paediatric) (NPDA)
Elective surgery (National PROMs Programme)
Emergency use of oxygen (British Thoracic Society)

Falls and Fragility Fractures Audit Programme (FFFAP)
Inflammatory Bowel Disease (IBD) programme
NLCA: lung cancer
TARN: severe trauma
"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)"
Confidential Enquiry into Patient Outcome and Death (NCEPOD)
Adult cardiac surgery: CABG and valvular surgery
National audit of intermediate care
National Cardiac Arrest Audit (NCAA)
National COPD Audit Programme (RCP)
National comparative audit of blood transfusion programme
National complicated acute diverticulitis audit (CADS)
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, AAA, NVD)
NNAP: neonatal intensive care
Oesophago-gastric cancer (National O-G Cancer Audit)
Paediatric asthma (moderate to severe) (British Thoracic Society)
National emergency laparotomy audit (NELA)
Heart Failure Audit
National Joint Registry
National Ophthalmology audit
National Prostate Cancer

Title
Procedural sedation. Paracetamol overdose (care provided in Emergency Departments - College of Emergency Medicine)
Sentinel Stroke National Audit Programme (SSNAP)
UK Parkinson's Audit (Previously known as Nationals Parkinson's audit)
Vital signs in Children (Care in emergency departments)
VTE risk in Lower Limb immobilisation in plaster casts
Adult community acquired pneumonia (British Thoracic Society)
RCP: National Care of the Dying Audit
CCAD: Adult Carotid interventions
RCP: Audit to assess and improve service for people with inflammatory bowel disease
Potential donor audit (NHS Blood & Transplant)
Epilepsy 12 audit (Childhood Epilepsy)
Paediatric fever (College of Emergency Medicine)
National audit of seizure management in Hospitals
Severe sepsis & septic shock (College of Emergency Medicine)
National health promotion in hospitals audit
Fitting childcare in emergency departments
Mental health care in emergency departments
Older people care in emergency departments

2.4.4 Table 2 NCEPOD National Confidential Enquiries into Patient Outcome and Death 2015/16

Title
Chronic neuro disability – Focussing on cerebral palsy. December 2015
Adolescent Mental Health – focussing on self-harm. December 2015
Provision of Mental Health Care in Acute Hospitals July 2015
Non –invasive ventilation December 2015

The national clinical audits and national confidential enquiries that Blackpool Teaching Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2015/16 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry are as follows;

2.4.5 Table 3 National clinical audit projects participants

Title	Eligible	Participated	% Submitted
Acute coronary syndrome or Acute myocardial ischaemia (MINAP)	✓	✓	91%
NBOCAP: bowel cancer	✓	**Not participated in the year**	100%
Cardiac Rhythm Management (CRM)	✓	**Not participated in the year**	100%
CMP: adult critical care units ICNARC	✓	✓	100%
Child health clinical outcome review programme (CHR/UK) NCEPOD	✓	✓	100%
Congenital Heart Disease Paediatrics	✓	**Not participated in the year**	
Coronary angioplasty	✓	✓	100%
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	✓	✓	91%
Diabetes (Paediatric) (NPDA)	✓	✓	100%
Elective surgery (National PROMs Programme)	✓	**Not participated in the current year**	100%
Emergency use of oxygen (British Thoracic Society)	✓	✓	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	✓	✓	100%
Inflammatory Bowel Disease (IBD) programme	✓	**Not participated in the year**	
NLCA: lung cancer	✓	✓	100%
TARN: severe trauma	✓	✓	100%
"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)"	✓	✓	100%
Confidential Enquiry into Patient Outcome and Death (NCEPOD)	✓	✓	100%
Adult cardiac surgery: CABG and valvular surgery	✓	✓	
National Cardiac Arrest Audit (NCAA)	✓	✓	100%
National COPD Audit Programme (RCP)	✓	✓	
National comparative audit of blood transfusion programme	✓	**Not participated in the year**	100%
National complicated acute diverticulitis audit (CADS)	✓	✓	100%
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, AAA, NVD)	✓	**Not participated in the current year**	100%
NNAP: neonatal intensive care	✓	✓	100%
Oesophago-gastric cancer (National O-G Cancer Audit)	✓	✓	100%
Paediatric asthma (moderate to severe) (British Thoracic Society)	✓	✓	100%
National emergency laparotomy audit (NELA)	✓	✓	100%
Heart Failure Audit	✓	✓	100%
National Joint Registry	✓	✓	
National Ophthalmology audit	✓	✓	
National Prostate Cancer	✓	✓	100%
Procedural sedation. Paracetamol overdose (care provided in Emergency Departments - College of Emergency Medicine)	✓	✓	
Pulmonary hypertension (Pulmonary Hypertension Audit)	✓	**Not participated in the current year**	100%
Rheumatoid and early inflammatory arthritis	✓	✓	
Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	100%

Title	Eligible	Participated	% Submitted
UK Parkinson's Audit (Previously known as Nationals Parkinson's audit)		**Not participated in the year**	
Vital signs in Children (Care in emergency departments)	✓	✓	100%
VTE risk in Lower Limb immobilisation in plaster casts	✓	✓	Ongoing
Adult community acquired pneumonia (British Thoracic Society)	✓	✓	
RCP: National Care of the Dying Audit	✓	✓	100%
CCAD: Adult Carotid interventions	✓	✓	100%
RCP: Audit to assess and improve service for people with inflammatory bowel disease	✓	✓	9%
Potential donor audit (NHS Blood & Transplant)	✓	✓	100%
Epilepsy 12 audit (Childhood Epilepsy)	✓	✓	
Paediatric fever (College of Emergency Medicine)	✓	✓	
National audit of seizure management in Hospitals	✓	✓	100%
Severe sepsis & septic shock (College of Emergency Medicine)	✓	**Not taking place 15/16**	100%
National health promotion in hospitals audit	✓	✓	100%
Fitting childcare in emergency departments	✓	✓	Not being undertaken – replaced by Pathways at Trust
Mental health care in emergency departments	✓	✓	100%
Older people care in emergency departments	✓	✓	Ongoing

2.4.6 Table 4 NCEPOD National Confidential Enquiries into Patient Outcome and Death

Title	Eligible	Participated	% Submitted
Chronic neuro disability – Focussing on cerebral palsy. December 2015	√	√	100%
Adolescent Mental Health – focussing on self-harm. December 2015	√	√	100%
Provision of Mental Health Care in Acute Hospitals July 2015	√	√	100%
Non –invasive ventilation December 2015	√	√	Ongoing data collection

The reports of 7 national clinical audits were reviewed by the provider in 2015/16 and Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided see appendix A

The reports of 74 local clinical audits were reviewed by the provider in 2015/16 and Blackpool Teaching Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see appendix B).

2.4.7 Participation in Clinical Research in 2015/16

The number of patients receiving relevant health services provided or sub-contracted by Blackpool Teaching Hospitals NHS Foundation Trust in 2015/2016 that were recruited during that period to participate in research approved by a research ethics committee was 1384.

Of the 1384, 1377 participants were recruited to National Institute of Health Research (NIHR) Portfolio Studies which exceeds our target of 1000 for the year. On average there were 130 different research studies/trials open at any one time during 2015/16.

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 remains abreast of the latest possible treatment possibilities, and active participation in research leads to successful patient outcomes.

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

A proportion of Blackpool Teaching Hospitals NHS Foundation Trust's income in 2015/16 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 2015/16 and for the following 12 month period are available electronically 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 2015/16 conditional upon achieving quality improvement and innovation goals is £7,062,697; The Trust achieved a monetary total value of £6,900,812 for the associated payment in 2014/15.

CQUINs this year have focussed on a number of quality and improvement initiatives including clinical pathways, service improvements and quality innovations.

The main areas of risk related to the clinical pathway element of the CQUIN, particularly in relation to acute kidney injury, sepsis and heart failure. Processes to drive improvement were agreed at the latter end of 2015/16 with plans to review all mission critical points within each pathway to bring them in line with the latest guidance.

2.4.9 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. Blackpool Teaching Hospitals NHS Foundation Trust has the following conditions on registration; no conditions.

The Care Quality Commission has not taken enforcement action against Blackpool Teaching Hospitals NHS Foundation Trust during 2015/16.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC) and was last fully inspected in 2014 against the CQC fundamental standards of care of which the CQC stipulate standards of care should never fall below.

On the 21st / 22nd September 2015 the CQC carried out a follow up announced inspection to Maternity Services to review progress against the inadequate rating (April 14). The CQC also reviewed Urgent and Emergency Services in response to CQC monitoring intelligence regarding A&E performance.

The Trust received the final report in January 2016 and overall there was acknowledgment of improvements achieved since the last inspection with one regulated activity action and other areas for the Trust to review. The regulated activity has been included within the Trust wide development plan which is monitored by the Quality Committee and by the commissioner led Fylde Coast Advisory Board and has also been shared with Monitor. The regulated activity and all other areas identified to review are part of separate maternity and A&E led action plans, which are also monitored by the Quality Committee and quarterly progress shared with the CQC.

Maternity Services were noted to have made improvements since the last inspection with patient experience noted as positive and patient outcomes being in line with the England average on most of the compared measures. Maternity Services ratings moved from requires improvement to good.

Urgent and Emergency Services showed some areas of improvement since the last inspection. However, at the last inspection (January 14) the CQC had not fully developed the inspection methodology for the effectiveness domain and so had not rated this element at that time and gave this element a rating of requires improvement. The well led element noted improvements in leadership and structures. These were not fully developed at the time of the re inspection and this element also remained at a rating of requires improvement. The overall rating for Urgent and Emergency Services remained as requires improvement.

The overall rating for the Trust remains unchanged for 2015 / 2016 at ‘requires improvement’.

2.4.10 Special Reviews/Investigations

Blackpool Teaching Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting year.

2.4.11 Information on the Quality of Data

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

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, Healthcare Evaluation Data (HED), 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 for example in relation to slips, trips and falls incidents for patients. The quality and safety metrics are also reported monthly to the Board through the Integrated Performance Report and the Quality Committee Assurance 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 an annual audit programme which provides assurance on the weekly monitoring process of 'patient target list' meetings where all divisions are represented and their performance data presented and reviewed. Random checks on pathways are facilitated by the Trusts internal data team and this is further supported by an external annual review. These measures will continue to be implemented going forward.

The Trust has reviewed its objectives as part of the Trust Strategy Review process and has continued to emphasise its commitment to quality, with the aim of achieving excellence in everything it does. Its quality goals through out 2015/16 were to:

- All patients and carers involved in decisions about their care
- Zero inappropriate admissions
- Zero harms
- Zero delays
- Compliance with standard pathways

Good quality data will continue to inform performance against the key quality goals and will influence future developments to enhance achievements against metrics attached to each of the quality goals.

2.4.12 NHS Number and General Medical Practice Code Validity

Blackpool Teaching Hospitals NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses Service (SUS) 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:
- 99.6% for admitted patient care;
- 99.9% for outpatient care; and
- 98.7% for accident and emergency care.

– Which included the patient's valid General Medical Practice Code was:
- 99.9% for admitted patient care
- 99.8% for outpatient care; and
- 99.9% for accident and emergency care.

2.4.13 Information Governance Assessment Report 2015/16

Blackpool Teaching Hospitals NHS Foundation Trust's Information Governance Assessment Report overall score for 2015/16 was 83% and was graded satisfactory (Green) from Information Governance Toolkit Grading Scheme.

For 2015/16 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

Information Governance (IG) is to do with the way organisations 'process' or handle information. It covers personal information, i.e. that relating to patients/service users and employees, and corporate information, e.g. financial and accounting records.

The IG Toolkit is an online system which allows organisations to assess themselves or be assessed against Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit assessments.

The purpose of the assessment is to enable organisations to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

2.4.14 Payment by Results (PBR) Clinical Coding Audit

Blackpool Teaching Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during this reporting period by the Audit Commission.

3 Review of Quality Performance

3.1 The NHS Outcome Framework Indicators

The NHS Outcomes Framework sets out high level national outcomes which the NHS should be aiming to improve. The Framework provides indicators which have been chosen to measure these outcomes.

It is important to note that whilst these indicators must be included in the Quality Accounts the most recent national data available for the reporting period is not always for the most recent financial year and where this is the case these will be noted underneath the indicator description. It is also not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

Domain	Indicator	National Average	Where applicable – Best Performer	Where applicable - Worst performer	Trust Statement	2015/16	2014/15	2013/14
Preventing people from dying prematurely	SHMI The value and banding (January 2015 – December 2015)	100	68	116	The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason: • Data from national HED system up to November 2015 then local systems to March 2016 The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action: • Continued mortality governance programme overseen by Mortality Committee.	111 (Indicative)	116	119
Enhancing quality of life for people with long-term conditions	% of patient deaths with palliative care coded at either diagnosis or speciality level for Jan 15 – Dec 15 taken from Dr Foster Mortality Comparator	1.04%	15%	0%	The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason: • Data taken from National HED System The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action: • Education of staff regarding documentation of palliative care input	0.68%	0.67%	0.57%

Domain	Indicator	National Average	Where applicable – Best Performer	Where applicable - Worst performer	Trust Statement	2015/16	2014/15	2013/14
Helping people to recover from episodes of ill health or following injury	**Patient outcome scores for groin hernia surgery April 14 – March 15 (most recent full year of data)**	**Adjusted National Average** **0.084**	**Adjusted average health gain – best performer** **0.154**	**Adjusted average health gain – worst performer** **0.000**	**The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:** • **Patient reported outcome measures (PROMS) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following a clinical procedure** **The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:** • **Further increased promotion on the importance of completing questionnaires and enhanced patient awareness that they will receive post- operative questionnaire.** • **Regularly review scores at service and Trust level to increase our responsiveness to feedback.**	Data not available at time of publishing	Health gain **0.008**	**Health gain** **0.045**
Helping people to recover from episodes of ill health or following injury	**Patient outcome scores for varicose vein surgery April 14 – March 15 (most recent full year of data)**	**Adjusted National Average** **0.095**	**Adjusted average health gain – best performer** **0.154**	**Adjusted average health gain – worst performer** **-0.002**	**The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:** • **Patient reported outcome measures (PROMS) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following a clinical procedure** **The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:** • **Further increased promotion on the importance of completing questionnaires and enhanced patient awareness that they will receive post- operative questionnaire.** • **Regularly review scores at service and Trust level to increase our responsiveness to feedback.**	Data not available at time of publishing	Health gain **0.223**	**Health gain** **0.115**

Domain	Indicator	National Average	Where applicable – Best Performer	Where applicable - Worst performer	Trust Statement	2015/16	2014/15	2013/14
	Patient outcome scores for hip replacement surgery April 14 – March 15 (most recent full year of data)	**Adjusted National Average** **0.437**	**Adjusted average health gain – best performer** **0.524**	**Adjusted average health gain – worst performer** **0.331**	**The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:** • **Patient reported outcome measures (PROMS) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following a clinical procedure** **The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:** • **Further increased promotion on the importance of completing questionnaires and enhanced patient awareness that they will receive post- operative questionnaire.** • **Regularly review scores at service and Trust level to increase our responsiveness to feedback.**	Data not available at time of publishing	Health gain **0.490**	**Health gain** **0.366**
	Patient outcome scores for knee replacement surgery (most recent full year of data)	**Adjusted National Average** **0.315**	**Adjusted average health gain – best performer** **0.418**	**Adjusted average health gain – worst performer** **0.204**	**The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:** • **Patient reported outcome measures (PROMS) measure quality from the patient perspective and seek to calculate the health gain experienced by patients following a clinical procedure** **The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:** • **Further increased promotion on the importance of completing questionnaires and enhanced patient awareness that they will receive post- operative questionnaire.** • **Regularly review scores at service and Trust level to increase our responsiveness to feedback.**	Data not available at time of publishing	Health gain **0.327**	**Health gain** **0.276**

Domain	Indicator	National Average	Where applicable – Best Performer	Where applicable - Worst performer	Trust Statement	2015/16	2014/15	2013/14
Helping people to recover from episodes of ill health or following injury	28 day readmission rate for patients 0-15	N/A	N/A	N/A	The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason: • The number of patients readmitted to hospital within 28 days of being discharges from hospital expressed as a % of all discharges in the period. The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action: • Clinically led reviews of readmissions to identify and implement actions to reduce avoidable admissions • Inclusion of commissioners on joint working group to identify and implement health economy wide readmission avoidance schemes • Monitoring at Trust Board a quality improvement programme for the year	12.35	11.88	10.73
	28 day readmission rate for patients 16 or over	N/A	N/A	N/A	The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason: • The number of patients readmitted to hospital within 28 days of being discharges from hospital expressed as a % of all discharges in the period. The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action: The following measures have been implemented to reduce the number of incidences. • Clinically led reviews of readmissions to identify and implement actions to reduce avoidable admissions • Inclusion of commissioners on joint working group to identify and implement health economy wide readmission avoidance schemes • Monitoring at Trust Board a quality improvement programme for the year	7.64	8.03	12.04

Domain	Indicator	National Average	Where applicable – Best Performer	Where applicable - Worst performer	Trust Statement	2015/16	2014/15	2013/14
Ensuring that people have a positive experience of care	**Responsiveness to inpatients personal needs: CQC national inpatient survey**	**National Average** **68.9**	**Best performer** **86.1**	**Worst performer** **59.1**	**The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:** • **The Trust considers our patients feedback to be crucial in ensuring that our services develop in order for the Trust to meet** **The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:** • **Raising awareness of the Trust's 'Tell Us' campaign** • **Continue to work with our listeners (volunteers).** • **Share our National Inpatient survey results throughout the Trust and work collaboratively to make improvements**	70.1	**67.1**	**65.6**
	Percentage of staff who would recommend the Trust as a provider of care to their Friends or family. Staff Survey	**68%**	**89%**	**43%**	**The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:** • **Narrative feedback from the Great Place to work Survey suggests the Trust has excellent facilities for patients, with a committed and dedicated workforce who are caring and highly qualified.** **The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:** • **Further analysis to be undertaken at Divisional level to identify targeted areas of concern and subsequent action plans.**	**66%**	**62%**	**Data not available FFT not in place**

Domain	Indicator	National Average	Where applicable – Best Performer	Where applicable - Worst performer	Trust Statement	2015/16	2014/15	2013/14
	Percentage of patients who would recommend the provider to friends or family needing care. Inpatients	**Data not available**	**Data not available**	**Data not available**	**The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:** • **The FFT is an overarching indicator of patient experience, which when combined with the follow up question can be used to drive cultural change and result in an increased focus on the experiences of patients.** **The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:** • **Increasing the response rate to give a true reflection on how our patients rate our inpatient service.** • **Review written feedback to develop themes which will inform improvement plans**	Data not available	**94%** **average of patients likely to recommend**	**75** **average Net Promoter Score Scoring for the FFT changed in April to a % score**
	Percentage of patients who would recommend the provider to friends or family needing care. Patients discharged from Accident and Emergency	**Data not available**	**Data not available**	**Data not available**	**The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:** • **The FFT is an overarching indicator of patient experience, which when combined with the follow up questions can be used to drive cultural change and result in an increased focus on the experience of patients** **The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:** • **Increasing the response rate to give a true reflection on how our patients rate our inpatient service.** • **Review written feedback to develop themes which will inform improvement plans.**	**Data not available**	**92%** **Average of patients likely to recommend the service**	**68** **Average Net Promoter Score** **Scoring for the FFT changed in April to a %**

Domain	Indicator	National Average	Where applicable – Best Performer	Where applicable - Worst performer	Trust Statement	2015/16	2014/15	2013/14
Treating and caring for people in a safe environment and protecting them from avoidable harm	**Percentage of admitted patients' risk-assessed for Venous Thromboembolism April – December 16**	**96%**	**100%**	**79.9%**	**The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:** • **Identified via electronic Trust system** **The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:** • **Ongoing monitoring and Audit**	**99.4%**	**99.9%**	**99.7%**
	Rate of CDifficile per 100,000 bed days of cases reported amongst patients aged 2 or over (2015/2016)	National table not yet published	National table not yet published	National table not yet published	**The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:** ***The trajectory for the Trust is nationally set was 40 incidences of CDiff defined with a lapse in care. Of the 66 incidences 43 have been defined as due to a lapse in care. 23 incidences have been agreed as no lapse in care.** **The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:** • **Enhanced availability of Antibiotic formulary** • **RCA process redefined and improved** • **Increased environmental cleaning.** • **Enhanced Education and training programme**	*66 cases 21.8	54 cases 18.2	26 cases 8.99
	The number and rate of patient safety incidents (per 100 admissions) (Q1 & 2)	National data not yet published	National data not yet published	National data not yet published	**The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:** • **The Trust continues to promote a culture of open and honest reporting by using Ulysses electronic reporting system** **The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:** • **Encouraging culture, voluntary reporting** • **Implementing a monitoring system on the number and management of incidents** • **Implementation of lessons learned processes**	7.67 (6 months data)	6.60 (12 months data)	6.48 (12 months data)

	The number of and percentage of patient safety incidents per (100 admissions) that resulted in severe harm or death (October 15 – March 16)	**N/A**	**N/A**	**N/A**	**The Blackpool Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reason:** • **The Trust continues to promote a culture of open and honest reporting by using Ulysses electronic reporting system** **The Blackpool Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this (percentage/proportion/score/ rate/number) and so the quality of its services, by undertaking the following action:** • **Encouraging culture, voluntary reporting** • **Implementing a monitoring system on the number and management of incidents** • **Implementation of lessons learned processes**	0.07% (6 months data)	0.24% (12 months data)	0.28% (12 months data)

Domain: preventing people from dying prematurely

The standardised Hospital Level Mortality Indicator (SHMI) is a measure of mortality developed by the Department of Health, which compares our actual number of deaths with our predicted number of deaths.

The Trust has continued to implement its mortality governance programme concentrating on pathways of care and has seen significant reductions in SHMI rates.

Domain: Helping people to recover from episodes of ill health or following injury.

Patient reported outcome scores

A patient reported outcome measure is a series of questions that patients are asked in order to gauge their views on their own health. In the example groin hernia, knee replacement, hip replacement and varicose vein surgery, patients are asked to score their health before and after surgery. We are then able to understand whether patients see a 'health gain' following surgery.

The data provided gives the average difference between the first score (pre-surgery) and second score (post-surgery) that patients give themselves. In all procedures where data is available there are improvements in the average score.

However, it is important to note that sample size for all patient reported outcome scores is very small which may impact upon the meaningfulness of the data.

Domain: Ensuring that people have a positive experience of care

Responsiveness to Inpatients' personal needs

This indicator provides a measure of quality, based on the Care Quality Commission's National Inpatient Survey. The score is calculated by averaging the answers to five questions in the inpatient survey. The highest score achievable is 100%.

The Trust is proud of its 'Tell Us' campaign which is part of our patient experience 2015/2018 strategy which provides the structure to increase the feedback we obtain from patients and relatives which we use to influence and evolve service developments.

Domain: Treating and caring for people in a safe environment and protecting them from avoidable harm

Risk assessing inpatients for venous thromboembolism (VTE) is important in reducing hospital acquired VTE and the Trust has worked hard to ensure our patients are risk assessed properly and appropriate treatment timely commenced.

Domain: Treating and caring for people in a safe environment and protecting them from avoidable harm

Sign up to Safety national campaign is a unified programme for patient safety across the NHS in England and the trust has proudly been involved in this programme aimed at reducing avoidable harm by half and saving 6000 lives over a three year period.

Domain: Treating and caring for people in a safe environment and protecting them from avoidable harm

Patient safety incidents are reported to NHS England. The rate of patient safety incidents per 100 admissions reported by Blackpool Teaching Hospitals NHS Foundation Trust is 7.64% for Quarter 1 & 2 2015/2016. Organisations that report more incidents usually have a better and more effective safety culture and the Trust continues to perform within the top 25% of patient safety incident reporters nationally.

3.2 An Overview of Quality of Care

The measures in the table below provide performance in 2015/16 against indicators selected by the Board which reflects the list of priorities that the Board deemed necessary to continue to monitor throughout the year. Previous years priority indicators were reviewed at the beginning of the year and some de-selected as priorities for 2015/16 as they had achieved significant progress or considerable improvement had been delivered and other improvement programmes became a priority.

The below are areas that feature in the Trust's strategy for quality improvement, feature within the new Trust's Quality Strategy and fit into the work-streams underpinning the Trust's future strategic direction. The Trust wishes to highlight them in the quality accounts.

	Indicators – To be agreed	*2015/16*	*2014/15*	*2013/14*
Patient safety Outcomes	Hospital Standardised Mortality Rate (Summary Hospital Mortality Indicator)	111 (Indicative)	116	119
	Stroke Mortality Rate *Data Source HED:*	126.28	132.80	124.34
	Sign Up to Safety Pressure Ulcer harm reduction	Stage 2 13% increase Stage 3 & 4 pressure ulcers 19.67% reduction	Not in place	Not in place
	Sign Up to Safety reduction in harm as a result of a fall	6% reduction	Not in place	Not in place
Clinical Effectiveness	Compliance with implementation of NICE guidance	NG – 9/45 20%	0/8 0% Note national guidance introduced at this point	N/A Not in place
		CG – 64/95 67%	60/96 63%	46/79 58%
	Opportunities to care within clinical pathways - sepsis	91%	93%	N/A Not in place
	Opportunities to care within clinical pathways - AKI	74%	82%	N/A Not in place
	Opportunities to care within clinical pathways - pneumonia	93%	91%	N/A Not in place
	Opportunities to care within clinical pathways - Stroke	87%	92%	N/A Not in place
	Opportunities to care within clinical pathways - #NOF	** 76%	88.73%	N/A Not in place
	Opportunities to care within clinical pathways – Cardiac Chest Pain	96%	98%	N/A Not in place
	Opportunities to care within clinical pathways - COPD	* 94%	97.82%	N/A Not in place
Patient Experience	Percentage of Adult Inpatient who rate care as excellent/very good/good	Data not available	81%	79%
	Percentage of Adult Inpatients who have been treated with Respect & Dignity	Data not available	90%	86%
	Percentage of Adult Inpatients who felt involved in their care and/or treatment	Data not available	73%	67%

*COPD start date was 28th May 2014 (not a full years data)

**#NOF launch date was 25th June 2014 (not a full years data)

3.3 The Risk Assessment Framework

Blackpool Teaching Hospitals aims to meet all national targets and priorities and we have provided an overview of the national targets and minimum standards including those set out within Monitor's Risk Assessment Framework 2015.

National Targets and Minimum Standards	Target	Target 2015/16	2015/16	2014/15	2013/14	2012/13
Access to Cancer Services - All Cancers: one month diagnosis to treatment	First Treatment	>= 96%	Achieved Q1 99.8% Q2 99.6% Q3 99.8% Q4 – 99.8%	Achieved: Q1 98.8%, Q2 98.9%, Q3 99.8% Q4 99.5%	Achieved: Q1 98.9% Q2 98.9% Q3 99.8% Q4 99.3%	Achieved Q1 99.3%, Q2 99.4%, Q3 98.5%, Q4 98.9%
	Subsequent Treatment – Drugs	>=98%	Achieved Q1 100% Q2 100% Q3 100% Q4 100%	Achieved: Q1 100%, Q2 100%, Q3 100 % Q4 100%	Achieved: Q1 99.2% Q2 100% Q3 100% Q4 100%	Achieved Q1 100%, Q2 100%, Q3 99.2%, Q4 98.6%
	Subsequent Treatment – Surgery	>=94%	Achieved Q1 97.6% Q2 100% Q3 100% Q4 97.8%	Achieved: Q1 100%, Q2 100%, Q3 100% Q4 96.6%	Achieved: Q1 100% Q2 98.7% Q3 96.3% Q4 97.3%	Achieved Q1 100%, Q2 95.8%, Q3 96.7%, Q4 100%
Access to Cancer Services - All Cancers: two month GP urgent referral to treatment:	62 day general	>=85%	Achieved Q2 87.7% Q3 85.8% Under achieved: Q1 82.3% Achieved Q4 – 86.7%	Achieved: Q1 87.1%, Q3 88.7% Under achieved: Q2 76.7% Q4 82.4%	Achieved: Q1 86.6% Q2 89.4% Q3 85.2% Q4 86.6% Annual percentage Excluding rare cancer 86.5%	Achieved Q1 85.1%, Q2 89.5%, Q3 85.5%, Q4 83%
	62 day general (Including Rare Cancers)	No performance Standard	Not applicable	Not applicable	Achieved: Q1 86.8% Q2 89.4% Q3 85.4% Q4 86.7% Annual percentage 87.1%	Not applicable
	62 day screening	>=90%	Achieved: Q2 90.9% Under achieved: Q1 86.6% Q3 82.0% Q4 – 89.8%	Achieved: Q1 95.1%, Q2 92.9% Under achieved: Q3 74.2% Q4 74.4%	Achieved: Q1 89.1% Q2 91.7% Q3 90.1% Q4 94.7%	Achieved Q1 94%, Q2 91.3%, Q3 98%, Q4 96.6%
	62 day upgrade	90%	Q2 94.9% Q3 93.0% Under achieved: Q1 89.4% Q4 – 89.4%	Achieved: Q1 93.3%, Q3 92.3% Q4 95.8% Under achieved: Q2 86.5%	Achieved: Q1 85.4% Q2 95.9% Q3 93.6% Q4 92.6%	Achieved Q1 91.4%, Q2 90.9%, Q3 92.2%, Q4 95.6%
	Breast Symptoms – 2wk wait	93%	Achieved: Q1 94.8% Q3 95.9% Under achieved: Q2 90.4% Achieved Q4 – 99.3%	Achieved: Q1 96.6%, Q2 93.7%, Q3 94.3% Q4 98.0%	Achieved: Q1 94% Q2 94.8% Q3 96.7% Q4 93%	Achieved Q1 93.8%, Q2 96.5%, Q3 97.2%, Q4 93.4%

Data comes from the NHS Information Centre Portal

National Targets and Minimum Standards	Target	Target 2015/16	2015/16	2014/15	2013/14	2012/13
Cancelled Operations	Percentage of Operations Cancelled	0.8%	Achieved 0.75%	Under Achieved 1.76%	Under Achieved 0.92%	Achieved 0.45%
	Percentage of Operations not treated within 28 days	0%	0%	Achieved 0%	Achieved 0%	Achieved 0%
Access to Treatment	18 week Referral to Treatment (Admitted Pathway)	>=90%	Under Achieved 88.7%	Under-achieved 88.75%	Achieved 92.02%	Achieved 94.66%
	18 week referral to treatment Patients on an incomplete pathway	>+92%	Achieved 95.11% (A)	Achieved 92.03%	Achieved 94.78%	Achieved 94.37%
	18 week Referral to Treatment (Non-Admitted Pathways [including Audiology])	>=95%	Achieved 95.41%	Achieved 95.24%	Achieved 96.78%	Achieved 97.51%
Infection Control	Incidence of MRSA	0	5 Not Achieved	3 (Target 0)	1 (target 0)	3 (target <=3)
	Incidence of Clostridium Difficile	40	43 Not Achieved	54 (Target <=28)	26 (target <=29)	28 (target <=51)
Access to A&E	Total time in A&E	95% of patients to be admitted, transferred or discharged within 4hrs	Under Achieved 92.06% (A)	Achieved 96.15%	Not updated on National website as yet	Achieved 96.61%
Access to healthcare for people with a learning disability	The Trust provides self certification that meets the requirements to provide access to healthcare for patients with a learning disability	N/A	Achieved	Achieved	Achieved	Achieved
Where needed the criteria for the above indicators has been included in the Glossary of Terms						

Data comes from the NHS Information Centre Portal

NB. For all indicator figures where the Trust are providing limited assurance, they are clearly referenced with (A)

3.4 Statements from Local Clinical Commissioning Groups (CCGs), Local Healthwatch Organisations and Overview and Scrutiny Committees (OSCs) –

3.4.1 Statement from Blackpool Clinical Commissioning Group - dated 24/05/2016 and Fylde & Wyre Clinical Commissioning Group – dated 19/05/2016

Blackpool Clinical Commissioning Group (CCG) Statement on the 2015/16 Quality Account:

Blackpool CCG as Commissioner for Blackpool Teaching Hospitals NHS Foundation Trust's services welcomes the opportunity to comment on the Quality Account for 2015/16 and are pleased to acknowledge that there is a clear focus on the key quality elements and Blackpool Teaching Hospital NHS Foundation Trust has referenced its quality strategy 2015/18. The Quality Account is concise given the breadth of information it is required to reference.

We note the improvements in (SHMI) hospital mortality rates in 2015/16; however despite improvements the Trust continue to be an outlier in this respect. Blackpool Teaching Hospitals NHS Foundation Trust needs to maintain its focus on mortality in order to see the Hospital Mortality Rates reduce further. Blackpool CCG will continue and are committed to supporting further improvement in 2016/17 in specific care pathways such as stroke and sepsis. We welcome the continued review and monitoring of internal clinical pathways and support the implementation of reducing mortality from Chronic Disease as a priority in 2016/17.

It is disappointing to note that the Trust exceeded the 2015/16 trajectories for C Difficile infections and MRSA cases attributed to the Trust. Blackpool CCG and Fylde and Wyre CCG have worked collaboratively with the Trust to undertake post infection reviews of each incidence of Health Care Acquired Infection (HCAI). A health economy approach was maintained during 2015/16 in order to promote reduction in HCAI using a lessons learned approach. Public Health England has set the same trajectory for 2016/17 for the Trust (a maximum of 40 C Difficile cases). Blackpool CCG will continue to work with all stakeholders including local GPs to develop and implement joint improvement strategies and plans for the benefit of the Fylde coast population.

As commissioners we are pleased to see that there has been a 21% decrease in reported stage 3 and 4 pressure ulcers in 2015/16 and note that the Trust included all the Community related pressure ulcer incidents in this data. We recognise the effort and focus the trust has placed on achieving this reduction and associated improvement in the quality and safety of patient care. We fully support the Trusts review of pressure ulcer lessons learned and actions to reduce the incidence of newly acquired pressure ulcers.

The CCG is pleased to note that the Friends and Family Test ratings at the hospital are good and have achieved above the national average rates with many patients recommending the Trust to their friends and family. We would however like to see an increase response rate in some Trust services. The CCG recognises the activities led by the internal patient relations team within the Trust to promote improvement in patient experience and patient satisfaction. The "Tell Us" campaign is a positive approach to get real time feedback.

Blackpool Teaching Hospital NHS Foundation Trust continues to be a high reporter of patient safety incidents together with an associated decrease in reported levels of harm. The CCG view is that this is a positive indicator which clearly demonstrates an organisation with an open transparent culture, and clear and accessible reporting mechanisms. We note the activity to prevent falls has had a positive in year impact (6% reduction) and look forward to seeing the 2017 trajectory of 20% reduction being fully met. We do commend the ongoing work to promote harm free care within the Trust particularly the work to reduce falls.

We recommend future Quality Accounts include any Never Events.

Our comments are based on a draft version of the Quality Account 2015/16; responses to all our data queries were not fully available at the time of comment. In summary; Blackpool CCG are satisfied that on the whole this is an accurate quality account of progress in a challenging year.

24.5.2016

The Fylde and Wyre Clinical Commissioning Group holds a contract with Blackpool Teaching Hospitals NHS Foundation Trust and welcomes the opportunity to comment on the Trust's 2015/16 Quality Account.

As commissioners, we are pleased to see that through sustained effort over several years, the trust has achieved its target for reducing grade 3 and grade 4 pressure ulcers and is maintaining efforts to address grade 2 pressure ulcers. This is contributing to the Trust being close to target for the bundle of measures which make up the Harm Free Care target. It would be helpful in future publications if in-year achievement against milestones on trajectories to longer term targets could be stated and explained.

The utilisation of harm free care measures in community and maternity services evidences the Trust's drive for integration of care across community and acute settings. It will be necessary to see how the work of the Falls Risk and Response Nurses and the Tissue Viability Nurses has been embedded in general clinical practice across the hospital and community services to maintain effective falls and pressure ulcer avoidance.

Involvement of a wide range of professionals, Governors and patient experience representatives in the oversight of the Sign Up to Safety Campaign is good practice and should provide beneficial scrutiny and challenge, in being assured about real progress with pathway compliance for example.

The CCG continues to closely monitor and work with the Trust to address the on-going concerns about mortality. The Trust has identified that compliance with clinical pathways eg Sepsis and Acute Kidney Injury has been a concern over the year and hence further work is being undertaken with regard to pathway compliance and taking up every opportunity to care.

It is pleasing to note that the Trust has provided practical tools and training to enable the workforce to understand the spirit behind the Duty of Candour regulation as well as how to evidence when and how the duty has been fulfilled. This can be sustained through the approach to disseminating and applying lessons learned from incidents which are reported.

The CCG is working to support a reduction in health care associated infections across health care settings and recognises that the Trust operates a robust approach to reviewing and learning from each infection experienced by a patient in their care. It is disappointing that the target of cases has been breached and the CCG will continue to work with the Trust and the wider Lancashire health economies to understand and address contributing factors.

Patient feedback and patient confidence in local services are relevant to commissioner decisions. Hence the 95% of patients being likely to recommend the service and the positive in-patient survey results are reassuring. The Always Event pilot is particularly important, as it links to patient knowledge and confidence when leaving the hospital. It is hoped this approach can be rolled out to other areas of the hospital.

3.4.2 Statement from Governors dated 11/05/2016

In common with almost all NHS Hospital Trusts the context within which Blackpool Hospitals Trust operates has proved increasingly difficult over the last year. The numbers of patients attending A&E continues to increase. Funding is continually being squeezed. There are National shortages of qualified Staff and recruitment and retention is a major issue.

Against this background it is a credit to the hard work and commitment of Staff that standards of care in many areas have been maintained or improved. Mortality, as measured by an indicator called SHMI, has continued to improve; patients rate the care they receive very positively; a recent CQC inspection noted many commendable improvements including Maternity. All this has been achieved whilst achieving major reductions in costs.

However in some areas such as A&E waiting times, compliance with clinical pathways and the number of MRSA and CDiff infections, performance has deteriorated. Some aspects of cancer care need improvement.

The Governors are pleased that the Board has undertaken major reviews of both its Quality Strategy and the overall strategic direction of the Trust so as to better meet the increasingly challenging future requirements. Wide Staff involvement in these reviews is warmly welcomed.

It will be important in the next few years to closely monitor that the ambitious changes which the Trust is embarking on deliver the required cost savings and quality and safety improvements. Governors will welcome feedback from patients and members on their experience of care from the Trust.

3.4.3 Statement from Local Healthwatch Blackpool dated 25/05/2016

Healthwatch Blackpool
Empowerment
333 Bispham Road
FY2 0HH
Tel 0300 32 32 100
hello@healthwatchblackpool.co.uk
www.healthwatchblackpool.co.uk

Healthwatch Blackpool would like to thank the Trust for providing the opportunity to view and comment upon their Quality Accounts Report 2015/16. Healthwatch Blackpool welcomes such a detailed and comprehensive report. As an organisation we are committed to our continued support for the Trust in delivering quality healthcare whilst advocating with, for and on behalf of those who use these services.

Maternity services and outpatient services have seen many challenges in recent years and the findings of our reports and visits to these services reflect what is included within this report. Many people we spoke to were very satisfied with the improvements to the maternity departments and told us they were always treated with dignity, care and praised the passion of the staff. The emphasis on patient and staff relations has been felt by many who use the hospital and its outpatient services. We were often told by the people during our engagement days that the location of the hospital, the parking facilities and the welcoming navigators at the entrance were all important reasons for choosing to visit Blackpool Teaching Hospitals. Healthwatch Blackpool

is keen to continue its close work with the hospital and will endeavour to build and develop effective relationships with key personal in order us to provide an open conduit for patient feedback.

We look forward look forwards the coming year and working with the Trust, with patients and the wider public to achieve an excellent person centred local health service.

Healthwatch Blackpool Manager

3.4.4 Statement from Local Healthwatch Lancashire date 10/05/2016

Quality Account 2015/16 – Stakeholder Feedback
Blackpool Teaching Hospitals NHS Foundation Trust

The basic structure of the Quality Accounts are clear with a contents page and the sections clearly identified. The summary of key areas of activity one page overview of progress is positive. The section which follows develops each of the projects in more detail which is helpful in developing the narrative. In terms of content the use of interactive technology to broaden feedback on the Family and Friends test(in addition to a paper based survey) is very positive.

For each of the quality improvement projects set out in Section 2.1, there is a quick glance box setting out "What", "How Much", "Outcome" and "Progress" – this language doesn't always translate very well against the figures in these boxes and it is difficult to identify how much progress had been made against an indicator / target. Context may be useful in these projects too – in particular setting out the year's performance against any previous data to show a trend ie, is performance on falls better than in previous years; which areas have the trust done better on than expected; which areas remain "hot spot" issues.

Under the section on patient safety, It would be useful to show how these breakdown, and how this compares against previous years. Which areas are continuing to show as high risk or emerging risks and what mitigation plans are in place going forward into next year's priorities? Tell Us Campaign – would welcome examples (individual stories from patients / carers and staff) where feedback has influenced or re-shaped services.

The Always Event programme described in page 19 – sounds like this has been received very well.

Digital technology – a fuller description of the Trusts priorities and areas for development both in terms of patient and carer engagement around quality of services, but also in terms of delivering more effective services, eg the role of technology in clinical pathways .

In terms of PROM (Patient Reported Outcome Measures) it would be useful to include a description of any plans by the Patient Experience Department to improve participation and patient response rates.

We would urge the Trust to maintain and develop in practical ways its contribution to Healthier Lancashire and the Transformation and Sustainability Plan for Lancashire and South Cumbria as the best way to improve outcomes for patients in the context of tight resources via 'whole system' change.

Healthwatch Lancashire has developed a 'care circle' approach, where several patients/service users share their experiences without the presence of staff, which we believe provides an additional approach to enrich individual patient stories.

Davina Hanlon, Non-Executive Director
Mike Wedgeworth, Chair
Sheralee Turner-Birchall, Chief Officer
Healthwatch Lancashire

10th May 2016

3.4.5 Statement from Lancashire Health Scrutiny Committee

The Lancashire Health Scrutiny Committee will not be providing a statement this year

3.4.6 Statement from Blackpool Heath Scrutiny Committee dated 04/05/2016

Quality Account Response – LCFT

The Resilient Communities Scrutiny Committee welcomes the opportunity to provide comments on the 2015/16 Blackpool Hospitals Foundation NHS Trust Quality Account and would like to thank the Trust for their continued engagement with the Committee and attendance at meetings over the previous 12 months.

The Committee receives monthly patient experience reporting from the Trust, which is invaluable in assisting Members to understand how patients view services provided by the Trust. In addition regular reports are also received on topics of interest including the results of the Care Quality Commission inspection undertaken in 2015. The Committee would like to build on the work with the Trust and develop the type and quality of information it receives throughout the year focussing on achievement of priorities and in particular considering the long term priority of reducing mortality rates and performance in this area.

Members note that a key priority of the Trust is to achieve honesty and candour and appreciate that this is a difficult cultural change for many organisations. However, it is exceedingly important and the Committee would like to highlight the Francis report which raised concerns regarding the honesty of reporting to local Scrutiny Committees. The Committee would like to continue to build their relationship with the Trust to ensure that areas of concern are openly discussed and recorded in order to ensure the best care for patients.

Resilient Communities Scrutiny Committee, Blackpool Council

3.5 Statement of Directors' Responsibilities in Respect Of the Quality Account

The Board of Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 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 NHS 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 2015/16* and supporting guidance*:*

- 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 2015 – March 2016
  - Papers relating to Quality reported to the Board over the period April 2015 – March 2016;
  - Feedback from the commissioners - Blackpool Clinical Commissioning Group dated 24/05/206; and Fylde & Wyre Clinical Commissioning Group – dated 19/05/2016
  - Feedback from Governors dated 11/05/2016;
  - Feedback from Local Healthwatch organisations – Local Healthwatch Blackpool dated 22/05/2015
  - Feedback from the Blackpool Council's Health Scrutiny Committee dated 04/05/2016
  - The Trust's Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2015 – March 2016;
  - The 2015 national patient survey published Data not available
  - The 2015 national staff survey published 2015;
  - Independent Auditors Report to the Council of Governors of Blackpool teaching Hospitals NHS Foundation Trust on the Annual Quality Report 12/04/2016;
  - The CQC Intelligent Monitoring Report dated May 2015 (No more reports received)

- 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: Chairman:

Date: 25th May 2016 Ian Johnson

3.6 Independent Auditor's Report to the Council of Governors of Blackpool Teaching Hospitals NHS Foundation Trust on the Annual Quality Report

Head of Internal Audit Opinion

2015/16 Head of Internal Audit Opinion to Blackpool Teaching Hospitals NHS Foundation Trust

Basis of opinion for the period 1 April 2015 to 31 March 2016

Our internal audit service has been performed in accordance with KPMG's internal audit methodology which conforms to Public Sector Internal Audit Standards. As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) or International Standard on Assurance Engagements (ISAE) 3000. PSIAS require that we comply with applicable ethical requirements, including independence requirements, and that we plan and perform our work to obtain sufficient, appropriate evidence on which to base our conclusion.

Roles and responsibilities

The Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The Assurance Framework should bring together all of the evidence required to support the AGS.

The Head of Internal Audit (HoIA) is required to provide an annual opinion in accordance with Public Sector Internal Audit Standards, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the system of internal control). This is achieved through a risk-based programme of work, agreed with Management and approved by the Audit Committee, which can provide assurance, subject to the inherent limitations described below.

The purpose of our HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist the Board in the completion of its AGS, and may also be taken into account by other regulators to inform their own conclusions.

The opinion does not imply that the HoIA has covered all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and Management-led Assurance Framework. As such it is one component that the Board takes into account in making its AGS.

Opinion

Our opinion is set out as follows:

- Basis for the opinion;
- Overall opinion; and
- Commentary.

The basis for forming our opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes;
- An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of these areas; and
- An assessment of the process by which the organisation has assurance over its registration requirements of its regulators.

Our overall opinion for the period 1 April 2015 to 31 March 2016 is that:

Significant with minor improvements assurance can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

The commentary below provides the context for our opinion and, together with the opinion, should be read in its entirety.

Our opinion covers the period 1 April 2015 to 31 March 2016 inclusive, and is based on the four core and five strategic audits that we completed in this period.

The design and operation of the Assurance Framework and associated processes

Overall our review found that the Trust's Assurance framework is founded on a systematic risk management process and provides appropriate assurance to the Board.

The Assurance Framework reflects the organisation's key objectives and risks and is reviewed on a quarterly basis by the Board following review by the Risk Committee. It was last reviewed by the Board on 27th January 2016.

It should be noted that despite our positive conclusion around the overall framework for seeking and receiving assurance around strategic risks, we have deferred two of the strategic reviews which formed part of our 2015/16 Internal Audit Plan into 2016/17. These are the Sustainability review and the Clinical Engagement Review. The delay has been at the request of Trust management, and reflects the greater assurance which management feel would be provided by delaying the reviews until the new Trust strategy and governance structures have been fully embedded.

The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year

In 2015/16, we issued one report that provided 'partial assurance with improvements required'. None of our reports had a conclusion of "no assurance".

The report receiving only partial assurance related to Discharge Process.

This does not prevent us from issuing an overall opinion of "significant assurance with minor improvements" as the organisation is implementing the recommendations raised as a result of our work to address the issues identified.

One of our strategic reviews covered Medical Device. As agreed with the interim Chief Executive, the format of this document is an action plan which we have worked to develop with management rather than a traditional assurance report. As the report does not provide a level of assurance it does not impact on our annual opinion.

In our 2015/16 reports, we did not raise any high risk recommendations.

KPMG LLP

KPMG LLP, Chartered Accountants, Manchester 12 April 2016

4 Appendices

Appendix A

Title	Actions taken following National clinical audit
Paracetamol overdose (care provided in Emergency Departments - College of Emergency Medicine)	Audit results identified comparable performance in accordance with MHRA guidance Capability assessment by Senior doctor at triage available 09.00 till 22.00 Monday to Friday. Monday to Friday 09.00 to 22.00 consultant to triage training of triage nurses. The emergency department will continue to work at improving the availability of Parvolex for patients at time of need through responsive prescribing and administration within the team
Coronary angioplasty (subscription funded from April 2012) Continued from 12/13	Above National average - No actions required. Reports disseminated throughout Division for information and reflection, will continue to participate in National Audit
Adult cardiac surgery audit (ACS)	Audit results discussed at Divisional meeting,
2012 National Comparative Audit of the use of Anti D	Notification of blood transfusion status added to the electronic discharge. Ongoing education in awareness amongst staff around the need for consent to transfusion
Diabetes (Paediatric) (NPDA) (14/15)	Audit findings from national audit discussed at speciality audit meeting. Agree to continue participation in the national audit.
National Post-Partum Haemorrhage Audit 2014	Early recognition of PPH & blood loss estimation, Early escalation to seniors following accurate assessment , PPH management guidance issued OBS/GYNAE/GUID/113
National Care of the Dying Audit round 4	Access to specialist support for care in the last hours or days of life available for all Divisions across the Trust which includes access to specialist support for care in the last hours or days of life. Highlight importance of Healthcare professional's discussions with patient and relative/friends regarding recognition of dying ongoing Transform Training, amend staff survey to Include question about confidence in having these discussions. Review of the number of assessments undertaken in patient's last 24 hours of life to be included in future service evaluation / audits

Appendix B

Title	Actions taken as a result of local clinical audit
Unscheduled Care	
NCEPOD Study - Tracheostomy study 2013 - A review of care received by patients who underwent a tracheostomy	Tracheostomy insertion and care documentation revised and implemented .
Compliance with NICE CG101 Management of COPD	Production of a new COPD clerking proforma is underway. Respiratory Nurse now designated 'COPD Champion'. Education has been introduced at induction and at weekly respiratory educational meetings.
Management of AF post stroke/TIA	Anti-coagulants to be prescribed to AF patients with stroke or TIA unless contraindicated treating Guidance implemented
Emergency Oxygen Audit	Daily review of prescription chart on ward round to include review of oxygen therapy.
Upper GI follow up for Gastric Ulcers	Sub section added to endoscopy report
Compliance with NICE CG 100 Alcohol Disorders and CORP/PROC/487	Alcohol Liaison Nurse Service ensure appropriate care is maintained using the referral system.
Audit of clinical quality indicators of Acute Medical Unit	Introduction of Advanced Nurse Practitioners to AMU. Recruitment in progress for increased consultant numbers on the ward. Plans approved for Triage area in AMU.
Biologic use of Ankylosing Spondylitis	No actions needed
Monitoring and dose adjustment of therapeutic low macular weight heparin in patients with renal impairment for venous thromboembolism	Alteration of VTE treatment poster by moving the section on renal impairment to the top of the poster to highlight the importance of calculating the creatinine clearance, Education of junior doctors focusing on foundation programme
Treatment with immunosuppressant/anti-TNF's in Inflammatory Bowel Disease	Pro forma connected to each patient with IBD filled in and kept in each patient notes by Gastro department.
Alcohol Assessment Audit	AMU staff reminded of the importance of recoding alcohol misuse. Staff reminded at induction about the importance of recording alcohol misuse.
Scheduled Care	
Is prescribing of post-operative oxygen therapy in line with trust guidelines	Ongoing education to Anaesthetists in prescribing oxygen
To monitor compliance with ETCO2 monitoring in theatre recovery	Capnography teaching workbook compiled for all ODP's
Audit of post-operative pain management in paediatric surgical patients	Clarify local anaesthetic use in tonsillectomies this is not used because of 2 reasons -
NSTEMI and medical therapy	Education to GPs and clinicians .
Cardiac CT in stable chest pain patients	Protocol for ordinary cardiac CT developed. New guidance due April 2016
Are we complying with local and national guidelines for the surgical management of Otitis Media Effusion (OME)	100% Compliance no actions needed.
Permanent pacemaker implantation post cardiac surgery	Above national average, no actions required.
Endoscopic stapling pharyngeal pouch	Liaison with booking department to ensure correct coding attached from the point of listing.
Endoscopic Dacryocystostomy	Audit compliance above national average no actions taken.
Time interval between decision to operate and operation in urgent paediatric surgical patients	Intervals will be documented
Visual and anatomical outcome of intravitreal ozurdex for retinal vein occlusion at BVH	100% compliant with our management and audit
Baseline audit of Surgical Complications	Assisted operating restrictions lifted
Audit of indications and outcomes	Ongoing education at Ophthalmology Grand Rounds

of MRI/CT Scan	
Perioperative temperature management	Anaesthetic record modified promoting the continuation of the monitoring of temperature intra-op.
Audit of prevention of post-operative nausea and vomiting in paediatric surgical patients	Guidelines disseminated when released
NW Regional Functional Female urology Audit	Action cannot be implemented due to job planning issue - Risk assessment completed
Implementation of NICE guidelines for wet ARMD treatment	All targets met
Clinical Support	
Histopathology reports of adult renal cell carcinoma	Latest pro-forma to be utilised. Use of electronic dataset/masterlab upgrade.
Audit of Histopathology reporting of Oesophageal biopsies for diagnosis and surveillance of Barratt's Oesophagus in compliance with the BSG guidelines	Second review documented in all reports.
Histopathology reporting of Endometrial cancers in resection specimens	Ongoing education of clinicians to provide accurate clinical information and use of pro-forma style reporting at departmental service review meeting.
Audit of Cutaneous melanoma reporting in keeping with KPI's published by RCP	Reporting pro-forma available in the cut up room and with consultants. Clinicians informed of the need to provide accurate information.
Opioids in Pallative Care - CG140	Trust policy being developed to cover the whole of the Trust including community. Appropriate Lead on behalf of the Trust nominated
Safe and Secure handling of medicines - ordering, receipt, storage and distribution on wards and departments	Results discussed at medicines Management Committee (MMC) and disseminated to Divisional Clinical Directors,
NPSA15 (National Patient Safety Agency)	Ongoing education from Pharmacy to Ward Managers on ensuring staff are aware of and follow Trust Policies and Procedures in the safe management of controlled drugs
Re-audit Reducing harm from omitted and delayed medicines in Hospital/correct use of omission codes	Audit undertaken by Pharmacy - results disseminated to wards who will cascade results and arrange training.
Safe and Secure handling of medicines - ordering, receipt, storage and distribution on wards and departments	Continuous monitoring of temperature of medicines storage area, medicine cupboards clearly labelled, area clean and tidy.
Appropriate use of CT Coronary Angiogram following a CT calcium score >400	Testing reviewed for confirmation
Appropriate use of CT Coronary Angiogram following a CT calcium score of 0	Testing reviewed for confirmation
Families	
Regional audit of women undergoing LLETZ procedure	Colposcopy pro-forma on line system will be available.
Management of Multiple Pregnancy & Birth	Use of multiple pregnancy proforma encouraged, twin pregnancy Hb at 20 and 28 weeks now documented on proforma
Audit of management of adnexal mass	Education to all doctors undertaken in documentation of BMI and RMI and Intra-operative comments on internal organs
Induction of Labour	ongoing education in adherence to clinical process and documentation. Maternity dashboard reviewed.
Re-audit of the Management of severe pre-eclampsia	Results and management plans reviewed
Management of 2nd stage caesarean section	Ongoing education at induction to new registrars
Audit of Consultant involvement in intrapartum care of women on delivery suite	Raised awareness of deficiencies in Consultant presence, skill mix on DS and availability of ward round stickers
Shoulder dystocia 2015	Education of staff to be included on Drills day, reminder poster from guidelines. Add diagnosis question to Euroking.
Termination of pregnancy	Trust guidelines updated.
Consultant involvement in the	Trust guidelines updated

intrapartum care of women on delivery suite	
Monitoring and management of coeliacs disease following diagnosis	Testing to be added to new diabetic routine bloods, with further screening only routinely offered if positive. New guideline to further rework the screening and diagnosis of celiacs ratified and in use.
Diagnosis and Management of Children with DKA	Ongoing education in DKA Calculator use, Long Acting Insulin use and documentation of neuro obs.
Management of orbital and peri-orbital cellulitis un children stage 2	Ongoing training of guidelines
Documentation of x-ray results in the notes	Ongoing education of junior doctors in reviewing requested x-ray and documenting on the x-ray sticker, dated, timed and signed.
Management of low grade cervical smears	Colposcopy guidelines updated
Routine postnatal care of women and their babies	Continue with ongoing development of NIPE system
Corporate	
Health Records Keeping Standards - Basic Clinical Record Keeping	Audit pro-forma designed audits to be undertaken on specialities monthly
Retention, Disposal and Destruction of Acute Health Records	Policy and guidelines reviewed and disseminated
Best Practice Undertaking clinical audit	Policy reviewed and disseminated
Health records folder location audit	KPI monitored and reported
To review the clinical audit process within the Trust as per recommendations in KPMG External audit 'Quality Assessment'	National reports to be circulated to Divisional Management Teams when published via the Clinical Audit & Effectiveness Department
Isolation audit	Ward managers/Matrons to re-iterate Trust procedure
Accuracy of MUST screening on initial contact	To be replaced by the national BAPEN nutritional care tool audit.
Resuscitation trolley audit	No actions required
ALTC	
Dental Audit	Practice has a nominated lead responsible for Infection control and decontamination. Practice and performance reported via Leads
Improving safeguarding for young people who attend sexual health services	Focus Group to be set up to review /rewrite Fraser Assessment to reflect recommendations from audit.
Health Promotion in Hospitals	HP in hospitals promoted Trust wide
Peer records audit for pressure ulcer management standards	Daily assessment in place and monitored .

Appendix C

Table 1: Glossary of Abbreviations	
Abbreviation	**Meaning**
SUTS	Sign up to Safety
NICE	National Institute Health and Care Excellence
CAUTI	Catheter Associated Urinary Tract Infection
WHO	World Health Organisation
NHS	National Health Service
AKI	Acute Kidney Injury
CLIP	A combined quarterly Complaints, Litigation, Incidents and Patient Relations Service report
IV	Intravenous
CCG	Clinical Commissioning Group
CDI	Clostridium Difficile Infection
SMART form	Signs, Medication, Appointments, Requirements, Time
PROMS	Patient Reported Outcome Measures
HED	Healthcare Evaluation Data
NEL Admissions	Non Elective Admissions
IAPt	Improving Access to Psychological Therapies
URL	Uniform Resource Locator (reference to a resource on the intranet)
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
GP	General Practitioners
MRSA	Methicillin Resistant Staphylococcus Aureus
NCEPOD	National Confidential Enquiries into Perinatal Outcomes of Death
NICE	National Institute for Health and Care Excellence
PbR	Payment by Results
SHMI	Summary Hospital Level Mortality Indicator
SUS	Secondary Uses System
VTE	Venous Thromboembolism
RCP	Royal College of Physicians

Table 2: Glossary of Terms	
Abbreviation	**Glossary of meaning**
Amber Care Bundle	A group of interventions which are proven to provide best care for patients whose recovery is uncertain and are at risk of dying in the next 1 or 2 months.
Aseptic Non Touch Technique	A specific type of technique to protect key sites and key parts of a patient from microorganisms which may be transferred from a healthcare worker or the environment to a patient.
Butterfly Scheme	National scheme using Butterfly emblem to identify patients with a diagnosis of dementia or cognitive impairment to highlight specialist needs.
Catheter associated urinary tract infection	An infection which it is believed to have started by a urinary catheter.
Clinical	Relating to the care environment.
Comfort boxes	A box of tools to assist with supporting cognitive impairment and provide cognitive therapy and diversional therapy.
Commissioners	Group responsible for most healthcare services available within a specific geographical area
Clostridium Difficile	Clostridium Difficile (C. diff) is a bacterium that is present naturally in the gut. 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.
CQUIN	Commissioning for Quality and Improvement. This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.
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
Friends and Family Test	A test that provides us with a simple, easily understandable way to obtain patient feedback to pinpoint areas for improvement Further information can be located at the following link: http://transparency.dh.gov.uk/2012/11/28/nhs-friends-and-family-test
Healthcare Evaluation Data (HED)	Enables users to monitor/compare and evaluate hospital performance indicators across different hospital trusts nationally.
Methicillin Resistant Staphylococcus Aureus	MRSA stands for Methicillin-Resistant Staphylococcus Aureus. It is a common skin bacterium that is resistant to some antibiotics. Many people carry this bacteria without developing an infection. MRSA bacteraemia – An MRSA bacteraemia means the bacteria has infected the body through a break in the skin and multiplied, causing symptoms.
Mortality	Mortality relates to death. In health care mortality rates mean death rate.
Monitor	Monitor was established in 2004 and authorises and regulates NHS Foundation Trusts. Monitor works to ensure Foundation Trusts comply with the conditions they signed up to and that they are well led and financially robust.
National Johns Campaign	National campaign to promote the right of families and carers of people with dementia to be allowed to remain with them in hospital for as many hours as they are needed
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/
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 caring for people in a safe environment Available at:http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance

Glossary of Terms (continued)	
Abbreviation	**Glossary of meaning**
NICE	National Institute of Excellence. An independent organisation that provdes national guidance and standards on the promotion of good health and the prevention nd treatment of ill health.
Organisational Strategic Framework	The organisations process of defining it strategy, or direction, and making decisions on allocating its resources and priorities to achieve the strategy.
Patient Reported Outcome Measures	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
Percentage of admitted patients risk-assessed for Venous Thrombo-Embolism	Location of the latest published data can be accessed from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_131539
Quality Strategy	A document which outlines the aims and objectives of the Trust relating to patient safety and improving quality
Quality Improvement	A formal approach to the analysis of performance and systematic efforts to improve it resulting in better outcomes for patients, better systems performance and better staff development.
Registration in the RCP National Audit of Dementia Care	A Nationally led audit to compare care provision for patients cared for in a hospital setting who have a diagnosis of dementia
Rem Pods	These are pop up reminiscence rooms used to turn any care space into a therapeutic and calming environment
Root Cause Analysis	A method of problem solving that tries to identify the root causes of issues and why they are happening
Safety Thermometer	A point of care survey which is used to record the occurrence of four types of harm (pressure ulcers, falls, catheter associated urinary tract infection and venous thromboembolism)
Sign up to Safety Campaign	This is a national campaign and unified programme for patient safety across the NHS in England
Summary Hospital Level Mortality Index	The Summary Hospital-level Mortality Index (SHMI) is a system which compares expected mortality of patients to actual mortality. 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
Venous Thrombo embolism (VTE)	Venous Thromboembolism (VTE) is the term used for deep vein thrombosis (DVT) and Pulmonary Embolism (PE). A DVT is a blood clot that forms in a deep vein. Sometimes the clot breaks off and travels to the arteries of the lung where it will cause a pulmonary embolism (PE).
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.

Table 3: Glossary of Terms	
Abbreviation	**Glossary of meaning**
Clostridium. Difficile Target	Number of patients identified with positive culture for C. Difficile
Rate of Clostridium Difficile	Location of the latest published data can be accessed from: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/ClostridiumDifficile/EpidemiologicalData/MandatorySurveillance/cdiffMandatoryReportingScheme/ The following information provides an overview on how the criteria for measuring this indicator has been calculated: • Patients must be in the criteria aged 2 years and above • Patients must have a positive culture laboratory test result for Clostridium Difficile which is recognised as a case • Positive specimen results on the same patient more than 28 days apart are reported as a separate episode • Positive results identified on the fourth day after admission or later of an admission to the Trust is defined as a case and the Trust is deemed responsible
MRSA Target	Number of patients identified with positive culture for MRSA bacteraemia
Rate of MRSA	The following information provides an overview on how the criteria for measuring this indicator has been calculated: • An MRSA bacteraemia is defined as a positive blood sample test for MRSA on a patient (during the period under review); • Reports of MRSA cases includes all patients who have an MRSA positive blood culture detected in the laboratory; whether clinically significant or not, whether treated or not; • The indicator excludes specimens taken on the day of admission or on the day following the day of admission; • Specimens from admitted patients where an admission date has not been recorded or where it cannot be determined if the patient was admitted, are attributed to the Trust; and • Positive results on the same patient more than 14 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where the specimens were taken.
Maximum 62 days from urgent GP referral to first treatment for all cancers	The following information provides an overview on how the criteria for measuring this indicator has been calculated: • The indicator is expressed as a percentage of patients receiving their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer; • An urgent GP referral is one which has a two week wait from the date that the referral is received to first being seen by a consultation (see http://www.dh.gov.uk/prod-consum-dh/groups/dh-digitalassets/documents/digitalassset/dh-103431.pdf); • The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait); • The clock start date is defined as the date the referral is received by the Trust; and • The clock stop date is defined as the date of first definitive cancer treatment as defined in the NHS Dataset Change Notice (A copy of this can be accessed at: http://www.ish.nhs.u/documents/dscn/dscn2008/dataset/202008.pdf. In summary this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.
Rate of patient safety incidents and percentage resulting in severe harm or death	Location of the latest published data can be accessed from: http://www.nrls.npsa.nhs.uk/resources/?entryid45=132789

Waiting times and the 18 weeks referral to treatment (RTT) pledge	The NHS Constitution gives patients the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible Patients have the legal right to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral, unless the patient chooses to wait longer or it is clinically appropriate that the patient wait longer.
4 hour A&E waiting times	The maximum four-hour wait in A&E is a key NHS commitment and is a standard contractual requirement for all NHS hospitals. In addition, NHS England has an added contractual requirement covering NHS hospitals that no A&E patient should wait more than 12 hours on a trolley.